reviews

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Healing Dramas and Clinical Plots: the Narrative Structure of Experience

Cheryl Mattingly

Cambridge University Press, £14.95, pp 192
ISBN 0 521 63004 5

Rating: ★★

In this book anthropologist Cheryl Mattingly analyses communication by occupational therapists treating life altering illnesses such as spinal cord injuries. Her opening statement admits that the book gave her trouble as her thoughts developed over a decade. She also wondered how much of her personal opinions and feelings should be openly expressed, and her analysis ultimately reflects the interaction between patients, therapists, and observer.

The book, which builds on existing work, does not read as an introductory text and would probably appeal most to those with a particular interest in narrative research. Looking into the connection between language and action, Mattingly weaves philosophical and psychological arguments into her discourse, concluding that healing words and gestures follow a story-like structure.

Some of the concepts detailed by Mattingly are neither new nor unique to rehabilitation therapy. For example, she observes that the present is configured by the past (as a reference point to help put illness in a life context) and by anticipation (the story toward which one is heading). She notes that therapists draw from their global experience yet must individualise their therapeutic approach, and she refers to the desired congruence between therapists' and patients' goals.

Other publications (such as M Stewart and colleagues' *Patient-Centered Medicine*) discuss such matters in a language more accessible to a practitioner. Comments on the challenge of deciphering not only the language but also the actions of others can also be found, in succinct but clear form, in texts like D L Sackett and colleagues' *Clinical Epidemiology*.

Mattingly is at her best when describing the challenges specific to occupational therapy ("therapeutic plots"), such as the need to make the treatment process matter to patients in spite of a long path rewarded by only small, irregular gains. Her description of encounters between patient and therapist is so vivid that one can actually visualise the individuals and feel their emotions. She emphasises the need to focus on a plot structure rather than on a succession of doings, since the ultimate goal is to have patients integrate the problem solving process into their lives and continue to apply it even when the therapist is no longer present.

This book will be of interest to most occupational therapists, but it has particular value for those considering occupational therapy as a career because of its meticulous description of that profession's challenges.

F Lortie, *consultant, Baycrest Centre for Geriatric Care, Toronto, Canada*

Brave New NHS?

Jo Lenaghan

Institute for Public Policy Research, £7.50, pp 135
ISBN 1 86030 065 0

Rating: ★★★

None of us, least of all geneticists, should be denied the bitter sweet sapience prayed for by Robert Burns, "tae see ourselves as ithers see us." The Institute for Public Policy Research report *A Brave New NHS?* anticipates the impact of genetics in the millennium and doesn't pull its punches: "The NHS is sleepwalking into the future." My specialty was under examination; I felt threatened and was ready for fight or flight.

Jo Lenaghan assembled this report by contacts with geneticists, a family doctor, the Genetic Interest Group, and a public health professor. The subject is topical, and this book fills a gap among the many recently published review papers and books.

Where are we in 1999? A national network of accredited genetic centres provides the opportunity to link genetic information to the advantage of the wider family (while preserving confidentiality). The centres are constrained by limited NHS funds and are unable to contribute sufficiently to the educational exercises needed to inform non-genetic colleagues such as family doctors. In addition to maintaining established services, geneticists grapple with new work such as the genetic element of the multidisciplinary provision for cancer genetic services.

Policy planners who wish to develop the genetic paradigm within the NHS have advantages over those abroad because of our primary care system, the regionally located genetic centres, developing interest in public health genetics, and several relevant advisory bodies (both national ones such as the Human Genetics Advisory Commission and independent bodies such as the Nuffield Council for Bioethics and the Genetic Interest Group).

This report is gloomy about the range of bodies but excited at the opportunities if activities are coordinated. By being independent and fairly neutral in handling the many genetic controversies and by reaching understandable and achievable conclusions, the Institute for Public Policy Research provides a sound and useful summary of the current state of genetics for non-experts. One conclusion of the report is that there must be more genetic work in primary care, backed up by genetic centres and particularly by genetic nurse specialists.

Four years ago, the distinguished editor of a high impact medical journal declined my invitation for him to speak at a meeting entitled "Genetics is the Core of Medicine." He gave three reasons: he hated speaking, he knew nothing about the topic, and he didn't agree with the proposition. After reading *A Brave New NHS?* he might wish to reconsider his decision.

J A Raeburn, *professor of clinical genetics, Nottingham University*

Reviews are rated on a 4 star scale (4=excellent)

Scottish fears over PFI

Few ideas can be more assured to work the press into a lather than the notion of taxpayers' hard earned money being used to swell the coffers of rich private conglomerates. And so it has proved to be with the issue of the private finance initiative (PFI)—a scheme introduced by the Conservative government and adopted by the present Labour administration, which involves private companies building hospitals and schools and then leasing them back to the state over a 20 or 30 year period. The buildings may never revert to public ownership, prompting the Scottish National Party (SNP) to dub PFI "Privatisation For Infinity." It has become one of the most fiercely fought over issues in the election for the first Scottish parliament for 300 years, generating many column inches in the newspapers over the past few weeks.

The Scottish press has variously described the private finance initiative as "the only practical means of providing patients and staff with first class treatment facilities"; "a poor deal for taxpayers, who will pay huge sums for buildings they will never own"; "equivalent to arranging a mortgage through a loan shark," and other, less flattering, definitions. The tabloid *Scottish Sunday Mail* led the charge against PFI in a series of articles which set out to expose the scandal of the scheme, as the newspaper saw it. The articles concentrated on the deal to build a replacement for the Edinburgh Royal Infirmary. The new hospital will cost £180m ($290m), but the NHS will pay an annual charge of £30m for 30 years to the private consortium that will build it—a total of £900 million. "Wrong, Wrong, Wrong" read one banner headline in the *Scottish Sunday Mail*.

The story was taken up by others newspapers, with the *Herald*, in particular, examining some of the implications of the Edinburgh PFI deal and not being too happy with what it found. It quoted an analysis carried out by a leading critic of PFI, Professor Allyson Pollock of University College, London, which concluded that staffing and bed numbers at the new Edinburgh Royal Infirmary would have to fall significantly to pay for the project. In a later letter to the newspaper Professor Pollock said the hospital trust would cut its operating costs by £31m a year by reducing staff, supplies, and NHS capital charges. However, £20m of this money would not benefit the NHS but "will be used to service the consortium's bank debt and provide returns to shareholders," she wrote.

The row over PFI then spilled over into the Scottish election. The BMA in Scotland wants PFI schemes abandoned, and the policy has been rejected by both the SNP and the Liberal Democrats. The SNP has proposed replacing the scheme with Scottish public service trusts, which would still use private investment for public buildings but retain them in public ownership.

The SNP has attacked Labour's support of PFI and has been supplied with plenty of ammunition. Widespread coverage was given to the decision of a leading union official, Mark Irvine, to quit the Labour party over the issue and to subsequent critical comments from the party's Scottish treasurer, Bob Thomson, that PFI was a bad deal for the taxpayer. Members of the public sector union, Unison, at the Edinburgh Royal Infirmary withdrew their support from Labour, and there was further embarrassment when it was revealed that a Labour election candidate, George McGregor, had likened PFI to "a mortgage from a loan shark" at a conference last year. Mr McGregor said he was speaking at the time on behalf of his union and these were not his personal views, but Labour's otherwise assured election campaign was being undermined by continual bad publicity over PFI.

During all this, the Scottish health minister, Sam Galbraith, has maintained that the critics of the scheme have got it wrong. The Edinburgh consortium is not being paid £900m to build a £180m hospital because the annual charges also cover running costs. "Let me make it clear that when PFI funding is used, it saves money for the taxpayer. It is not a hire purchase agreement. I repeat it is cheaper than the public sector option and where it is not, it is not permitted," he said in the *Scotsman*. However, most of the Scottish papers later quoted a report by accountants Chantrey Vellacott DFK that estimated that, for every £1bn of spending financed by PFI, the Treasury paid £50m more in interest than if it had borrowed the money directly.

At a time when the mass media seems to be obsessed with personalities and human interest stories, the Scottish press deserves credit for devoting attention to this complex but important issue. Given the welter of claim and counter claim about PFI, it is difficult to know if the public has emerged any wiser. What is clear is that there is an instinctive reaction against a system that hands over such large amounts of money to private companies, and the advocates of PFI will have to work a lot harder to explain the supposed benefits if they are to convince people that such schemes are in the public interest.

Bryan Christie, *journalist, Edinburgh*

WEBSITE OF THE WEEK

www.scottish-devolution.org.uk/ A fresh start is generally enjoyable, and those who are dreaming up the structures of the Scottish parliament, to be elected next week on 6 May and due to start sitting in early June, seem to be taking full advantage of the opportunity. As all the detailed planning for the parliament has taken place after the explosive growth in use of the internet, many of those plans involve the web. The website set up to report on the transition labels its buttons with some rather painful acronyms (CSG, FIAG, ICT), which were meaningless to me, and, I imagine, to most of Scotland's population. Although explanation is only a mouse click away, well designed links should anticipate the content behind them in order to avoid unnecessary downloads.

In fact, the acronyms stand for Consultative Steering Group, Financial Issues Advisory Group, and Expert Panel on Information and Communication Technologies, respectively—the last of which drew my interest. Hansard has been on line for some time now, at www.parliament.the-stationery-office.co.uk/, and, although it's a chore to wade through, it works. With no legacy technology to detain it, the ICT is marching full ahead into the electronic frontier. Scotland's parliamentary network will be set up on the presumption that information, unless specifically restricted, should be publicly available. The ICT advocates not only that transcripts of debates in the chamber should be online but that websites should be set up for public debate on controversial issues, with voting on the internet. Members of the Scottish house will have terminals in the chamber to receive up to date information, and anyone who is interested will be able to "Dial a Debate" by telephone.

"Piseach riaghail" (luck to your rule), as you might say if you had access to an online Gaelic dictionary (www.ceantar.org/).

Douglas Carnall
BMJ

PERSONAL VIEW

BMJ should stop confusing its readers over national differences

Almost every week the *BMJ* makes mistakes about which elements of the health service apply in England only and which are true for the rest of the United Kingdom. It is not alone in this. Most of the London based media confuse their readers and viewers about the differences between the four countries of the United Kingdom, and it is time for them to do better. Devolution makes this essential.

Take NICE (the National Institute for Clinical Excellence). This will work for England and Wales. Scotland, instead, has SHTAC (Scottish Health Technology Assessment Centre). But since the beginning of the year the *BMJ* has twice told its readers that NICE will cover the whole of the United Kingdom.

The journal is similarly confused about the white papers on the health service. The National Health Service, a British institution, has had separate arrangements for the four main countries ever since it was set up in 1948. Health policy in Scotland often mirrored or followed arrangements in England (and Wales), but documents had to be "tartanised" to reflect differences north of the border. The systems are, however, diverging. The 1989 white paper, *Working for Patients*, applied to the United Kingdom and included a chapter for Scotland, whereas the 1997 white papers were separate and different for England and Scotland. The *BMJ* regularly fails to make these differences clear, just as it does not make clear that the four countries have different health ministers and chief medical officers. We read about the "UK health minister" or the "UK chief medical officer," creatures who do not exist.

Another rich source of confusion is that at the Union in 1707 Scotland kept its separate legal system. This has an important impact on many decisions about health care—good examples are the differences in consent for children's treatment or decisions about patients in a persistent vegetative state. In England surgeons should obtain explicit consent for any proposed treatment of a child under 16 from the person with parental responsibility, whereas in Scotland there is a special provision for patients under 16 to consent to medical procedures. In Scotland 16 year olds can get married without parental consent: hence the popularity of Gretna Green. The Tony Bland case in England set the precedent for decisions about patients in the persistent vegetative state, but in Scotland it was the case of Janet Johnston. Legally England and Wales are paired, Scotland and Northern Ireland have their own jurisdictions.

A mistake that the *BMJ* has made twice in the past two years is to write about "the three special hospitals in the United Kingdom: Ashworth, Rampton, and Broadmoor." There is a fourth, Carstairs, which serves Scotland and Northern Ireland. In the broader media, a BBC *Panorama* programme about "criticism of the UK Special Hospitals" was widely publicised in advance. Only when the programme started did it become clear that it was only the three English special hospitals that were singled out.

Readers of the *BMJ* from outside Britain may view the United Kingdom as just one country, and England is regularly used to mean the whole of the United Kingdom. But there are marked differences between the four main countries, which are well illustrated by sport. Allegiances vary depending on the sport concerned. For example, rugby union has one Irish national team, association football has two. Only the United Kingdom is allowed to send competitors to the Olympic Games. The "Tebbit test of Britishness" proposed by former Tory minister Norman Tebbit is misnamed. He suggested that support for the English test cricket team was a prerequisite for any Briton yet many Scots would fail the test, particularly if Scotland was playing England.

> "Devolution is just one of the catalysts for change"

Devolution is just one of the catalysts for change that makes these mistakes increasingly irritating and important. Another is continuing membership of the European Union with its policy of regionalisation and subsidiarity which means that we will be in a state of constant flux. This is a challenge for the media. It will be even harder for the public and doctors to understand what is happening, and the media (including the medical media) must report facts accurately. The *BMJ* should lead the way in raising standards, not be at the back of the pack.

It should not be as parochial as a recent BBC Radio 4 programme reporting on the results of a survey of delivery of first class mail. "Tests have shown the Post Office is not fulfilling its requirement for next day delivery of first class mail … and we are not just talking about remote areas such as the Shetlands and Northern Ireland, also closer to home in north London."

If you would like to submit a personal view please send no more than 850 words to the Editor, BMJ, BMA House, Tavistock Square, London WC1H 9JR or email **editor@bmj.com**

Arthur Morris, *chairman, BMA Scottish council and consultant plastic surgeon, Dundee*

SOUNDINGS

Arise, Sir Lancelot

Greying beard, dark suit, middle age spread, consultant status. Coincidence, or have I been subconsciously working on my image? Anyone over 50 feels like a youngster in an ageing body, but for a few of us, Simon Sparrow is trapped inside Lancelot Spratt.

Doctor in the House was published in 1952, when I was 4 years old. The film was produced in 1954 by Betty Box, who died recently. Sir Lancelot was played by James Robertson Justice, who died 24 years ago. The images, however, live on, giving the book's last words a prophetic quality: "From now on it was always going to be like this."

With screen doctors spanning the alphabet from Cameron through Gillespie to Zhivago, why should Spratt remain the most recognisable? One reason is the brilliant portrayal. James Robertson Justice (a name impossible to shorten) was a former naturalist and journalist and his intelligence showed. Today's directors prefer senior consultants to be played by cardboard actors with untwinkling eyes.

The main reason, though, is that Sir Lancelot is like Santa Claus. Deep down, everyone wants to believe that he exists. Richard Gordon's creation was humane beneath his bluster, but what still attracts us is his armour plated self assurance. He is the embodiment of what zoologists call the dominant male. As Desmond Morris keeps reminding us, humans are little different from our cousins the apes. Like them, we are programmed to be part of a hierarchy. The leader may be challenged but nobody likes to see him bleed.

Nowadays, however, an unreconstructed Sir Lancelot would last about 48 hours before a whistleblower reported his bad attitude. This sets a problem for his successors. Can we reconcile the primordial need for leadership with the current distaste for medical authoritarianism?

The quandary was brought home to me recently during a meeting which included some routine doctor bashing from consumer representatives. The medical profession, they said, is still as arrogant as it was in 1952. Silence would have meant assent but taking offence reinforced the irascible stereotype.

We usually cope by agreeing, finding scapegoats, and looking for leadership from outside medicine. Better, I think, to rediscover our self confidence. We can banish paternalism from the individual consultation without completely abrogating our collective authority.

James Owen Drife, *professor of obstetrics and gynaecology, Leeds*