Personal view: multiculturalism and the NHS, p 156

REVIEW OF THE WEEK

Snorting and lunching

A sharply scripted US comedy about a New York nurse plays with the conventions of medical soap operas, finds **Jim Drife**

Nurse Jackie
BBC Two (www.bbc.co.uk/programmes/b00mwd1j)
Rating: ★★★☆

In the days when emergency departments were called A&E I was, briefly, a junior casualty officer. Once, called to a young man held down by the Edinburgh constabulary, I said something like, "Release my patient, please." The policemen exchanged glances and relaxed their grip just long enough for him to take a swipe at me and miss. Another lesson learnt.

My mistake was not being a nurse in a US television series. When Nurse Jackie gave a similar command in an emergency room (ER) in New York the awestruck attendants stepped back and the patient burst into tears. He was angry, he sobbed, because the healthcare system had refused to insure his sick mother.

A rare moment of repose for saint Jackie

Each 27 minute episode of *Nurse Jackie* (a "dark comedy drama") covers a lot of ground. By the end of the pilot we had had enough misbehaviour from the title character (brilliantly played by Edie Falco, late of *The Sopranos*) to keep the UK Nursing & Midwifery Council busy for months. She snorted painkillers, forged an organ donor card, and flushed a patient's severed ear down the toilet.

But it was all OK really. She is in constant pain ("What do you call a nurse with a bad back? Unemployed"), the organs would save lives, and the man who had his ear cut off was an underling at the Libyan embassy with a bad attitude to women. A wide eyed student nurse called Zoey summed it up: Jackie is a saint.

BBC Two showed the first five episodes on consecutive nights, presumably so that after the initial shock we could quickly get into the story. Away from the ER Jackie is a mother of two with an exemplary house husband. Going to work each day, she removes her wedding ring, and at noon she has uncomfortable stand-up sex with Eddie, the hospital pharmacist who supplies her painkillers. Then, at lunchtime proper, she and an immaculately manicured doctor go to a smart restaurant and swap cynical aphorisms.

By the end of week one the storylines were cooking nicely and the swearing had settled down a bit. The warning "strong language from the start" means someone is going to say an obscenity soon after the titles, and sure enough the first show sounded like the terraces of a British football match. This must be the writers' way of saying they're hoping to win an award. Later the expletives were used more selectively as code words to indicate sincerity.

Most of the writers, it turns out, are female. This is a show aimed at women no longer upset by foul language—that's how far we've come, girls. The angst of the nurse-mother's work-life balance grew in importance, and Friday's cliff hanger involved Jackie's 10 year old daughter going off the rails while Jackie herself was on the phone to the 10 year old daughter (and sole carer) of a patient. Clear enough for you?

As you would expect from a series set in New York the scripts are sharply self aware. In all hospital soaps, patients admitted as emergencies are wheeled in at breakneck pace. When a breathless paramedic comes in firing off a clinical history at an incomprehensible speed, Jackie looks at him saying, "You: too fast," and then turns to his colleague: "You?" The second paramedic obliges with a slowed down version. It's a little in joke that's over in a second, but we get it.

The doctors also start out as stereotypes, the most recognisable being the overconfident recent graduate. Shades of 1971 for me, though even then I was less stunningly handsome than Dr Cooper ("Hey, call me Coop"). He loses a patient despite Jackie's sage advice and she gives him a stern talking to: "I've seen hundreds of you jerk-offs blow through these doors." But this show is set to have lots of twists, and Coop soon emerges as salvageable. Maybe terrific, even. Wait and see.

Jackie's elegant luncheon companion, Dr O'Hara, is ultra-cool. She has an English accent, that's how icy she is. We are asked to believe that, at least in New York, someone can be an emotion free zone and a superb doctor at the same time. (Quick reality check: the most caring doctor I know is a New Yorker.) But her armour is pierced by a naive question from Zoey, and no doubt her back story will emerge.

Although these doctors may eventually become rounded characters, the medical profession in general remains as much of a cliche as the Libyan diplomatic corps. When Jackie asks, "What do you doctors have against healing people, for Chrissake?" O'Hara replies: "Healing? That's why you're a nurse. When I was a little girl I took a butter knife and opened up a dead bunny to see how it worked. That's why I'm a doctor." A butter knife? This rubbish tells us more about American cutlery than about medicine.

Questions hang in the air for the remaining six episodes. Will the nurse manager remain as the only truly comic character? ("Mrs Akilitus" is superb, particularly when she accidentally Tasers herself.) Will either of the gay nurses (Thor and Mohammed) ever say something unpleasant? Why is Jackie's lover named after the dog in *Frasier*? If you find out, let me know, but there's no need to rush.

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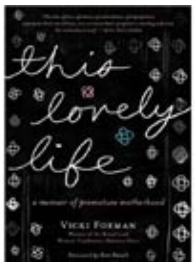
Cite this as: *BMJ* 2010;340:c195

REVIEW

The cost of survival

A mother's description of the effects of premature birth deepens our understanding of the consequences of the life and death decisions made by doctors, finds **David C Taylor**

This Lovely Life: A Memoir of Premature Motherhood
Vicki Forman
Mariner Books, pp 272, £8.47
ISBN 978-0547232751
Rating: ★★★★



The chance of survival of babies weighing between 500 g and 600 g is "approximately 20%," says the website of the Children's Hospital of Philadelphia. The nature and quality of "survival" is not particularised in that text. But some of the possibilities are vividly described by Vicki Forman, whose tiny twins were "saved," albeit briefly in the case of one of them. They were saved against her express wishes and better judgment because Californian law, while permitting abortion at 23 weeks, requires all live-borns of that gestational age to be afforded all means of care. This allows the state a one in five chance of adding at least one more Californian to the existing 37 million and at least one more human to the seven billion on the planet.

But who "affords" this care? Does the state that required this action take financial and social responsibility for it? Do the medical and insurance industries provide free care under the law or in consequence of its treatment of infertility? This family, even though seeking help to conceive a child, were professionally well informed enough to plead against the proposed resuscitation of their twins. The financial costs of the consequent medical care—to negligible benefit—that the state obliged the parents to purchase are not mentioned in the book.

However, page after page describe the utilisation of huge quantities of medical resources. Seemingly endless periods of neonatal intensive care, outpatient treatment, special equipment, nursing care, and medical opinions on this and then that and yet another dysfunctional body system consumed huge resources. Then there are surgical operations and the search for treatments of the ensuing complications. The state does not seem to consider that irreplaceable medical resources could be put to better purposes.

Ellie, the girl twin, dies, after agonising hours in her mother's arms, soon after her birth. So there is now mourning for that child contemporaneously with sustaining hope for the boy, Evan, through the agonising emergence of more and more of his deficits and alarm signs. The psychological split between love and loss thus imposed on the parents is dreadful. They are paralysed over the disposal of their daughter's tragic, tiny, cremated remains. But the state, it seems, also prescribes in fine administrative detail the legal location of those remains.

The wonderful writing avoids hyperbole. It allows the events, the engagements with medical staff, and the awesome vacuity of hospitals to convey the strong feelings, the agonies, of this painful childbirth. The fundamental premise of medical practice has been "first do no harm." Medical intervention has been predicated on what good it might do, as opposed to doing nothing. But the "outcome" of intensive care of babies born at 500 g is now, it seems, measured as "success" with the one in five who "survive." This book shows how much harm can be done to the four out of five. The real outcome of interfering with nature is the balance of harm costs against worthwhile survival. Only if an intervention does no harm can its occasional success be rated worthwhile. The history of medicine is littered with examples showing that truth. Reading this book might force that truth into otherwise reluctant minds.

Furthermore, the harm cost to the families is painfully apparent to the medical staff involved, who must also experience it for themselves. They deal with what they are experiencing and with what they see and feel that the parents and other family members experience in the variety of ways humans have to deal with intolerable situations. Warmth, empathy, and sensitivity to the parents' plight are pleasant and helpful. But it is also psychologically and emotionally very costly to be empathic over and over again in situations where informed staff foresee gloomy outcomes. "Denial" is the most powerful and universal psychological defence. Forman experiences both warmth and callousness from the staff. Not only "the Law" but "the Rules" can be invoked to support the staff's frail moral position. These were used to attempt to preclude a visit from an older sibling; and they denied the mother her wish to be at her son's extubation after weeks of waiting.

"Those responsible for resuscitating your babies . . . left you with a severely disabled child and ruined your life and his"

Coming home with Evan—when he eventually meets all the statutory requirements—allows his mother to instantly replace three shifts of experienced nurses and be given a schedule of procedures and manipulations on which his life is said to depend from moment to moment. Forman does not say, but it seems plain that in case of "an event" the fault would lie with her. One example: the alarm monitor goes off so frequently as to wreck the sleep of the entire household. As the alarm is useless, Forman turns it off. She is admonished by the technician who comes to check it, and she is reported to the hospital authorities.

Within a month the severity and hopeless prognosis of Evan's heart condition is made plain. His murmur turns out to be a life limiting cardiomyopathy. Faced with this further cataclysm there is no defence left save denial. Fortunately, Forman's well informed and experienced mother is able to put the matter to her plainly: "Those responsible for resuscitating your babies . . . left you with a severely disabled child and ruined your life and his."

To me, the group of "those responsible" is very large. Gradually, over the past 50 years, the private and personal contract between doctors and their patients has been expropriated by managers, administrators, politicians, and special pleading groups. Doctors "might" be unreliable, so gradually more and more of the choices available to doctors are proscribed. This book is a catalogue of some of the consequences of such proscription and their disastrous psychological consequences on all those intimately concerned, as well as the range of physical disorders visited on a small child.

Managing Evan until his death a few days before his eighth birthday is not spoken of very much. Sudden seizures are probably the most alarming further catastrophe, and Evan is virtually blind. And the brief exhalation that was his sister Ellie's life occupies his parents for a long time before they can finally lodge her remains in a place they find tolerable.

This book is a rebuke, an indictment of current laws and practices. What it describes is not rare; the rarity comes from the voice that an expert writer can give. It should be compulsory reading for medical students, rule makers, and law givers. That Forman shows that love can be sustained and outlive these ephemeral children despite all adversities does not justify deliberately creating adversity.

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Cite this as: *BMJ* 2010;340:c99

Multiculturalism and the NHS—the experience of a not so foreign "foreign doctor"

PERSONAL VIEW **Andrew Low**

The appearance of the leader of the British National Party on a mainstream political television programme last year sparked an intense debate. Furthermore the BBC documentary *Panorama* recently aired an undercover investigation into racism in Britain ("Undercover: Hate on the Doorstep," 19 October 2009, BBC One), and I was horrified to find it was based in Bristol, my home town of the past 10 years. I was even more distressed by the fact that the housing estate in question was where the hospital I had worked in as a new house officer was located. It led me to consider my experience of race relations in Britain. I must say I feel very fortunate: it has been a long time since I have experienced any sort of racial abuse, something that has not been a large feature in my life. This is in contrast to the experience of my father, who was subjected to significant amounts of racism while growing up and at work, although thankfully this no longer seems to be the case.

Racism has been almost non-existent in my hospital setting, with the exception of the odd Friday or Saturday night when I worked briefly in the emergency department. I've heard "Go back to your own country," or, "I'm not being treated by his sort," or worse. There, racism was only one of the many forms of verbal abuse that is "not tolerated" but that staff are subjected to none the less. What I more frequently experience as a doctor is questions about my background: "So, where are you from then?" I find that "Sheffield" tends to be an unsatisfactory reply to the questioner, who then responds with, "No, where are you originally from?" or, "Where were you born?" Similarly "I was born in Sheffield" tends to result in confusion. But then the answer, "My dad is a third generation, British born Chinese, and my mother is a Malaysian born Chinese, while I was born in Sheffield," just seems incredibly long winded and just as confusing. I tend to go for the simpler, "My family is from China; I was born in Sheffield," or "I'm Chinese; I was born in Sheffield"—not entirely accurate, but it gets the message across.

Perhaps the most bizarre questions I've had include: "So which part of South Korea are you from then?" and "Are you from Hong Kong or Japan?" The former question certainly provoked much restrained mirth from my colleagues on the ward round. My favourite comments to receive are those such as, "You speak very good English," or "You speak with a good accent." The reply, "Thanks, so do you," or, "Yes, they do teach English in the North," seem a little sarcastic (though I have used them at times.) Long gone are the days when I thought that these were in reference to my Yorkshire accent—which, sadly, is getting increasingly subtle after a decade in the south west.

What I more frequently experience as a doctor is questions about my background: "So, where are you from then?" I find that "Sheffield" tends to be an unsatisfactory reply to the questioner, who then responds with, "No, where are you originally from?"

A new question to me recently was in reference to a stuffy clinic room: "So, are you getting used to the climate here then?" I was confused: I didn't really think that the weather in Weston-super-Mare was that different from Bristol's. And how did he know that I've just recently started commuting here? I had to ask my patient what he meant, which only became clear when he asked, "How are you finding the weather after moving to this country?" My reply, "I was born in Sheffield, so I am coping with the climate down here just fine, thank you," felt just a bit awkward (not everyone gets my sense of humour.)

I come across such questions and comments on an almost weekly basis, but I am certain they are never meant in malice. Far from it. They tend to be from the patients with whom I have developed a good rapport; they are genuinely interested about my background and want to make conversation. Sometimes they come from people who have travelled or worked overseas or from patients whose relatives have married people from different ethnic backgrounds. Often people are just keen to hear stories of my exotic past. Imagine the disappointment on their faces: tales of the home of steel and the mighty Owls just don't seem to quite have the desired effect.

Are these patients guilty of stereotyping? It would be terribly unfair of me to say, given that I always seem to retell the stories to my wife in a thick west country accent, which is rarely true to the reality.

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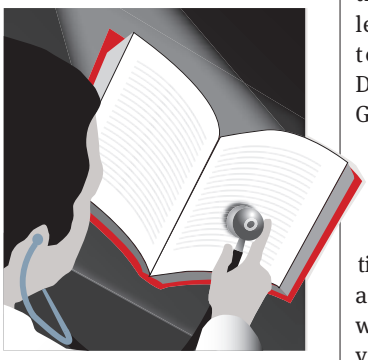
Cite this as: *BMJ* 2010;340:c96

An aural question

BETWEEN THE LINES
Theodore Dalrymple



Is it indeed possible to poison someone to death by pouring a leprous distilment in their ear?

Doctor Johnson once said that a man is seldom so innocently employed as when he is making money. He might have added: as when he is reading or writing Shakespeare criticism. What more harmless diversion could there be for the human intellect? Not, of course, that such criticism is always free of rancour, for what would scholarship be without the edge of enmity to spur it to ever higher flights of ingenious redundancy?

J Dover Wilson's *What Happens in Hamlet*, published in 1935, is one of the most famous works of Shakespeare criticism. It starts off with a puzzle whose existence had eluded critics for three centuries—namely, that of the failure of the dumb show in Act III to alarm Claudius, only for him to have a fit of guilty rage when the very same scene is enacted before him with words a few moments later.

The ghost of King Hamlet had informed Hamlet of how Claudius murdered him, and it was this murder that the dumb show re-enacted: "Upon my secure hour thy uncle [Claudius] stole / With juice of cursed hebona in a vial, / And in the porches of my ear did pour / The leprous distilment, whose effect / Holds such an enmity with blood of man . . . / that it invariably kills him."

What is hebona? The pharmacological puzzle eludes Dover Wilson, because he is not a doctor; nor does he ask whether it is possible to poison anyone to death by the aural route. (*Hamlet* has other toxicological questions—for example, the nature of the poison Laertes uses to tip his rapier with which he kills Hamlet and of the poison in the wine that kills Gertrude: laurel water, perhaps?)

I asked an eminent toxicologist friend of mine whether any poison could be absorbed from the external auditory meatus in sufficient quantity to kill instantaneously, and perhaps reassuringly he did not know.

Now it so happens that I once gave a lecture in Germany to the excellent Deutsch-Englische Gesellschaft (the society founded after the second world war to restore Anglo-German relations) on Shakespeare and medicine, in which I raised the very question of the aural route of poison. Germans love Shakespeare and also lectures about Shakespeare: my audiences (for I gave the lecture five times) were far larger than any that would have come to hear me in Britain, where I am at least equally unknown.

It was inevitable, then, that a member of the audience on one occasion should have something learned to say on the question—namely, that there is a similar such case of poisoning in Castiglione's *Book of the Courtier*.

I felt like Holly Martins, the writer of pulp western novels in Graham Greene's *The Third Man*, who gives a lecture to a Viennese literary society that mistakes him for a highbrow novelist. Martins is asked by a cultivated member of the audience whether he was influenced in his work by James Joyce, of whom he has scarcely heard and has certainly never read.

I resolved to read Castiglione but regret that I have not yet done so. And what if the member of the audience had misremembered the identity of his Italian renaissance author? Does that mean that I shall have to read Benvenuto Cellini's autobiography (surely a more likely source of a story of a poisoning) and all the rest?

Can anyone save me this trouble? And is it indeed possible—in fact, not in literature—to poison someone to death by pouring a leprous distilment in their ear?

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Cite this as: *BMJ* 2010;340:c164

MEDICAL CLASSICS

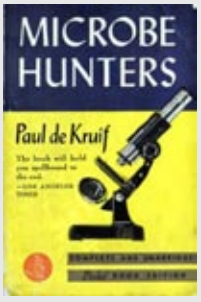
Microbe Hunters By Paul de Kruif

First published 1926

Microbe Hunters tells the stories of the research of 14 microbiologists, from Leeuwenhoek to Paul Ehrlich. The science writer and former editor of *New Scientist* Bernard Dixon has said that the book "must have drawn hundreds of thousands of young people into either biology or medicine," with its "rumbustious" portraits of Louis Pasteur, Robert Koch, and their peers and its enthralling and accessible account of great episodes in the development of modern medical science.

De Kruif wrote these narratives about real people with vivid lives more as imaginative accounts than medical history. He chose to write about one or two key research episodes in everyday language and detail—for example, for Ehrlich it is the story of compound 606 (salvarsan), the magic bullet for the disease that de Kruif could not name.

Its accounts, with their domestic details and invented dialogues, are engrossing, yet the science is accurate. De Kruif was a young microbiologist who served in France in the first world war and then joined the Rockefeller Institute in New York. He also wrote popular magazine articles and soon left the institute to become a writer. De Kruif collaborated with Sinclair Lewis, spending several months on what was to have been a joint novel, although Lewis published *Martin Arrowsmith* without crediting de Kruif. Later editions carry a warm tribute.



Microbe Hunters followed. It was serialised in newspapers, was translated into 18 languages, was the basis of two Hollywood films and a Broadway play, and was even used for puppet shows by the New Deal Federal Theatre Project.

It inspired many. The US medical researcher Albert Sabin wrote: "*Microbe Hunters* was a great stimulus. That's the life for me." Others who have written of its influence include Michael Oldstone, Stanley Plotkin, James Watson, Jonas Salk, Joshua Lederberg, and Eli Chernin.

However, not everyone was pleased with the book. Several physicians wrote a scathing letter to the *BMJ* and the *Lancet* complaining that the book, "alleged to have been written by one Paul de Kruif—a gentleman whose name is quite unknown to us," had libelled them. As a result some chapters were quietly deleted from the British edition to avoid legal action. Theobald Smith and David Bruce were the only subjects de Kruif had actually met. It has to be said that his account of Bruce's Malta fever research is romantic, one sided, and misleading.

My copy is a US wartime paperback published in 1945 and bought in York in 1947 just before I left the army: by then it had been reprinted 67 times. I was especially intrigued by the researches of Koch and Ehrlich—their stories as told by de Kruif have background detail I have not found elsewhere, and they still fascinate me.

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Cite this as: *BMJ* 2010;340:c98

A letter to me at 23

FROM THE FRONTLINE
Des Spence

Dear me

Stop being so angry, understand that you can get fat, and cut your hair now! Stop obsessing about the Beatles, for there is great music to come. Also, your parents were right about everything, and your own children will take a sledgehammer to your life. You won't emigrate to Australia, tiring of burnt outdoor food, fizzy bland beer, and the tedium of sunshine. Instead you will pine for rain, pubs, complaining, sarcasm, and—most of all—family. Remember that money can't make you happy but can make you miserable.

You will attain enough postgraduate diplomas and certificates to spell out Mickey Mouse after your name, but this won't make others respect you; respect is only in the gift of yourself. Never score points off colleagues or nurses; this only disrespects you. Respect your seniors; they have worked harder than you will ever know. And always trust the experienced before the learned. Forgive the overconfident, for overconfidence is a mark of stupidity or insecurity and often both. Strive to forgive the dull and tedious, because they know not what they do. Be wary of the "certain," for they are most certainly wrong.

Fortunately you missed many lectures at university, because unlearning is more difficult than learning. Most of what you were taught was half true, not true, or simple fabrication. Indeed many of the illnesses you learnt in pained detail disappeared before you started to practise. Be warned that the remaining clinical conditions never present with the "classic symptoms" you learnt. Also understand that all that pretends to be medical is not. Many symptoms are unexplainable: the more bizarre the symptoms, the less the likelihood of pathology.

Read guidelines, but for God's sake don't always follow them. Listen to your patients and colleagues (or at least pretend too). Always be polite, because this is the best way to infuriate the rude. Seize opportunities, but know when to let go, because failure and success are conjoint twins. Smoking and drinking are bad for you—honest.

Don't go on pharma jollies, as they will make you feel cheap, and understand that any drug with a catchy name probably doesn't work. Patients will always complain, but apologising to them doesn't mean you were wrong. Neither politics nor the state can solve the unhappiness of humanity. Most importantly, invest in a Mac, because by 2010 PCs take three years to boot up, and the screen is obscured by error pop-ups. Lastly, don't start watching *X Factor*—it will take your soul.

Best wishes

Me

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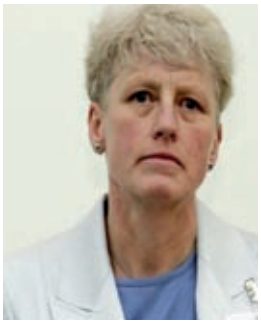
Cite this as: *BMJ* 2010;340:c180

All made up

OUTSIDE THE BOX
Trisha Greenhalgh



I was billed to give the opening keynote lecture at a conference in a trendy European city. I had sent my PowerPoint presentation weeks ago to be translated into the three official languages. The night before I had checked into my five star hotel and been dined at a splendid restaurant by the organising committee before decamping with old friends to a bohemian bar downtown. It's a hard life.

I got back to my room just before midnight to find a plain white envelope pushed under my door. "Please report to the Speakers Room one hour before the start of the opening session"—that is, 7 am local time, 5 am mine. I dutifully set my alarm and presented myself, suited and booted and with a double spaced copy of my lecture folded neatly in my pocket. "Come this way," said the uniformed hostess. "You need to see the make-up artist."

I followed her backstage to a dressing room with five mirrors and what looked like a dentist's chair set to full recline. The make-up lady briefly examined my face, wrinkled her nose, and began to swathe me in towels.

"Hang on," I said. "I don't normally wear make-up. And I don't think the audience cares much what I look like."

She smiled: "All lecturers are required to be made up. I'm just going to optimise your face for the big screen."

She took a pastry brush, selected a buff coloured powder from an extensive palette, and began to transform me from English rose to café au lait. She painted several shades of lip gloss on the back of her wrist and held it against my cheek to make her selection.

"Look, I don't want to be rude, but I'm actually speaking on a slightly feminist topic. I can't walk on stage looking too dolled up."

She laughed, as if it had been in her remit to do more than damage limitation. Then she opened a pot of rouge and dabbed it skilfully onto my zygomatic arches.

"I thought you needed to get rid of the red."

"I did, but now I'm putting it back in the right place."

"Ah. Thanks."

We reached a truce over the mascara. None—or I would leave the building.

I got to the podium with minutes to spare, to find that my male co-presenter had made omission of the "compulsory" makeover a condition for appearing.

When I got home the kids explained it all. Why did the blonde put foundation on her forehead? To make up her mind.

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Cite this as: *BMJ* 2010;340:c161