Des Spence on the exploitation of non-communicable disease, p 51

PERSONAL VIEW **Nadeem Moghal**

I don't need my own office

I recently returned from an 18 month secondment from my institution to a fantastic facility rebuilt through the private finance initiative. A separate office block for consultants and other clinical staff is still being built. My existing office is in a Victorian building due for demolition. It has a desk, a computer, two filing cabinets, a shelf of dusty books untouched for years, and even a window. I have been in my office twice in the past three months: once to get some whiteboard markers and once to get the charger for my pager.

When we were consulted over the building's replacement, one contentious matter was whether we should have open plan or private, individual offices. All of us were exercised about the potential loss of private professional and personal space. I thought I needed my private place. I had collected there all the paraphernalia that meant something to me and signalled something to those who came into my space. Then there was the need for confidential conversations with patients, colleagues, and trainees, and for somewhere to concentrate. Open plan offices have lower building and maintenance costs and non-clinical managers also argue that open plan offices encourage team behaviour.

Open plan offices are common in other industries. How well they work is hard to gauge because the definition of open plan varies. The arguments for and against have remained unchanged over the decades, and moving the argument away from the individual to the team or organisation remains challenging.

I decided to see if I could function without any office. I sometimes use a desk with a computer in an adapted corridor next to the secretaries. This works well because I have immediate access to the people I need. The space is part of a thoroughfare between consultants' traditional offices, the printer, photocopier, toilets, and seminar room. I get distracted by colleagues passing, but after their initial queries about why I am working there, our conversations turn to clinical questions, projects, or just small talk. I come to this space for a purpose, and when I complete my tasks I move on.

When I am on call I spend almost the whole day in the clinical facility. I move between wards, use several desk spaces and computers, and interact widely and often with other staff who are doing clinical work. I am much more accessible, and I react more promptly to referrals. I can do clinical and non-clinical work as I move around. I carry what I need, including a whiteboard marker. Paper mail and clinical notes and questions come into the in-tray managed by the secretaries. I ensure daily access to that tray and achieve the aim of keeping it empty almost every day.

I make calls to families about clinical matters without breaching confidence by using a cordless phone. I meet trainees for supervision and colleagues to discuss quality improvement projects and I do appraisals—never in my office. I even use the lounge in the new building—a space with several food and drink outlets and plenty of seating.

If executives and middle managers were locked out of their offices for a day or a week what, I wonder, might they do? What might they learn and what might the organisation gain?

ROB WHITE

Only once in three months did I feel that I needed an office, when I wanted to hide from someone because I just didn't have the energy to engage. I used a colleague's office. The spaces I occupy now are open to the world. Yes, I get distracted, but I welcome the distractions. They are people making connections and asking questions and sharing small problems, reflections, experiences, and even the odd joke. My natural tendency was to build a space that said something about me. I don't need that now. I don't know if this makes me a better colleague, but it makes me more visible and available where the work is. And still I occasionally seek out a quiet moment—for example, on a bench facing a church, surrounded by greenery and people going to or from lunch. I eat my sandwich, drink my coffee, and reflect on the day past and ahead.

I don't know the design planned for our new office block. But all I need is a small amount of storage space (for things I suspect I will rarely need), a space near the secretaries, computing facilities (already in place and evolving) to enable remote and mobile working, and access to the spaces where clinical work is done.

My test has proved to me that I work better without my own office space, and I prefer it, but this might not be for everyone. If executives and middle managers were locked out of their offices for a day or a week what, I wonder, might they do? What might they learn and what might the organisation gain?

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REVIEW OF THE WEEK

What goes around

Kindness is essential in helping patients to heal, but healthcare professionals need to be treated with kindness too. Unkind though it may be, **Iona Heath** would force you to read this book

Intelligent Kindness: Reforming the Culture of Healthcare

John Ballatt and Penelope Campling

RCPsych Publications; 224 pages; £25

Rating: ★★★★

This wonderful book is an urgent plea for kindness as both the driving force and the touchstone of healthcare in the NHS. Anyone who has been seriously ill knows that it is the individual acts of kindness, thoughtfulness, and sensitivity on the part of healthcare staff that make it possible to cope with the panic and indignity of a failing body. Kindness helps healing. Yet, as recurrent scandals unfold, most recently in the Mid Staffordshire NHS Foundation Trust, it is all too clear how quickly the sustaining web of kindness can unravel into neglect and even abuse. Why should this be?

Authors Ballatt and Campling remind us that, "it is easy to forget the appalling nature of some of the jobs carried out by NHS staff day in, day out—the damage, the pain, the mess they encounter, the sheer stench of diseased human flesh and its waste products." Of course, such forgetfulness is not at all easy for those actually doing this work, those struggling not to allow any hint of their physical revulsion to show, but these challenges seem hardly to register in the conscience or consciousness of those charged with the running of the NHS. Parts of the NHS have become repositories for aspects of humanity that our contemporary hedonistic and individualistic society finds difficult to acknowledge.

The NHS represents the last vestige of social inclusiveness and solidarity for frail, elderly people; for traumatised children; for people with intellectual disability, dementia, or severe mental health problems; and for people who repeatedly harm themselves, either directly, or persistently through the misuse of drugs and alcohol. And yet the staff who do the hard work of maintaining that solidarity are subject to a constant stream of criticism, efficiency savings, and instructions to do better. Exposed to precious little kindness themselves, they are nonetheless expected to provide it unstintingly. "There is a lack of understanding, a lack of thoughtful connection—a lack of kindness in the way the organisation as a whole is treated."

This book is published by the Royal College of Psychiatrists, and the text is suffused with fascinating psychoanalytical insight. Psychiatry has a long history of dealing with those whom society has seen fit to lock away, and psychiatrists have seen this done with more or less kindness over the centuries. They are fully aware of the toll the task of caring in these circumstances can take on the individual member of staff and on attempts to work together in teams. "The capacity for groups of staff—be they in prisons, children's homes or hospitals—to participate in cruel and abusive regimes is ever evident. It is well to remember that such teams often have to face and process distress and disturbance that cannot be managed elsewhere in personal and community life." Ballatt and Campling see clearly the extent to which the "culture of 'efficiency' and engineered processes" discriminates systematically and pervasively against the most vulnerable patients with the most complex and inexorable needs.

The book is timely and carefully unpicks the degree to which the continuous and public dissatisfaction with the NHS shown on the part of our political leaders, and the insistent emphasis on the need for so called reform, undermines the potential for acts of kindness at the front lines of healthcare. The authors ask a telling question: "Could it be that the constant restructuring . . . is in part a social defence system that distracts from the existential anxieties associated with the uncertainty of sickness, pain and death, or the enormity of the task of dealing with it? The powerful denial of the cost of the consequences of the disruptions involved suggests that this might be so."

"Could it be that the constant restructuring . . . is in part a social defence system that distracts from the existential anxieties associated with the uncertainty of sickness, pain and death, or the enormity of the task of dealing with it?"

Parts of the NHS have become the repository for aspects of humanity that our contemporary hedonistic and individualistic society finds difficult to acknowledge

In calling for intelligent kindness, and in stark contrast to the stated aspiration of the current government, the authors call for reform of the culture of healthcare without further tampering with the structure. They note that "the behaviour of government purporting to believe clinicians know best, while systematically ignoring their general discomfort and alarm in the face of the commissioning arrangements proposed under the Health and Social Care Bill 2011, has been depressing to witness."

What is really needed, they argue, is a culture of kindness throughout the organisation, against which proposals for change would be evaluated and within which the real difficulties faced by front line staff would be acknowledged rather than denied. The priority of everyone involved would be to "help front line staff to help patients." Such a culture of kindness would play out in encouragement, support, and the celebration of achievements rather than the current obsession with condemnation and rooting out poor practice. Staff should be given the space and stature to take pride in their work, not forever feeling the dead hand of inspection and regulation.

This book is more than recommended reading. If I ruled the world, I would arrange for everyone who wields any power in the NHS to be locked in a room until they had read it. But then, of course, that is precisely the sort of dictatorial behaviour that the authors see as the antithesis of intelligent kindness, and so I am obliged to fall back on an unrestrained enthusiasm that I hope will prove infectious.

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BETWEEN THE LINES **Theodore Dalrymple**

And in this manner he died

Elizabeth Gaskell's biography of Charlotte Brontë, published in 1857, two years after its subject's death, caused a controversy and produced the threat of several libel actions (there were changes to the second edition). One of the reasons for the controversy was Mrs Gaskell's description of Miss Brontë's death, which was thought at the time to be indecently graphic. Recently married, Charlotte Brontë was pregnant:

She was attacked by new sensations of perpetual nausea, and ever-recurring faintness . . . A wren would have starved on what she ate during those last six weeks . . . Martha [her maid] tenderly waited on her . . . and from time to time tried to cheer her with the thought of the baby that was coming.

From this it seems that she died of hyperemesis gravidarum (*BMJ* 2012;344:e567), though her death certificate said phthisis, which is certainly what her sisters Emily and Anne died of. These two sisters had a distinctively different attitude to medical attention: Emily refused it completely; Anne accepted it. Of Emily, Charlotte wrote only eight days before her death, "her repugnance to seeing a medical man continues immutable,—as she declares 'no poisoning doctor' shall come near her."

Anne was altogether more tractable. She took all that was prescribed because "she was too unselfish to refuse trying means, from which, if she herself had little hope of benefit, her friends might hereafter derive a mournful satisfaction." The means in question were cod liver oil: "She perseveres with the cod-liver oil, but still finds it very nauseous," wrote Charlotte, the doctors having thus added to her symptomatology without saving her life: an old, but I hope not continuing, tradition.

Charlotte Brontë: indecently graphic death?

The modern equivalent of the Yorkshire squire's death, I suppose, would be to die while playing a video game and sending last messages on Facebook

At the beginning of the biography, Mrs Gaskell illustrates the forthright nature of the Yorkshire people among whom the Brontë sisters were born with a couple of anecdotes.

We [Mr and Mrs Gaskell] were driving along the street, when one of those ne'er-do-well lads who seem to have a kind of magnetic power for misfortunes, having jumped into the stream that runs through the place, just where all the broken glass and bottles are thrown, staggered naked and nearly covered with blood into a cottage before us. Besides receiving another bad cut in the arm, he had completely laid open the artery, and was in a fair way of bleeding to death—which, one of his relations comforted him by saying, would be likely to "save a deal o' trouble."

Then there was a squire who "died at his house, not many miles from Haworth" (the Brontës' home):

His great amusement and occupation had been cock-fighting. When he was confined to his chamber with what he knew would be his last illness, he had his cocks brought up there, and watched the bloody battle from his bed. As his mortal disease increased, and it became impossible for him to turn so as to follow the combat, he had looking-glasses arranged in such a manner, around and above him, as he lay, that he could still see the cocks fighting. And in this manner he died.

This was hardly an instance of the good death of which our medieval ancestors once spoke, but of which we speak no longer. The modern equivalent of the Yorkshire squire's death, I suppose, would be to die while playing a video game and sending last messages on Facebook.

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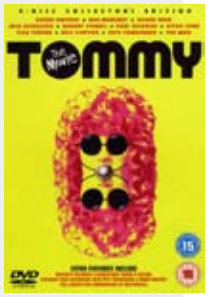
MEDICAL CLASSICS

Tommy

A film directed by Ken Russell; story and lyrics by Pete Townshend, and music performed by The Who

Released 1975



Tommy provides an education in psychiatric trauma, abuse, and the psychology of inadequate parenting. This musical film and rock opera is one of the key artistic works responsible for helping to move these often intentionally hidden issues into public consciousness. As a boy, the protagonist Tommy sees his father killed by his mother's lover, Frank. The trauma is compounded when his mother and Frank instruct Tommy that he did not hear or see the murder, and forbid him from telling anyone about it. The intrapsychic conflicts of the loss of one parent, the need to love the culpable other, and the abandonment by the mother in favour of the lover cause an immediate onset of conversion disorder (dissociative sensory loss). Tommy becomes deaf, dumb, and blind; his symptoms reflect the instructions of the murdering adult figures. The dissociated Tommy sings, "see me, feel me, touch me, heal me," highlighting the primacy of the unconscious and its representation of the true self and its true wishes in the film.

Russell's film shows the vulnerability of abused people. Tommy (played by Roger Daltrey of The Who) is neglected, and left with his bullying cousin. Despite his dissociation he feels pain, when, for example, his cousin tortures him with a hot iron. Tommy is sexually abused by his uncle, who knows that Tommy cannot inform on him, and who sings, "You won't shout as I fiddle about."

Tommy credits mentally disordered people with originality and specialness; the lyrics of "Amazing Journey" read: "Sickness will surely take the mind where minds can't usually go." Despite being deaf, dumb, and blind, Tommy can intuitively play pinball, and wins a championship, bringing riches to his family. This achievement, however, is insufficient to cure him, and relief for Tommy's dissociation only comes from his mother's emotional honesty: she has a breakdown from her overwhelming and long overdue concern for her son, smashing a mirror into which he stares. At last, Tommy recalls his father's murder, and his mother acknowledges this memory. Tommy's cure is shown spectacularly as an integration of the conscious, the unconscious, and the physical, with singing, butterfly stroke, and cartwheels by Roger Daltrey.

Tommy starts a cult to lead others to enlightenment, but he succumbs to the cyclical and perpetual nature of abuse—he expects his disciples to wear ear plugs, mouthpieces, and eye shields to replicate his experience. By depicting the apparently cured Tommy as an abuser, the film recognises one of the distasteful complexities of psychiatric trauma: Tommy maladaptively learns from his abuse through social modelling, and goes on to perpetuate abuse.

But by its end *Tommy* shows that abuse can be resisted by the victim and the perpetrator, as Tommy is rejected by his disillusioned disciples and as he throws away the symbol of his cult (the letter T topped by a pinball). The film teaches that cure of the victim's suffering is not enough: it is necessary to ensure that this suffering is not passed on. Only when Tommy rejects his abusive self is he shown to be fully enlightened—he is reborn in the waterfall where he was conceived, and faces the rising, life giving, sun.

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FROM THE FRONTLINE **Des Spence**

Exploiting non-communicable disease

The developed world is ever more cynical about Big Pharma, having suffered decades of marketing spin, drug scandals, and the manipulation of research. So drug companies are now eyeing the developing world, with its huge populations, rapidly increasing wealth, and light touch regulation. This is the new colonial frontier, ripe for a health land grab. Non-communicable diseases are the new commodity to exploit. Because they require lifelong prescriptions, chronic diseases are a profit goldmine for drug companies. Meanwhile, wealth inequality, poverty, and basic public health are the elephant in the room.

Risk modification through medication is now global. High cholesterol and hypertension, for example, aren't diseases but risk factors for vascular disease. They are common in the developing world, and there are potentially billions of patients. Drug interventions are based on classic studies, involving thousands of patients over several years. But these were big studies for a reason: they had to be. The events were so infrequent that only a large study would detect a significant effect of treatment. For example, in the case of high cholesterol, 2% of people might die in the statin treatment group, against 3% in the control group, over the five year study period. The death rate gives a headline grabbing 33% reduction. But the absolute reduction is only 1% over five years. In other words, 100 people needed to be treated to delay one death. As the study lasted five years, however, you need to treat 500 people a year to delay one person dying per year. This is the treatment paradox: the person taking the treatment almost never benefits from years of popping pills. Any improvements are seen only at a population level.

The promotion of polypharmacy is pointless for the many and is resource intense

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But it gets worse. In the case of hypertension and cholesterol, the studies were done 20 years ago. Since then the prevalence of vascular disease has halved, but this changing epidemiology has not been adequately explained. So the absolute benefit of treatment also may have halved, thus potentially doubling the number needed to treat for the same benefit. So for the example above this would now be 1000 people a year to delay one person dying each year. Finally, add in the inverse care effect—it is low risk, better educated patients who present for treatment—and the real numbers needed to treat will be much higher. The promotion of polypharmacy is pointless for the many and is resource intense. No doubt the drug industry will seize this as an opportunity to promote expensive branded drugs. Will limited heath resources be siphoned off by Big Pharma and away from public health programmes in the developing world?

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PAST CARING **Wendy Moore**

Doctors in Dickens

Everyone has a favourite character from Dickens, whether it's a selfless hero like David Copperfield, a rapacious villain like Fagin, or a half crazed eccentric like Miss Havisham. But anyone with great expectations of finding a likeable medical character in Dickens's novels will be sorely disappointed.

Dickens depicted about 50 doctors in his books. But, with one or two exceptions, his medical men range from bumbling fools to negligent crooks. At best, Dickens's doctors stand by helplessly and mop a clammy brow as a patient expires from fever or consumption. At worst, they conspire in insurance swindles and abet murder.

Born 200 years ago into modest origins, Dickens experienced at first hand the suffering of London's poor: his family was imprisoned for debt while he was forced to work in a blacking factory. Dickens was a tireless campaigner for social reform. He supported Great Ormond Street Hospital and numbered several doctors among his mutual friends, including the founding editor of the *Lancet* Thomas Wakley. But throughout his life Dickens maintained a healthy scepticism towards orthodox doctors and conventional medicine. Instead he favoured mesmerism, phrenology, and hydrotherapy, and befriended mavericks such as John Conolly, who campaigned to end restraints in asylums, and John Elliotson, who had to resign as professor of medicine at London University when two sisters he had used in mesmerism experiments were denounced as frauds.

Dickens wrote before the advent of antisepsis or antibiotics, when doctors were ignorant of the causes of most infectious diseases and powerless to prevent or treat most ailments, so his contempt for standard medicine is understandable. He expressed his scorn in names like Sir Tumley Snuffim, Mr Slasher, Dr Kutankumagen, and Dr Fee, and physicians, surgeons, and medical students are all ruthlessly satirised by his endlessly busy pen.

Throughout his life Dickens maintained a healthy scepticism towards orthodox doctors and conventional medicine. Instead he favoured mesmerism, phrenology, and hydrotherapy, and befriended mavericks

In *The Pickwick Papers*, the medical student Bob Sawyer cheerily declares: "There is nothing like a dissection to give one an appetite." In *Martin Chuzzlewit*, the medical assistant Lewsome supplies Jonas Chuzzlewit with poison to murder his father in return for cancelling some debts.

Only Allan Woodcourt, the lowly surgeon in *Bleak House*, shows true compassion as he treats the poor. After his marriage to Esther Summerson, she admits: "We are not rich in the bank," but adds: "I never walk out with my husband, but I hear the people bless him . . . I never lie down at night, but I know that in the course of that day he has alleviated pain, and soothed some fellow-creature in the time of need." And she asks: "Is not this to be rich?" Plainly Dickens felt so.

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