VIEWS & REVIEWS

Is it about the patients?

PERSONAL VIEW Anonymous

In the strange new world of the modern NHS doctors must now be prevented from seeing their patients. I had attended a woman with a massive postpartum haemorrhage who nearly died. After resuscitation and various medical and surgical procedures, she needed a hysterectomy. She recovered well and went home after a week with her baby. She did not attend her postnatal follow-up, but no further appointment or letter was generated.

Eventually, she went to her general practitioner with various questions as she was unhappy. After a saga involving lost letters, an appointment was finally made with her consultant obstetrician and me, the operating surgeon.

Two weeks before the scheduled appointment an exploratory legal letter arrived at the trust. Without sight of the GP's letter, the head of legal services decided that the patient was on "a fishing trip" as "the solicitors were well known to be aggressive." It was said that the issue was not clinical, and there was a fear that two consultants might jeopardise the hospital by admitting liability. I was asked to cancel the appointment, on my colleague's behalf, as he was on

leave. I refused, and made vigorous representations that this was the wrong course of action; I was supported by the clinical director and the medical director.

Women whose fertility is unexpectedly and dramatically ended are often upset. Patient care justifies my existence, and consultants make themselves available if GPs refer for opinions. Even though the woman's life was saved, she might have been traumatised and was entitled to ask questions about her care.

I wrote a detailed report and was pleasantly surprised to find good notes and documentation, exemplary management from the whole team, and no areas of medicolegal risk. I gave the trust the Medical Defence Union's advice, which was to meet the patient, especially as cancelling would likely be inflammatory. I offered to have a tape recorder or others in attendance; all to no avail. The appointment must be cancelled. The MDU also warned me that employees have to obey instructions. My calls to the legal department were not returned. The chief executive was dragged in. The legal department advised that cancelling was the advice of the NHS Litigation Authority (NHS LA), and with less than 48 hours' notice, the chief executive authorised the cancellation by recorded delivery.

When things go wrong, the General Medical Council advises that patients "have a right to expect prompt, open and constructive response . . . You must not allow a patient's complaint to prejudice the care or treatment you provide or arrange for that patient." It seemed odd that the NHS LA would give conflicting advice, particularly when its website recommends resolution, so I inquired whether it was happy that the decision to cancel had been made in its name. The NHS LA chief executive replied diplomatically: the NHS LA hadn't been asked for advice and would have recommended continuing with the appointment, but the matter was one between employer and employee, in

which, of course, the authority wouldn't wish to interfere.

I went back to the head of legal services and medical director. I obtained permission from them to clarify the medical issues and rang the GP, who expressed bafflement at the interference in a normal referral process. They may have been moved by the revelation that the chief executive's action had exposed two senior consultants to a direct complaint to the General Medical Council. After many battles (via emails, phone calls,

By neglect of the "clinical" in "clinical manager," the patient and her needs were lost in bureaucratic exchanges

letters, responses, and entreaties) and four months after the original appointment was cancelled, we were "allowed" to see the patient. She had a discussion about the events and consequences and was examined. She was

offered a copy of the notes, a specialist referral, and a letter with further plans for care and support was sent to her GP. She went away happier, though she did subsequently obtain an independent report from a plaintiff's expert, who reassured her we had not been negligent.

Did simple medical care need to be so difficult? My small skirmish was, of course, a pyrrhic victory. By neglect of the "clinical" in "clinical manager," the patient and her needs were lost in bureaucratic exchanges. Basic professional values were compromised, and consistent medical advice from four advocates (the GP, two consultants, and the medical director) was over-ridden. The decision is explicable only if protection of an institution takes precedence over good care of its patients. The trust's behaviour was disappointing. One should not be fooled by rhetoric about "putting patients first" or catchphrases such as "delivering excellence." Watch the behaviour, and judge if it's really about patients.

The must read for
neurosurgeons
p 1441

REVIEW OF THE WEEK

Women on the verge of a nervous breakdown

Richard Hurley witnessed a performance in which women incarcerated in a mental institution a century ago share their stories with women of today

Hysteria

A site specific, interactive performance by Grupo XIX de Teatro, Brazil

Directed by Luiz Fernando Marques

4-14 June 2008, The Great Hall at St

Bartholomew's Hospital, London

19-21 June 2008, Victoria Baths, Manchester

24 August 2008, Villa Maria Zelia, Rio de Janeiro

www.grupoxixdeteatro.ato.br; www.barbican.org.uk/theatre/event-detail.asp?ID=6665

Rating: ★★★☆

It was sad to hear that these 19th century women feared their doctors as much as the husbands and fathers who had had them committed

Hysteria is a theatrical piece inspired by real cases of ordinary women who were wrongly interred at a psychiatric hospital in the late 1800s. They were incarcerated for such improprieties as promiscuity or being too vocal and were subsequently diagnosed as having hysteria. Their histories are juxtaposed with stories from today, revealing how society's attitudes towards women have changed—and how some have not. In examining these women's relationships with men and with each other, *Hysteria* presents an ethereal journey into the female psyche.

In the 18th and 19th centuries diagnoses of hysteria were common in women, effectively pathologising emotional expression. In devising *Hysteria* the Brazilian theatre company used case reports from the Pedro II Mental Institution in Rio de Janeiro and referred to interviews, anthropological studies, and the work of the Parisian psychiatrist Jean-Martin Charcot.

Hysteria is described as "site specific," and has been performed more than 370 times, in historic buildings in South America, Africa, and Europe. Bart's is arguably the oldest remaining hospital in England. So its baroque-style Great Hall as venue was both appropriate and, with its panelling and ornate ceiling, spectacular.

The piece is also described as "gently interactive," and the audience is segregated by sex. First the men were ushered to comfortable tiered seating at one side of the hall. The women in the audience, however, join the all female performers as part of the show. The five-strong cast, long hair and white petticoats

flowing, brought in our visibly apprehensive female counterparts. With cries of "madams, madams: not there—here" they sat them in the middle of the room on wooden benches and on the bare floor cross legged. The subordination of women to men is also a central theme in the women's stories.

Over the next hour and a half the 19th century inmates floated among the female half of the audience. They sat with them, talked to them, and befriended them. The performers questioned the female audience members about how they live and love and in return shared intimate glimpses of their own selves. The disjointed fragments of memories, echoing acoustics, and the cast's accents and occasional Portuguese made it possible to draw only loose conclusions about the interred women.

But we came to understand something of their situation. One woman mourned the loss of her five children and her husband. "A woman should only leave home three times in her life: to be baptised, to marry, and to die," she said. Another seemed to have been left at the hospital at a young age with a note her only belonging. Two of the women spoke of sexual transgressions—lust, masturbation, adultery. The fifth woman was often polishing with her scarf and trying to keep the others in check: "Don't put your feet on the benches; don't touch the windows; and don't touch the walls." Perhaps she was their nurse.

Gradually the cast built rapport with the women in the audience. They prayed with them and picked imaginary lice from their hair,

forging closer relationships as trust developed. More than a century apart, perhaps surprisingly, the women found common ground. The admissions of the performers were tender and often funny—and so were those of the women in the audience. Particularly moving points included one actor improvising poetry about an audience member, and later when the cast encouraged many women to dance raucously together.

Did the male observers have an easier 90 minutes? At times the voyeurism was fun but at others it was frustrating to be excluded and invisible. And some moments were less comfortable. It was disturbing to see the mental hospital portrayed as prison and punishment rather than for treatment. It was sad to hear that these 19th century women feared their doctors as much as the husbands and fathers who had had them committed. And although it was endearing to see the women bond, it was brutal when the audience recoiled after a gruesome revelation or an unpredicted shriek.

Hysteria was thought provoking, touching, and beautiful to watch. It alludes to the injustice that these real women suffered because they didn't fit society's mould. And it shows how the medical diagnosis of hysteria, which is no longer recognised, was used to further justify their internment. Women's roles in society might have changed substantially over the past century or so, but this piece shows some resonance between the experiences of these prisoners of the past and women today.

Richard Hurley is technical editor, BMJ@rhurley@bmj.com

Delay, shame, and blame

FROM THE
FRONTLINE
Des Spence

These days GPs don't like reading the newspapers—they tell us that we are overpaid and lazy. Our punishment is a contract in constant flux; a change to “advanced appointment access,” whereby patients spend all day on the phone, never to see their preferred doctor and certainly never at a time that suits them; and, now, “additional hours” that nobody seems to want or need. All this doesn't bother me much, for it is the turn of fashion. But when an eminent super-specialist told Radio 4's *Today* programme last week that GPs are delaying diagnosis my toes curled. This conclusion was based on the research rock that is retrospective self reporting, which of course is inherently flawed. The suggestion was that if you educated your thickheaded GP colleagues then this practice would stop—although it was put in a kindly, if condescending, way.

Of course, this isn't to dismiss the distress caused by a perceived delay in diagnosis. But the issue is much more complex than a few poorly chosen soundbites might suggest. Delays are not wanton; and because we GPs tend to be soft, sensitive types, mistakes prey on us, keep us awake, and walk with us. Remember that GPs are the gate keepers to hospital care. We understand that all classic textbook descriptions of disease are lies and that vague and

unexplained symptoms are the norm, not the exception. Hospitals see only a fraction of the total number of patients, with some GPs seeing 60 people in a day—and only a decade ago we worked to 5 minute appointments. So we are left accepting and dealing with uncertainty, playing the game of probability. “Waiting and seeing” is a key diagnostic tool, and investigation and referral are done only after a period of observation. If we do refer, this must be with a specific benefit in mind.

If GPs were to refer more, the whole system would become an unworkable quagmire. Worse, patients would suffer the malignancy of overinvestigation, overdiagnosis, and overtreatment. Any healthcare system without an effective primary care filter is plain bad medicine.

The continual blaming and shaming in the media undermine public confidence in the profession and allow others—the media, government, professional bodies—to divide and rule. If new evidence indicates ways of limiting delays in diagnosis, there are many well established routes of communication within the profession. We work in various settings, and the occasional regrettable delay in diagnosis is, unfortunately, part of the GP's job description.

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

The last appraisal

IN AND OUT OF
HOSPITAL
James Owen Drife

When I'm lecturing I often use the phrase “my wife, who is a GP.” The all important comma after “wife” doesn't always come across clearly, so grammatically aware audiences are left with the impression that I have another wife who is not a GP. Or a harem of spouses in various specialties.

This name dropping is of course a pathetic attempt to increase my credibility. It says yes, I may be an academic in an ivory tower but hey, my other half lives in the real world. She knows exactly what to do when a butcher's assistant puts a blade through an artery or when an octogenarian wants to go to a family wedding in the Dominican Republic. She's seen it all.

At home we rarely talk shop and never mention names. This tacit agreement has spared her blow by blow accounts of

university committees but sadly it has deprived me of many insights. I get occasional glimpses of the real world's challenges, from how to keep shoppers out of the health centre car park to how to keep terminally ill people out of hospital. And how to support their families? I don't ask.

This awesome range of skills is taken for granted. Whatever the health scare on the breakfast news, worried viewers are advised to go to their GP. When the government announces some new piece of social engineering, it is the GP who will have to make the decisions. As we get into our cars I feel relieved to be heading for the labour ward.

Thirty something years on, along came appraisal. Days were spent anxiously filing records of attendance at courses and

performance against targets set by people who have never practised medicine. She told me that appraiser and appraisee are paid handsomely to review these papers together. The first time, she returned happy and relieved. After the third year of the same stuff, she allowed herself some remarks about taxpayers' money.

Last month she retired. Today the practice held a farewell lunch. When I returned from work this evening the house seemed full of flowers, cards, and presents. There's a book in which scores of patients have left little messages. It's still too affecting to read it. Time, I think, for a small glass of wine. To tomorrow, and her first yoga class.

James Owen Drife is professor of obstetrics and gynaecology, Leeds j.o.drife@leeds.ac.uk

A man of wit and clinical wisdom

One does not turn to medical journals for the delights of literature, or for blinding shafts of insight conveyed by aphorism. No one expects a double-decker bus to perform like a Maserati: which is not, of course, to denigrate double-decker buses. They are good at what they do.

The British endocrinologist and haematologist Richard Asher (1912-69), however, managed to combine wit and clinical wisdom with literary felicity. He it was who first thought of the adventures of Baron Munchausen in connection with that small group of patients who go from hospital to hospital with tales of dramatic symptomatology. I was pottering about my books the other day, as old men do, when I pulled out a slim volume entitled *A Sense of Asher*. The first piece, about the joys of reading the misdemeanours of one's colleagues in the reports of the defence societies, made me laugh out loud.

A piece about noise in hospitals also brought a smile to my face. Asher appeals for quiet during the day, for the sake of those unfortunate enough to have worked a night shift: "Those working by day should pity the poor night worker who, after spending the night shouting, laughing, slamming doors, and banging trays is, when daybreak comes, quite exhausted by his efforts and needs a good sleep."

A few remarks of his concerning trolleys reminded me of the trolley in my own hospital that used, at about 11 am each day, to pass my frosted window, which gave out on to a passageway between jerry-built edifices.

This trolley made a noise like a theatrical thunder-making machine, so loud that for a minute or two I could make or receive no telephone call. It was the loud-

BETWEEN
THE LINES

Theodore Dalrymple

Richard Asher resigned his post at the Central Middlesex on a point of principle. What a terrible example! If everybody did that kind of thing, the NHS would not now have a single doctor working for it.

est, slowest, longest drawn-out example of the Doppler effect I ever knew.

One day I went out to see what kind of behemoth or juggernaut made this colossal noise and was amazed to discover a small trolley, hardly bigger than the supermarket variety, with a wire basket containing a few pillows or sheets. Years of research must have gone into developing a vehicle so tiny and yet so noisy. I doubt it would have survived a day in the private sector. No representations I made to the management about it made any difference:

the trolley long outlasted me.

A Sense of Asher was a cause of great melancholy to me. It was edited by Ruth Holland (see *BMJ* 1996;313:631), whom I knew very slightly because she asked me to review a few books for the *BMJ* while she was in charge of the review section. One day I was waiting for a train at Milton Keynes station—I had gone to that strange new town, which if it had been named today would probably have been called Posh Beckham, to prepare a medicolegal report on someone—when it was announced that there would be a long delay. Like everyone else, I started grumbling, believing myself to have been severely let down and to be suffering horribly.

In fact, the train we were supposed to catch had crashed, with one fatality: Ruth Holland. Ever since then, I have grumbled a little less about delays of all kinds.

Another point: Richard Asher resigned his post at the Central Middlesex on a point of principle. What a terrible example! If everybody did that kind of thing, the NHS would not now have a single doctor working for it.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSIC

When the air hits your brain

By Frank Vertosick Jr

First published 1996

Frank Vertosick Jr describes his personal voyage from eager medical student to board certified neurosurgeon. By turns comic and tragic, this memoir has similarities with Samuel Shem's *The House of God* and is a must read for neurosurgeons but also of interest to most clinicians. Dr Vertosick provides, from an American perspective, a keen insight into a specialty which is often regarded with suspicion by other doctors. He did not initially intend to become a neurosurgeon, but "strayed too close to a dangerously seductive profession and became stuck for good like a fly in a spider's web."

On his first day as a neurosurgical resident, a cynical and weary chief resident takes him aside and outlines the "Rules of Neurosurgery." The first of these provides the title of the book: "You ain't never the same when the air hits your brain." A worrying proposition to those with no background knowledge, nevertheless this maxim pithily sums up the subtle, intangible change that often occurs after cranial surgery, but which cannot be neatly recorded on a chart. The other rules include such useful aphorisms as "the only minor operation is one that someone else is doing" and "if the patient isn't dead you can always make them worse," a contemporary variation on the Hippocratic motto: primum non nocere.

Though lighthearted in tone, the book addresses serious points that are relevant to the practice of neurosurgery in particular and medicine in general. Medical careers

tend to be dominated by anecdotes. Clinicians all remember their first times, the medical curiosities they have encountered, and, perhaps most importantly, their mistakes. Dr Vertosick leads the reader on a tour of neurosurgery via a series of memorable cases, charting the vicissitudes of the patients, his changing relationships with

colleagues, and the progress in his own knowledge and acumen. From the young trauma patient who dies quickly in the emergency room to the child with an incurable brain tumour and the young man rendered tetraplegic with a spinal epidural haematoma, each case provides important challenges to the author both as a doctor and as a human being. The clinical detachment and sangfroid that are necessary to function as a neurosurgeon can be taken to extremes as his colleagues metamorphose into "surgical psychopaths." The difficulty is to "care but not too much." Dr Vertosick's trial by fire comes during a craniotomy and clipping of aneurysm. At first the case progresses well, but suddenly he is faced with a "crimson flood" as the aneurysm ruptures, with catastrophic results for the patient. It is the maturity required to deal with the impact of his own complications that identifies him as a well rounded surgeon.

In the author's words, neurosurgery can occasionally resemble Shakespeare's *Hamlet* "in that nearly everyone dies in the end." Dr Vertosick challenges this perception but does not seek to avoid the many highs and lows of a neurosurgical career.

Chris Barrett specialist registrar in neurosurgery, Newcastle General Hospital, Newcastle upon Tyne
chris.barrett@nuth.nhs.uk