reviews

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ART

Artist reignites debate over BMA sculptures

The Third Campaign: A Project by Neal White

An exhibition at the Henry Moore Institute, Leeds, until 27 March
www.henry-moore-fdn.co.uk

Rating: ★★★

Sculptures that caused a scandal when they were first carved for the BMA headquarters in 1908 have inspired an exhibition by contemporary artist Neal White. The sculptures, by Jacob Epstein (1880-1959), were 18 larger than life, naked figures that were commissioned to adorn the façade of the then new BMA's London headquarters on a prominent site at the corner of Agar Street and the Strand. White's exhibition is an attempt to reignite the debates that have raged over Epstein's sculptural scheme.

Charles Holden (1875-1960), the architect of the Strand building, used dark granite on the lower half, in deference to earlier buildings. However, he selected white Portland stone for the upper half to achieve a more modern effect. It was Holden who commissioned Epstein, intending that the

The façade of the former BMA building with the statues in place, and (below) the figure of Old Age in a niche

sculptor's white figures set against granite, on each side of the third floor windows, would visually suture together the façade's darker and lighter elements. Although Epstein rejected the BMA proposal that he depict famous medical men, he agreed to carve figures symbolising health, medicine, and chemical research.

In fact Epstein and Holden had a more radical agenda for the sequence, based on a shared belief that "we are ashamed of our nakedness—and yet it is in the frank confession of our nakedness that our regeneration lies." Epstein declared that he would carve "noble and heroic forms to express in sculpture the great primal acts of man and woman." Although his intention was to celebrate the inherent dignity of the naked body, "Maternity," depicting an amply proportioned mother and her child, provoked a storm of moral indignation in early summer 1908.

The new BMA building was across the road from the National Vigilance Association, which was immediately scandalised. On 19 June 1908 the front page of the *Evening Standard* thundered that Epstein's carvings were "a form of statuary which no careful father would wish his daughter, or no discriminating young man, his fiancée, to see." Not surprisingly, on 11 July, the *BMJ* reported that "the whole Strand opposite was packed with people, most of them girls

and young men, all staring up at the statues." The BMA chairman panicked; however, influential figures in the arts sprang to Epstein's defence, and he was allowed to finish carving the remaining figures.

The carvings remained undisturbed in their niches until 1935, when the government of Southern Rhodesia bought the building and its high commissioner expressed his disapproval of them, which provoked renewed defence by Epstein's supporters. Two years later, a piece of stone fell and bruised a pedestrian's foot, and the new owners saw their chance when the London County Council ordered them to make the sculptural scheme safe. Anything considered unstable, including heads and limbs, was chiselled off in an act of vandalism that ruined Epstein's work as a whole.

White's response to the earlier controversies surrounding the figures comprises photographs that survive in the Henry Moore Institute's archive and a new film by him of the contested site. His exhibition challenges us to consider our role, as the audience for public sculpture.

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Items reviewed are rated on a 4 star scale
(4=excellent)

The Philosophy of Psychiatry: A Companion

Ed Jennifer Radden

Oxford University Press, £45, pp 447
ISBN 0 19 514953 X

Rating: ★★★

Every day doctors have to make difficult decisions, often when on the run and under great pressure, that have serious repercussions for their patients; and no one seems grateful when the messy process is all over. So the profession understandably rolls its collective eyeballs skywards when philosophers start pontificating about medicine. It's all very well to wallow in the niceties of philosophical analysis—but what is the practical help to us, doctors will demand impatiently, when yet another book on philosophy and medicine thumps onto the ever growing (dusty?) pile in this category.

Philosophy attracts intense suspicion from those who are deeply impressed by medicine's apparent progress, driven by conventional science, because philosophy has a nasty tendency to show that we doctors are not forging forward quite as quickly as we like to imagine.

For example, this collection of philosophical contributions asks some uncomfortable questions that are usually too quickly glossed over in modern medical practice. But perhaps the reason this volume is better than conventional philosophical analyses of psychiatry is that most of the contributors seem to have pragmatic experience of both philosophy and clinical

practice and focus on areas where philosophy will actually aid the clinician's daily exertions.

In the chapter called "Desire" one issue is how homosexuality got removed from official diagnostic manuals, once doctors had "decided" that it should no longer be regarded a disease. However, when this medical decision is exposed to the hard edged precision of philosophical analysis, some rather painful politically incorrect problems begin to surface.

Whatever the reason brought to bear for not classing homosexuals as diseased and in need of medical attention, there are difficult implications, because exactly the same set of arguments could be used for removing a host of paraphilias or perversions from the diagnostic manuals as well. Perversions and paraphilias range from the familiar, such as sexual masochism and fetishism, to the more exotic, such as klismaphilia, sexual enjoyment derived from enemas. Many of these do not cause distress to other people, and any upset caused to the "patient" often seems to be largely exogenous—in other words, if wider society accepted the behaviour and didn't condemn or discriminate against it then personal suffering supposedly engendered by the condition might disappear altogether.

Another flaw with the medical definition and diagnosis of perversions lies in the words "Usually the fetish is required or strongly preferred for sexual excitement, and in its absence there may be erectile dysfunction," which comes from the definition in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, the bible of North American psychiatry. But the stubbornly flaccid husband who no longer finds his wife arousing is not necessarily impaired. The stimulus is inadequate; or a stimulus that would work for him—another woman—is missing.

The chapter on emotion raises another uncomfortable question: that there could be innumerable other common states of being that we doctors mess with in the cause of pure consistency that might better be left alone, in particular mood problems such as depression. Some forms of depression may be understandable reactions to genuine quandaries, a form of "existential alienation"—a reasonable and even desirable response to calling into question one's own values. This isn't a new idea. Aristotle asked, "Why is it that all men who have become outstanding in philosophy, statesmanship, poetry, or the arts are melancholic, and some to such an extent that they are infected by the diseases arising from black bile?"

It might be that the reduction of depression to faulty wiring in the brain or chemical imbalance is actually an impoverished understanding of the breadth and depth of the human predicament. The *New Yorker* magazine, in a tongue-in-cheek take on the medicalisation of life, began publishing a series of cartoons entitled, "If they had Prozac in the Nineteenth Century," featuring

Friedrich Nietzsche and (below) Karl Marx: how might Prozac have changed their outlook?

figures such as Karl Marx remarking, "Sure! Capitalism can work out its kinks!" and Friedrich Nietzsche saying to his mother after church, "Me, too, Mom. I really liked what the priest said about the little people."

The implication is clear: if stress and dysfunction are "natural" reactions to difficulties, and if Immanuel Kant is even partly right that melancholia is a result of the mind's imagination run riot, then what might we have lost as a culture if psychopharmacology had prevailed in earlier times?

The boundary between suffering that requires the ministrations of the medical profession and distress that should be coped with without professional intervention has become blurred, with massive implications in terms of cost and stress on the profession.

It is in the attempt to bring some focus in this area that philosophy is desperately needed. Indeed, with the remorseless advance of medical technology it is likely that our ability to interfere with states of being that are statistically extremely common is always going to be on the increase, meaning that philosophy will become ever more relevant.

This erudite volume, with its numerous practical examples, reminds us that philosophy and its tools of pitiless precision and brutal clarity are as vital a weapon against disease as brain scanners and multidisciplinary teams in the armament of modern medicine—perhaps even more so.

What might we have lost as a culture if psychopharmacology had prevailed in earlier times?

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Global Crises, Global Solutions

Ed Bjørn Lomborg

Cambridge University Press,
£19.99, pp 670
ISBN 0 521 60614 4

Rating: ★★

What an intriguing idea. Convene serious thinkers to create a list of critical issues facing the global community that are amenable to governmental intervention, prune and prioritise the list to the top 10, enlist leading economists to outline the challenges, add thoughtful commentaries, and then rank the final 10. A group called the Copenhagen Consensus under the leadership of Bjørn Lomborg did just this and teamed up with the *Economist* to disseminate the results. *Global Crises, Global Solutions* is the result, and disappointing it is, garnering at best two stars.

Instead of presenting innovation based on prior work, the book is constrained by

reflection and limited by a lack of anticipation. Economists, it turns out, are not effective lead authors. They are too comfortable building complex edifices on data acknowledged as weak; they seem reluctant to transpose what is known, even if inexact, into design models for future problem alleviation; their emphasis on cost benefit analysis inhibits a larger view that might encompass such critical factors as governance and custom. In addition, this text is poorly edited. Co-authors are not identified; abbreviations essential to a chapter are not highlighted; proofreading lapses abound; many pieces are overly long, testing the perseverance of the most dogged reader.

Of the 10 challenges identified, three impinge upon medicine: communicable disease, malnutrition and hunger, and sanitation and access to clean water. Of concern is the failure of the Copenhagen Consensus to accord greater priority to chronic illness and its global burden of disease and over-nutrition with impending epidemics of diabetes and heart disease in most of the developing world.

Contributors Anne Mills and Sam Shillcut restrict their discussion of communicable disease to HIV/AIDS and malaria in Africa. They barely discuss treatment of HIV/AIDS and its inevitable conversion to a chronic disease, and they limit their discus-

sion of primary medical care to a few paediatric diseases.

Jere Behrman, Harold Alderman, and John Hoddinott recreate what is known about the deleterious effects of malnutrition. Instead of revisiting the problems of low birth weight and micronutrient deficiencies, a more engaging piece leading towards innovative interventions would focus on governance, a lack of civil society, women's education, land inheritance policy, and enlightened rather than self-serving donor agency policies.

"Sanitation and access to clean water" by Frank Rijsberman is shorter, freer of jargon, and more willing to accept problems of governance and management. The problems and opportunities are better defined and addressed. Rijsberman blends component assessments of cost benefit analyses into larger overviews that anticipate feasible interventions.

Rather than read *Global Crises, Global Solutions*, the curious physician looking for insights into the complex societal and economic issues that cloud the future would be better off subscribing to the *Economist*.

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PERSONAL VIEWS

The tsunami and the dangers of goodwill

Following the tsunami in South Asia, there was, as would be expected, the rushing to the scene of a multitude of non-governmental organisations (NGOs), United Nations organisations, and other actors providing emergency relief. There was also a remarkable outpouring of public charity with massive funds being raised for the victims of the disaster. Many volunteers from abroad have independently inundated the afflicted areas. Although notable and well meaning, the public "goodwill" is not without its drawbacks.

In Sri Lanka, where I was dispatched with a relief agency, we found several issues for concern. Firstly, there were numerous foreign volunteer doctors operating makeshift clinics in the camps for the survivors. However well intended, the unregulated and uncoordinated activities of these health practitioners may serve to undermine rather than support the existing health systems in the affected countries. Several of the camps we surveyed received irregular and unpredictable visits by these independent volunteers. Follow-up was non-existent and the distribution of medication haphazard and non-uniform. Antibiotics had been prescribed liberally and it was not uncommon to find internally displaced persons who had received multiple drugs of unknown identity.

Another concern was the distribution of relief—rarely was it equitable, proportionate, or tailored to the needs of those affected. Some observers were also concerned that the aid, which has come rapidly and voluminously, might, just like the tsunami, dissipate just as quickly.

Many of the key concerns on the ground for both NGOs and local authorities were in keeping with those identified in the World Health Organization's emergency strategy—namely, the need for coordination, disease

surveillance, and outbreak mitigation, and the provision of essential health care to displaced people. Although it is appropriate to prioritise water and sanitation, shelter and food security in the post-emergency phase, it is probably also time now for all the major actors to consider the longer term needs. It is perhaps disappointing that nowhere in the WHO emergency strategy was the issue of mental ill-health addressed. The psychological trauma experienced by survivors will in time surface, and will need addressing in a culturally sensitive and appropriate manner.

While millions of dollars are raised for the tsunami victims, and the various humanitarian aid NGOs are awash with funds specific for the tsunami, other crises elsewhere in the world remain forgotten or overshadowed: Angola, Afghanistan, Sudan, the Democratic Republic of Congo, to name but a few. It is essential that the massive outpouring of public goodwill is harnessed, but more importantly, that it is directed towards areas of greatest need and not just the latest media hotspot. Unmet needs remain both in the countries affected by the tsunami, and in many other countries that were not.

Aid, which has come rapidly, might dissipate just as quickly

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PERSONAL VIEWS

How psychiatrists can play their part in the tsunami relief effort

See *Letters* p 254

I was on holiday with my wife and son at a hotel on the west coast of Sri Lanka when the tsunami struck. It was 10 am, Boxing Day. Only afterwards did we realise how lucky we were to get away unscathed. At the time we were on the third floor of our hotel watching and videotaping the staff clearing up the mess from an initial, small wave. We could have no perception of what would happen next. Two days later our recording of the wave appearing through the trees, crossing the pool, and hitting the hotel was shown on worldwide television before more spectacular films superseded it. My wife's nursing skills were immediately put to good use in the hotel lobby, where she dressed and cleaned wounds with the hotel staff, a casualty senior house officer, and a dentist with a suture kit. There was little for a psychiatrist to do at this time. Twelve hours later we were evacuated to Colombo.

When we realized the enormity of the disaster we offered our services to the British High Commission, via the Red Cross. A few hours later we had a phone call requesting our help. On the way I worried whether I would be of use. My medical and surgical skills were rusty, to say the least, and I was aware of recent research showing that psychological "debriefing" may do more harm than good. My experience, however, in the midst of that extraordinary time showed my worries to be unnecessary.

An accident and emergency consultant and his wife were doing a fantastic job and had organised a clinic in a small office. We joined in, helped by other medical and nursing volunteers. A steady stream of casualties from the west and east coasts were brought to the reception over the next few hours. We set to, checking wounds and cleaning and changing dressings. The more severe casualties had been taken to the hospitals. Many of

Psychiatrists have something useful to offer patients traumatised by the tsunami, argues the author, who took these pictures of destruction in Sri Lanka

ours had cuts and bruises to the legs and arms. Some wounds were already becoming infected, and we were able to give out antibiotics from rapidly dwindling supplies. Some people were covered in mosquito bites from sheltering in the trees overnight. A lot of the people we saw had lost everything in the disaster, including clothes, belongings, and passports, and were dressed in swimming costumes and little else. As a psychiatrist I concentrated on the psychologically traumatised patients.

In my work I often see people who have suffered terrible traumas but never as immediately as this. I initially sat with people, checking and cleaning their wounds while they talked about what had happened. It helped that I had been there when the wave came and could share experiences, even though I had come through without a scratch. I used the title of doctor rather than

psychiatrist, as medical skills were needed too and my title seemed irrelevant. People reacted to the trauma in different ways: some seemed dazed or tearful, others were stoical, one even laughing. What everyone had in common was the need to talk about their experiences. I saw people who had lost a partner, a child, or a baby and those who had witnessed the loss of others. Just listening seemed to be all that was needed. I was able to give advice to the High Commission staff about what to do with a family in hospital. Having to keep going while containing my own feelings and preserving empathy reminded me of shifts as a houseman.

After we came back to Britain I wanted to be back there doing something practical, but a special flight had been arranged by our travel company and we had to return. We were touched by the support and concern expressed by everyone back home. The full enormity of the tragedy has now emerged, and large sums of money have been pledged. Personal feelings are getting easier to control, and life is getting slowly back to normal. The end of 2004 is a time I and many others will never forget.

My conclusion is that psychological support for people immediately after trauma is valuable, but it helps if that support is combined with another more practical role, for example when provided by a doctor, nurse, or aid worker. Psychiatrists can offer their services without fear, and they do have something useful to offer. Support to other staff is also of value. Let us just not use the term "debriefing."

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None so naive as the well meaning

It was a moment of blinding clarity. In the wake of the Indian Ocean earthquake and tsunami I heard on the news that the Sri Lankan government was appealing for paediatricians. It suddenly occurred to me that I might be in an ideal position to go and do something to help, rather than my usual wringing of hands or donating the equivalent of a fraction of a clean water pump. I'm a fellow in paediatric infectious diseases currently doing research, so there would be no patients to miss me, and my colleagues wouldn't be burdened by rota changes. Also, I am financially supported so would not need to be paid, I have previously worked in a refugee situation, and I even already had a ticket for a flight to Malaysia. In my naivety I assumed that charities would be clamouring for my services, so I went to the internet.

Most of the websites had details on how to donate money but nothing about how I personally might be of assistance. I was encouraged, however, by the Red Cross website, which stated that although the charity didn't send volunteers out it did send doctors and nurses. Armed with the telephone numbers from the websites, I started cold calling.

I began with the British Red Cross, which said that I needed to speak to someone who dealt with overseas personnel and gave me a name and a different number. A young man from something called Crowthorne Associates said there was nobody there of that name and was I trying to get in touch with the Red Cross, as that was the fifth phone call he'd received that day. I called the Red Cross back and spoke to a different man, who spent a long time trying to find out to whom I should speak; and when he failed he said in a regretful tone that unless I was a fisheries expert they wouldn't need my services at present. I am not, so I decided to call Save the Children instead. It was more difficult to find its phone number, as the website directed me to the local Clapham shop, and I wasn't sure that the volunteers there would be able to help. I found a number for the International Alliance of Save the Children, but it couldn't deal with my inquiry and suggested I call Save the Children UK, giving me the phone number I needed. The woman who answered said that they did not need anyone at the moment but that she would take my name and number and someone would get back to me.

Wondering whether I was barking up the wrong tree, I thought that the Royal College of Paediatrics and Child Health might know whom I should contact. A nice woman tried to help me but couldn't offer much more

than that the college's response to the disaster would be on its website the following day. She gave me the email address of someone at Child Advocacy International, but the message bounced. Beginning to feel a little despondent, I called Oxfam and began, "I know you're going to say no ...," but the woman I spoke to was enthusiastic and said it was a lovely offer, although they weren't currently looking for personnel unless they had experience in public health advocacy (we both agreed that my ability to say "Everyone should be immunised" probably wasn't enough). She suggested that I call Médecins Sans Frontières and Médecins du Monde and found the numbers for both, assuring me that I was just the sort of person they were looking for. Newly encouraged I contacted Médecins Sans Frontières, which said that all its positions were

filled. I assumed the same would be true of Médecins du Monde but tried it as my last call anyway. I was told that it had sent out a first wave of its own medical staff but that it would need a second later on, and after a brief discussion someone took my details and asked for my curriculum vitae.

I may not be asked to go, but I learnt two things during this process. Firstly, how difficult it is during this kind of catastrophe to know how to get in touch with the people who might want to use your skills or whom to contact to find out whether those skills are even useful. Secondly, that it's all very well wanting to help, but it is pointless unless it is done in an organised way. The story above belies the longer conversations I had with several people who explained that most of the infrastructure was washed away by the tsunami and that there was no point sending medical staff who couldn't reach anywhere or be able to treat with even the most basic of drugs. That's why organisations such as Médecins du Monde exist, to avoid haphazard reliance on well meaning individual doctors who jump on aeroplanes to go off on their own to save the world. And if they don't need me, I still have a down payment on a water pump to offer.

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We welcome submissions for the personal view section. These should be no more than 850 words and should be sent electronically via our website. For information on how to submit a personal view online, see <http://bmj.com/cgi/content/full/325/7360/DC1/1>

SOUNDINGS

Out of hours cover

A long time ago, I sailed three or four of the seven seas in good company. Motives were mixed. I was a reservist and discontent with the NHS, the Royal Navy needed medical officers, and I needed time to write a novel. So I rang up a senior naval figure, the appointer, and asked for a ship going somewhere warm and coming back in time for the Edinburgh Festival.

He rang back minutes later, asking when the Edinburgh Festival started. I knew he had problems—even his Irishmen were leaving—and explained: usually towards the end of August. He seemed pleased: "I've got just the ship for you ... Heading for Hong Kong ... You'll love it."

I did. I loved that ship, from stem to stern. And the people were even better. I set to and wrote a novel.

In mysterious ways the navy helped. A stores assistant brought me reams of paper and a lot of variously coloured pens. I worked away in black and white, and the supply officer helped too, reading my first efforts as a weekly serial and reporting on them each Friday over dinner.

The medicine was fun. In a community of 200 people in a ship 200 feet long, one gets to know one's patients. Skivers and chancers checked in early; those with real problems later on. By the time I had settled in—not far south of Gibraltar—proper medicine took up to 15 minutes a day. More would have been meddlesome.

Patients were empowered. For skin problems, the sailor and I would consult a large textbook just right for a ship's doctor—big pictures and not many words—and agree on a diagnosis, a treatment, and a follow-up appointment. It was as easy as matching wallpaper.

Serious cases took longer, but if there were doubts about diagnosis or prognosis they could be shared. And—best of all—out of hours cover was miraculously straightforward: if a patient did badly and did not get back to me, his messmates certainly would. No one died.

I worry about out of hours cover in today's NHS. Unscheduled care is a disempowering euphemism. Call-centre care is already problematical. Automated telephone trails ("If your baby has turned blue, press *one* ...") might further disappoint. We just don't know yet. But it was a great privilege—a long time ago and in fairly protected circumstances—to look after patients I knew.

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