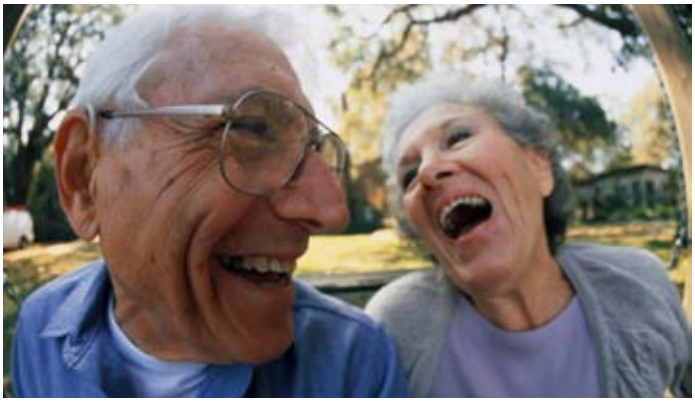
Have you heard the one about the patient with Alzheimer's disease?

Don't forget the importance of humour in caring for people with dementia, says **Sophie Behrman**



Working as a healthcare assistant in a nursing home I had the pleasure of looking after a woman in her 80s who had Alzheimer's disease. Apart from the occasional "Ta, pet" her communication was limited to facial expressions and occasional tutting and sighing.

This word, "limited," however, does not begin to describe the interactions possible and the fun and humour she brought to the nursing home. Words cannot do justice to her range of facial expressions and comic timing. Her lack of words somehow amplified what she could communicate. I have since gone on to care for people with dementia as a junior doctor and am struck by the complexity and depth of communication possible once a rapport has been established.

People with physical disability often find that they are not appropriately engaged in conversation, or some concurrent learning disability is presumed. I am concerned that people with dementia may also not be seen as worthwhile conversationalists, leaving them isolated and understimulated.

We may communicate differently with someone with dementia, perhaps tending towards more sparse language, forgoing jokes or puns with the aim of improving clarity and minimising potential misunderstanding. But is this modification of language appropriate and helpful for people with dementia, or does it perhaps deny them normal interaction? Is it ethical to joke with people with dementia given that they may not understand the joke? Is it ethical not to?

Some models view dementia as a regression through the developmental stages seen in infants and children,[1] based on evidence such as the re-emergence of primitive reflexes. This view of dementia may help resolve the cognitive dissonance that carers may experience between the expectation of independence in adulthood and the reality of a dependent elderly person. This regression theory is not only oversimplifying but also patronising and dangerous, negating the importance of the life experiences of people with dementia. In addition, it can be used to justify infantilisation—when people with dementia are treated without dignity and respect, perhaps as you might treat a naughty child.

Regressing through the language milestones achieved in childhood is an oversimplification of the difficulties of communication in dementia.[2] The more abstract social aspect of language, which develops later in childhood, is retained after functional loss, such as nominal aphasia. A Danish study found evidence of humour, irony, and sarcasm in nursing home residents with severe dementia and high physical dependence. These features of language do not emerge until after the age of 7 to 9 years, but regression theory would place these residents at a preschool developmental stage.[3]

Words cannot do justice to her range of facial expressions and comic timing. Her lack of words somehow amplified what she could communicate

Humour and laughter induce many physiological and psychological benefits, including improvements in cardiovascular, respiratory, and immunological parameters; reduction of pain and improvements in memory and alertness; a feeling of wellbeing; and a heightened ability to deal with stressful situations.[4 5] People with dementia may well also benefit. A psychoanalytical perspective ranks humour as a mature and powerful defence mechanism that may be invaluable for an individual and their family coming to terms with a diagnosis of dementia.

Use of humour also has an important social role: it reduces the depersonalisation that a person may experience, particularly in an institutional environment, facilitating a caring interaction. Humour functions as an equaliser in situations where a hierarchy is perceived, such as a doctor-patient relationship, and as a face saving strategy where an individual's "good face" may be challenged.[6]

With these benefits in mind, so called humour therapy has been developed and studied in dementia with mixed results.[7] Standardising humour and offering a planned intervention may make for a better trial, but perhaps this misses the point of the individuality and subtlety of humour. Interventions studied include sessions with a clown which, in my mind, conjures up the image of a child's party and uncomfortably resonates with regression theory.

Inappropriate use of humour can be unethical and dehumanising. The review of care after the abuse scandal at Winterbourne View Hospital highlighted the abuse of patients with learning disability and is littered with words such as "mocking," "laughter," and "goading."[8] People with dementia may be at similar risk if humour is misused. Humour can also be misinterpreted as threatening by people with dementia, who may already be anxious, and this may inhibit further communication.

When communicating with a patient with dementia it may seem logical (and kind) to simplify your language and avoid humour to minimise potential misinterpretation. This may be doing such patients a disservice, denying them human communication as well as the benefits of humour. The use of humour must be carefully modulated to suit the patient. Used judiciously, humour may represent an under-researched, undervalued, and underused resource in caring for patients with dementia.

Sophie Behrman is a core trainee 2 doctor, Oxford Clinic, Littlemore Mental Health Centre, Oxford
sophie.behrman@doctors.org.uk

SB thanks Dr Allan, Dr Gulati, R and D Behrman, and J Dear.

Competing interests: None declared.

Provenance and peer review: Not commissioned; not externally peer reviewed.

Patient consent not required (patients anonymised, dead, or hypothetical).

References are in the version on bmj.com.

Cite this as: *BMJ* 2013;346:f2872

FROM THE FRONTLINE **Des Spence**

Who's to blame for overcrowding in emergency units?

England's health secretary, Jeremy Hunt, blames general practitioners (GPs) for the overcrowding crisis in hospitals' accident and emergency departments,[1] because GPs gave up responsibility for out of hours care in 2004.

Is this fair? Before 2004, GPs had 24 hour responsibility for the care of patients. General practice has always been hard work, but demand and expectation were increasing unsustainably in the 1990s. Middle aged GPs (without the protection of junior staff) were often up through the night yet working the next day.

In comparison with their hospital colleagues, GPs' pay and status were poor. They were hugely undervalued. General practice was in crisis, with talk of widespread professional burnout.

As a consequence GPs started forming local cooperatives, sharing the burden of out of hours care. For many doctors, being on call just three or four sessions a month was a revolution in working practices and eased the pressure.

This model was inexpensive and worked well, and care was provided by locally accountable doctors. And many of us took pride in not referring patients to hospital, temporising until the patients were seen by their own GPs the next day.

NHS Direct became institutionally risk averse, addicted to clumsy clinical algorithms that often dispatched unnecessary ambulances

Twitter
Follow Des Spence on Twitter @des_spence1

But the Labour government offered to take all responsibility for out of hours care away from GPs. It introduced NHS Direct, offering telephone advice and vetting out of hours requests for GPs.

The intent was to reduce demand and costs. But telephone advice is fraught. NHS Direct became institutionally risk averse, addicted to clumsy clinical algorithms that often dispatched unnecessary ambulances. Access to GPs out of hours became bureaucratic, with distant call handlers and call backs taking hours. Many patients simply bypassed this mess and went straight to hospital emergency departments. NHS Direct's costs spiralled.[2]

As for out of hours consultations, initially it was older and experienced GPs who continued to provide care, but eventually they stopped. Fewer younger GPs had the experience or mindset to work out of hours.

Facing a recruitment crisis, GPs were shipped in at great expense from outside the area, this policy filling *Daily Mail* polemics. And doctors are never blamed for doing too much, so inexperienced and disconnected doctors have a much lower threshold for sending patients to hospital. Continuity, localism, and experience were lost. Lastly, society became more anxious about health, fuelled by the media peddling fear. These are the foundations of current overcrowding in emergency care.

How do we fix it? Keep it simple. Locate emergency departments in primary care centres, and make out of hours primary care available on a walk-in basis. Pay GPs to take back out of hours telephone triage, and keep some morning slots open so that out of hours demand can be deferred. Monitor this.

Finally, insist that emergency staff rotate through general practice, because overinvestigation in emergency care puts huge extra pressure on resources. Nobody wins in a blame game.

Des Spence is a general practitioner, Glasgow
destwo@yahoo.co.uk
References are in the version on bmj.com.

Cite this as: *BMJ* 2013;346:f2871

THE BEST MEDICINE **Liam Farrell**

Run wild, run free

Joe always has one symptom that requires examination and, as every doctor knows, the more clothes to be removed the less likely any important clinical finding. When he hangs his coat on the hook it's a territorial marker, the visual parallel to a hyena widdling on a tree. "I'm here," it says, "And I'm here for a while, till I'm ready to go, and nobody is gonna shift me."

His style looked preppie, with just a hint of old Etonian. Charming bits and bobs fell out during the process, from which the astute clinician could garner information about the patient's lifestyle: pipes, used bookies' dockets (retained in case the race is miraculously run again), ancient tissues. His clothes were an autobiography: "Through tattered clothes great vices do appear."

Frayed jockeys off, and there he was—naked. But strangely, no matter how many clothes Joe took off, he never seemed completely naked, because Joe is a hairy man. A really hairy man. So hairy that when he is naked you can't tell he is naked. A hundred years ago he'd have been in a sideshow tent and charging a fee. Venturing a stethoscope in there was like Stanley plunging headlong through the Congo rainforest and just as sweaty.

It may sound repulsive, but experience has taught me how to surmount this. The true secret of being a good doctor is not being liked by your patients but in you liking them. Joe is like a pet, and he has everything a pet should have—that is, a glossy coat, bright eyes, sweet breath, and the whitest teeth. Added to all these, he has the charm of speech and reason. Nothing could be more disgusting than the one impression; nothing more delightful than the other. It all depends on the point of view.

As every doctor knows, the more clothes to be removed the less likely any important clinical finding

Twitter
Follow Liam Farrell on Twitter @drlfarrell

Some birds aren't meant to be caged: their plumage is just too bright. "Run wild, mighty stallion," I said, "Gallop gloriously over the plain, your mane streaming upon your shoulders; even so went forth Paris from high Pergamus."

I opened the door and set him free.

I heard screams outside.

"Good night, sweet prince," I said, "May flights of angels sing thee to thy rest. And you forgot your jockeys."

Liam Farrell is a retired general practitioner, Crossmaglen, County Armagh
drfarrell@hotmail.co.uk

Cite this as: *BMJ* 2013;346:f2870