

Viewpoint

» The other side

Being a patient gives another perspective

Having recently been ensconced in hospital as an inpatient for seven days, I have been “released” with a new perspective on life as a patient. The clinical care I received was second to none, and I am interminably grateful to all of the healthcare professionals involved. But as the days passed, I began to understand why patients can become so upset, disillusioned, and even aggressive during their hospital stay.

Lying in a hospital bed gives you time to think, and think, and think. You think about what’s wrong with you; you think about what’s not wrong with you; you worry about the tests you have to have and the treatment you may face. The highlight and focus of your day becomes the doctor’s ward round. It is the few minutes out of each 24 hour period that you feel are productive: when you manage to find out what the plan is (usually), what your test results are (sometimes), and what’s wrong with you (infrequently). Imagine what it feels like when those few minutes are rushed and information is poorly communicated. Imagine

how I felt when the doctor popped his head round the door and said, “No change? Keep going,” and then left.

As a doctor, I could understand the general ward chat, and I cringed when I was referred to as “side room 5” or “the abdominal pain.” I winced when yet another doctor jumped to incorrect conclusions about my history, and I cried when a member of staff barged into the room during an intimate examination.

How many times have I been that rushed, busy doctor who hasn’t had time to explain things slowly and fully to patients? How many times have I popped my head into a side room with a medically stable patient who is waiting for social arrangements to be made before discharge, and just said hello and goodbye? Countless times; I’m as guilty as my colleagues.

Being a patient is a tiring, emotional experience, and we doctors have a duty to help our patients through this difficult time, not just with regard to their clinical management but, perhaps even more importantly, also their feelings and anxieties. I hope I never forget this invaluable lesson.

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First published in the *BMJ*, 2009;338:a966

Viewpoint

» Selecting the next generation

How can we best choose future doctors?

The Biomedical Admissions Test (BMAT) results are out; medical school applications are in and mostly processed; the interview season is well under way. I am bug eyed from reading personal statements, all of which seem to begin with “From an early age I have been fascinated by the workings of the human body.”

I have shaken hands with more outstandingly gifted youngsters than I have ever met outside the medical school application process. I have read how characters were honed in tropical jungles or by scaling Himalayan peaks. I have underlined examinations passed without dropping a mark and quirky arts subjects studied in parallel with hard sciences. I have noted exceptional social or material circumstances pointed out by teachers anxious to maximise number of offers from the Russell Group of top UK research universities for their school’s annual report.

I have been told so many times that the future of medicine is contiguous with that of the embryonic stem cell that I now believe this statement. I have also learnt that good leadership is about telling the nurses clearly and in simple terms what they should do. I have ticked “accept” on some forms and “reject” or “waiting list” on others.

In parallel with all this I have been a patient. I presented with a symptom that alarmed and distressed me. Uncomfortable and undignified investigations to exclude a malignancy were conducted with the utmost professionalism. The junior doctor who clerked me in for my operation took care to ensure that my record was flagged with a key allergy. He later reappeared with a large felt pen, apologising good naturedly for initially forgetting to mark the site of the operation. I was anaesthetised by someone who understood how terrified some people are by general anaesthetics. The cause of my symptoms was removed with great skill. When I developed what I believed (correctly, as it turned out) to be a postoperative complication, I was taken seriously and seen promptly.

If I live out my predicted life expectancy and follow the typical pattern of decline in industrialised countries (that is, if I don’t get really sick until within a year of my death), my serious illnesses will be diagnosed and managed by GPs and consultants who are being admitted to medical school around now. Most importantly, these men and women will be in charge of my terminal care.

Talented all rounders they may be, but will selecting for the litany of accomplishments towards which they are all groomed give us the doctors who will care most effectively and humanely for us in our dotage?

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First published in the *BMJ* (2008;337:a2963, doi:10.1136/bmj.a2963).

Exhibition Review

» War and Medicine

Wellcome Collection, London, in association with the Deutsches Hygiene Museum, Dresden, Germany
Until 15 February 2009; free; open daily
www.wellcomecollection.org/warandmedicine

Rating: ★★★



GILLIES ARCHIVES/QUEEN MARY'S HOSPITAL

This exhibition looks at the reality of war and emphasises the devastating physical effects of war on the human body, and the psychological scars left imprinted on survivors. There are more than 200 visual and auditory exhibits, including film, paintings, letters, medical artefacts, and personal video clips.

Before entering there is a warning that visitors may find some images disturbing. The opening leads to a table of death tolls, rising into the millions, from the Crimean war through to the present conflicts in Iraq and Afghanistan. The statement “Statistics in relation to war ‘are never exact, seldom truthful, and in most cases full of intentional misrepresentation,’ Carl von Clausewitz,” gives a taste of what lies ahead.

The exhibition comprises four separate rooms—theatre, organisation, the body, and the mind.

The theatre room is an uncomfortable experience by David Cotterrell. In this extremely dark room it takes some time for your eyes to adjust to the film projected across the wall, which depicts wounded soldiers being evacuated from a war zone. Simultaneously your ears are subjected to the loud continuous roar of an engine drowning out all that is being said.

The organisation room examines the Crimean war and the beginning of the triage system, initiated by the army surgeon Nikolai Pirogov. “Reverse triage: less seriously injured are treated in preference to the wounded”—these men could return to the battlefield. A softer theme also pervades here with the contribution of Florence Nightingale’s care for the many wounded soldiers.

The body and the mind rooms portray the effects of war on the individual. Images and personal video clips show the trauma that has been endured. And in parallel to this we can make comparisons with medicine today and the advances that have been made by scientists and our medical and surgical colleagues.

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Competing interests: None declared.

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

Personal View

» Ideas, concerns, and expectations

Take care not to scare patients in consultations

Yesterday I was a foundation year 1 doctor in cardiology, today I am a foundation year 2 doctor in general practice. I have my own office, computer, chlamydia screening kits, and even a secretary. I also, however, have my own patients. The problem here is that they arrive expecting to see a confident and experienced general practitioner. Unfortunately, I am neither. Luckily my tutor, who is both, is on hand to help during my consulting sessions, and also offers a weekly tutorial.

This week the tutorial was on consultation skills, and in particular how a doctor should elicit a patient's ideas, concerns, and expectations during a consultation. After the tutorial, I am keen to put this into practice. My next patient seems an ideal candidate: he is an elderly man who has come to see me about his constipation. There are no worrying features in the history, and it would have been easy to send him off with a prescription for my favourite laxative, but I stop myself. I ask, "What do you think might be causing the constipation?"

"I dunno," comes the reply. "You're the doctor," he helpfully reminds me.

"But are you concerned about anything in particular?" I persist.

"Not really."

There must be something on his mind, I think. Perhaps I need to be more direct. "Are you worried about cancer?" I ask.

"No, not at all," he replies sharply.

With the patient's ideas and concerns skilfully elicited, I move on: "What do you think would be the best course of action?"

"You're the doctor," is the predictable response.

The patient leaves with his prescription and an appointment to see me in a few days if he isn't feeling better. I congratulate myself on putting my new skills into action, thinking that the consultation had gone well, and moved on to see the next patient.

The next day I get a message asking me to telephone the constipated patient I had seen yesterday. I naturally assume the worst—he's probably perforated his colon, and his family want my General Medical Council number. However, when the telephone is picked up I get a worried answer from the man himself. He is concerned about the consultation we had yesterday and wants to see me to discuss it. I put him on the end of the afternoon's list and

wonder what the problem could be.

When the patient returns, I see he's looking worried. "What's the problem?" I ask.

"Do you think I have cancer, doctor?"

"No. Why do you ask that?"

"Well, you mentioned it yesterday out of the blue, and it hadn't even crossed my mind. I've been worrying about it ever since."

Suddenly the penny drops. In my clumsy efforts to elicit his ideas, concerns, and expectations, I had actually given him something to be concerned about. Cancer had never crossed his mind, and why should it have? Such direct questioning did nothing but give the poor man a sleepless night of worry.

During my general practice placement my consultations skills have improved considerably. Discussing ideas, concerns, and expectations is still high on the agenda, but now it is more delicately approached and more patient specific. If done correctly it allows the patient to give you all the answers you need, and often the diagnosis, without interruption.

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First published in the *BMJ*, 2008;337:a3135.

Film Review: Psychiatry at the cinema

Psychiatric care is increasingly delivered in the community, and it can be difficult for students to get experience. A florid psychotic patient presents difficult practical and ethical challenges in teaching. Cinema is there to entertain, and many films present mental health negatively, but some films also contain realistic depictions of mental illness that can be viewed without having to worry about consent.

» Some Voices

Directed by Simon Cellan Jones, 2000

Rating: ★★★★★

Schizophrenia is rarely depicted sensitively in film but an exception to this is *Some Voices*. Schizophrenia is a psychotic illness that affects 1% of the population in which the patient experiences hallucinations, usually voices, and delusions. Daniel Craig plays Ray, who is coming to terms with schizophrenia, leaving hospital, and trying to form a relationship. The viewer can identify with him easily thanks to Craig's excellent performance. The film could easily have succumbed to the stereotypes about mental illness but moves way beyond them. It also concentrates on the relationship that Ray has with his brother and gives a good idea of the effect that serious mental illness can have on patients and their families.

» Trainspotting

Directed by Danny Boyle, 1996

Rating: ★★★★★

An iconic film of the 1990s was *Trainspotting*, which follows the lives of a group of heroin addicts in Scotland. Heroin is an addictive drug, which takes over users' lives as they

seek their next "hit." Withdrawal causes restlessness, muscle pains, insomnia, flu-like symptoms, and diarrhoea and vomiting. Overdose is often fatal. *Trainspotting* vividly portrays the way heroin takes over and the squalor surrounding regular use. And injecting is shown realistically—how can you show students this otherwise? The memorable and vivid withdrawal scene is slightly unrealistic, however, because the leading character, played by Ewan McGregor, experiences hallucinations, which do not usually occur.

The film sparked controversy as to whether it glorified drugs; but many people view the way it emphasises the sordid nature of heroin misuse as a powerful antidrugs advertisement.

» Iris

Directed by Richard Eyre, 2001

Rating: ★★★★★

Another useful educational tool is *Iris*, a film of the life of the author Iris Murdoch, who had Alzheimer's disease. Alzheimer's disease is the most common form of dementia, presenting with problems with memory, judgment, language, and attention, leading to



Judi Dench as Iris Murdoch in the 2001 film

a more general cognitive decline. The film follows two periods in the author's life—Iris in her youth, played by Kate Winslet, who meets her husband, John Bayley, and the older Iris, played by Judi Dench, who experiences the diagnosis and progression of dementia.

The depiction is a condensed representation of the natural progression of the disease and provides a moving and realistic example of the effect of the illness on her carer. The couple's relationship and the effect of the disease form the core of the narrative, which is as much a love story as the story of her illness.

There can be disadvantages in using film as a teaching aid in psychiatry.¹ Characters with mental illness are often portrayed as unpredictable, aggressive, or evil, reinforcing negative stereotypes. Stigmatising attitudes to mental illness are perpetuated by the use of inaccuracies such as the "split personality." However, identifying and exploring why these negative portrayals occur so widely in film can be useful and some films portray reasonably accurate and positive depictions of mental illness and are probably underused as a teaching tool. St Georges, University of London, runs a Psychiatry and Film special study module, which is available to second year medical students.

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Competing interests: None declared.

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

1 Byrne P. Commentary on Bhugra: using film and literature for cultural competence training and teaching through cinema. *Psychiatr Bull* 2003;27:431-2.