James Owen Drife volunteers for the NHS film unit, p 756

Eating disorders: do gyms have responsibilities?

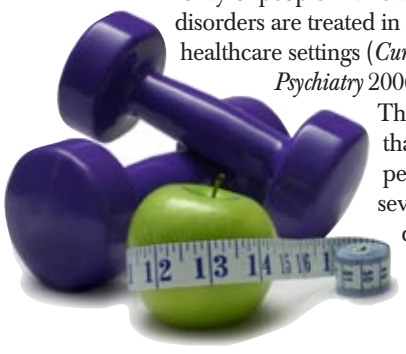
PERSONAL VIEW **Rony E Duncan**

A few months ago, while attempting my new morning exercise routine at the local gym, I noticed a young woman in her mid-20s. Let's call her Amy. I don't go to the gym as regularly as I should, but each time I do, Amy is there too. While I'm trying to wake up on the treadmill Amy is coming out of the early morning aerobics class, having finished an hour long workout. While the others head to the showers, Amy heads to the bicycles. Often she is still there by the time I leave.

I have no doubt that Amy has an eating disorder. This view is based not only on her exercise habits but also on the eating behaviour I have witnessed and her incredibly thin frame. Having shared several concerned glances with fellow gym members, I suspect I'm not the only one who is worried.

As a researcher working in the field of ethics and adolescent health, I can't help but wonder what constitutes appropriate action by my gym manager in Amy's case. Should something be done? If so, what? Do gyms have obligations when it comes to the wellbeing of their members? What is their role in the delicate and sensitive battle against eating disorders?

There are three key arguments in favour of gyms taking action with people like Amy. Firstly, it is an opportunity for intervention. The lifetime prevalence of eating disorders among Australian women has been estimated to be as high as 15.4% (*Aust N Z J Psychiatry* 2006;40:121-8). We also know that only a minority of people with eating disorders are treated in mental healthcare settings (*Curr Opin Psychiatry* 2006;19:389-94). This means that most people with severe eating disorders do not receive adequate treatment (*Int J Eat Disord* 2003;34:383-96). Gyms are well placed to identify individuals with such disorders, thereby increasing the chances of early diagnosis and treatment.



Secondly, many formal weight loss organisations refuse to take on clients who are not above a specific body mass index, thus reinforcing healthy messages about body image. If gyms intervene over members who may have an eating disorder they would act as advocates for a realistic and healthy body image.

Finally, when gyms fail to intervene over members who are below a healthy body weight, they risk becoming complicit in the delusions held by these individuals, strengthening the perception that more exercise and weight loss are needed. Not only does this harm the person with the eating disorder, it could harm other members of the gym who may begin to see the person's behaviour as normal or even exemplary.

Of course, taking an active role has potential for problems. Depending on the approach taken by the gym, the person with the eating disorder may feel embarrassed, angry, offended, humiliated, or ashamed. It is also possible that the person won't return to the gym, which may increase their isolation and break important social links. Gym employees are not counsellors or doctors and have not necessarily been trained in the skills required for successful intervention.

A variety of other businesses actively influence the health of their customers but are not required to monitor outcomes. Fast food chains, for example, are not required to refrain from serving obese customers. Alcoholic people are not refused service in bars. Gambling addicts are free to enter casinos. Smokers with chronic obstructive pulmonary disease can still buy cigarettes. It could be argued that requiring gyms to intervene over people with eating disorders would be to ask them to act outside their ethical remit. At the end of the day, gyms are independent, profit driven organisations.

Furthermore, we simply don't know whether intervening will actually improve outcomes. There is no evidence that a private conversation has the capacity to change exercise habits. Telling people they are underweight and alerting them to avenues for help may not result in their accessing treatment. And banning someone from a gym will certainly not prevent them from exercising. In the absence of evidence of benefit, it could be argued that refraining from intervention is the safest option—the least likely to cause harm.

When gyms fail to intervene over members who are below a healthy body weight, they risk becoming complicit in the delusions held by these individuals, strengthening the perception that more exercise and weight loss are needed

Eventually I asked my gym instructor about Amy. She said I wasn't the first to ask and that it was "a very difficult issue." She mentioned that the gym was following the appropriate guidelines ("Fitness Australia guidelines: identifying and managing members with eating disorders and/or problems with excessive exercise"). The guidelines, which I've seen, are impressive. They recommend a detailed step by step process that begins with a private conversation, can entail a request to see a GP, and, eventually, may entail suspension of membership.

I wonder, then, what has happened in the case of Amy, who has been attending my gym for at least a year now. Is the gym committed to following the guidelines? Is the current approach working? Is it sufficient? I'm not an expert in eating disorders, and I'm sure the situation is more complicated than I know, but each time I see Amy my unease increases. I welcome open discourse from those who are experts in the field.

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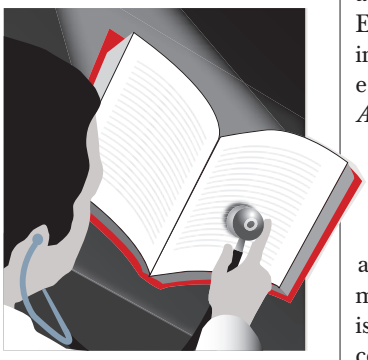
A life at stake

BETWEEN THE LINES
Theodore Dalrymple



In his *Christianismi Restitutio* (Christianity Restored), for the heretical nature of which he was burnt, Servetus first described the pulmonary circulation of the blood (an odd place to publish a physiological hypothesis)

Not many doctors, I think, have been burnt at the stake, though I am sure we could all nominate some of our colleagues who deserve to be. Perhaps the General Medical Council will soon reintroduce the medieval tradition for those doctors who refuse to abjure their errors and heresies; if so, surely the television rights and admission fees to the events could help to keep the annual subscription fee constant for a year or two.

The most eminent doctor ever burnt at the stake was Michael Servetus (1509 or 1511-1553), who studied medicine in Paris and managed the feat, difficult at the time, of being condemned to death for heresy by both the Catholics and the Protestants. He wrote against the doctrine of the Trinity while practising medicine in Vienne, near Lyon, and Calvin, getting wind of this, denounced him to the Catholic authorities there, who condemned him to death. Servetus fled (he was burnt in effigy), intending to go to Venice, but made the strange and still puzzled-over mistake, fatal in the event, of stopping off at Geneva. There he was arrested and tried, unwisely covering Calvin with invective.

In his *Christianismi Restitutio* (Christianity Restored), for the heretical nature of which he was burnt, Servetus first described the pulmonary circulation of the blood (an odd place to publish a physiological hypothesis): "That the communication and the preparation, are made through the lungs, we learn, from the various conjunction and communication of the vena arteriosa with the arteria venosa in the lungs; this is confirmed by the considerable bigness of the vena arteriosa, which hath never been so large, nor would send forth from the heart into the lungs, such a quantity of the pure blood, was it only for the nourishment of the lungs."

The first book about Servetus in English, published in 1723 (and second edition 1724), was *An Impartial History of Michael Servetus, Burnt Alive at Geneva for Heresie.* Servetus, regarded as a founder of and martyr for Unitarianism, was then still a controversial figure—an attempt to bring out a translation of his *Christianismi Restitutio* was suppressed on orders of the bishop of London, and the printed sheets of the book were destroyed.

The *Impartial History* was probably intended as an argument for complete freedom of opinion. It was an anonymous work, and much ink has been spilt by antiquarians, with their special delight in all that is useless, on speculating who wrote it. Sir William Osler, who wrote a short book about Servetus, said that Edward Gibbon was "scandalized by the death of Servetus more profoundly than by all the human hecatombs of Spain and Portugal [caused by the Inquisition]," and Gibbon probably derived his information about Servetus from the *Impartial History*.

Servetus was an uncompromising man, a combination of naivety and arrogance, but Calvin had the arrogance without the naivety. The *Impartial History* quotes Hooker's *Ecclesiastical Polity*: "Nature worketh in us all a love to our own counsels. The contradiction of others, is a fanne to inflame that love. Our love set on fire to maintaine that which once we have done, sharpneth the wit to dispute, to argue, and by all means to reason for it."

Thank goodness we are not at all like that nowadays.

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MEDICAL CLASSICS

The Book of Household Management

By Isabella Beeton **Published 1861**

Unstoppable epistaxis presents commonly enough to junior doctors in accident and emergency departments. What occasionally bemused me was not these patients' condition but their odd reply, when they were asked what remedies had been tried. One answer was that neither a key dropped down the back nor a cold compress between the shoulder blades had halted the bleed. It was only later that I discovered both these treatments in chapter 43 of Mrs Beeton.

The book's proper title is *The Book of Household Management*, though it is commonly referred to as "Mrs Beeton's cookbook." The common mistitling is no accident, for 38 of her 44 chapters deal with food and its preparation. Mrs Beeton comprehensively explored the range of topics relevant to managing a household, providing advice on the legal process of purchasing a house, engaging domestic servants, and bookkeeping. Her book was a best seller among the growing Victorian middle class (many of whom had but recently ascended to that rung of the ladder), with 60 000 copies in the first year of its publication.

She recorded a large number of remedies for common maladies, though what counts as a folk remedy and what is medicine is difficult to say in an age when the treatment for stroke was for a surgeon to immediately drain a quart of blood from the forearm. Some remedies, such as vinegar for insect stings, many would recognise today; others, such as powdered antimony for infantine convulsions, are no longer favoured. Though the remedies do not originate from her, there seems little doubt that she did much to popularise them.

Domestic goddess

POPPERFOTO/GETTY IMAGES

Of interest to the 20th century doctor are the vivid descriptions of ailments common in the 19th century. She accurately describes the small pupils of opium poisoning and the burning thirst of arsenic poisoning; she correctly notes that partial thickness burns are much more painful than full thickness burns and that the pustules of smallpox have a central depression that distinguishes them from those of chickenpox.

Though there is much that cannot be faulted, Mrs Beeton fails to recognise that measles and whooping cough are contagious, blaming the first on venous congestion and the second on "the faculty of imitation."

Access to drugs was unrestricted in Victorian times, and copying out a prescription from Mrs Beeton might save the housewife a two guinea trip to the doctor (and was likely of equal value). Regarding her attempt to educate the average reader about common medical complaints and their management, she preceded the family health guides of today. Her death at the age of 28—four years after the publication of her book—was a secret closely guarded by her husband and, later, the publishers who bought the copyright.

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Wielding the axe

FROM THE FRONTLINE
Des Spence

The axe is coming. But the NHS is considered sacrosanct and won't face cuts in spending; other public sector workers will take our pain. Now, I would go to the barricades to defend the NHS, but this protectionist policy is wrong, driven not by reason but a populist eye cast towards the next election. The NHS needs to share the pain of the public sector and indeed to demonstrate solidarity with workers in the private sector, who rightly believe that we are overpaid, overpensioned, and overprotected. Sparing the NHS fuels resentment and will serve no one. Recent projects such as new hospitals are welcome (although the private finance initiative means we will be paying for a generation to come), but the rest of the past decade's big spend has been too much, too quickly, with questionable benefit. There is plenty of waste: the time has come to rationalise, consolidate, prioritise, and even cut NHS services.

Staff have suffered under attempts to rebrand social issues as medical ones and have endured many poorly conceived and executed initiatives. Frontline workers now ignore new agencies (mostly just reshuffled staff with the same ideas, the same dysfunction) whose glossy literature goes straight into the bin. This is not nihilism, just realism—we know the limitation of medicine. So, at a macro level, staff know where the axe should fall: NHS Direct, IT projects, consultancy fees, the Quality and Outcomes Framework, quangos, and a halt on any new initiatives. But NHS managers will no doubt baulk at such cuts and seek instead to change pensions, freeze wages, and rely on the false economy of substituting "less expensive" professionals for doctors.

But clinicians have a responsibility too. Could we be more efficient by changing clinical practice? We could, for example, extend the seemingly arbitrary review intervals for "checking" blood pressure and cholesterol concentrations and the rest. Or we could limit numbers of expensive investigations generating return appointments and dubious referrals, often ordered to reassure the doctor not the patient—we need to learn to accept uncertainty. We could prescribe fewer drugs and up the "number not needed to treat"—patients with self limiting illnesses would be less likely to consult next time. Lastly, today it is health seeking behaviour that drives demand, not illness—so we need to hold that referral line. If we can limit costs in cheap and cheerful primary care, what could be saved in capital intensive secondary care? More thoughtful investigations and interventions and promotion of generalist medical skills to reduce internal referrals would be a start. Doing less is often so much more. An axe can be useful—it just depends on who wields it.

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The NHS film unit

IN AND OUT OF HOSPITAL
James Owen Drife

When I heard that the British Film Institute has a mediatheque on tour showing old films about coal, I felt a rush of nostalgia. I grew up in a Scottish mining village where "NCB," the logo of the National Coal Board, had a much higher profile than the NHS. The local cinema didn't do social realism, however, and until recently I had never heard of the NCB Film Unit.

Its spiritual forerunner, the GPO (General Post Office) Film Unit, is better known because of its 1936 classic *Night Mail*, a documentary about the London to Glasgow postal train, with music by Benjamin Britten and verse by W H Auden. The GPO Film Unit was influenced by Soviet cinema, and its first director, John Grierson, was a socially conscious Scotsman in the tradition of Lord Reith, founder of the BBC.

The NCB Film Unit, apparently, was set up in 1953 by another Scot with a conscience—Donald Alexander, a Cambridge graduate who had been appalled at the effects of the Depression on the Welsh valleys. Despite the dangers of filming underground it produced over 900 films before it closed in 1984, the year of the miners' strike.

The NHS, two years younger than the NCB, failed to follow in its cinematic footsteps despite being, like the GPO and NCB in their day, the nation's biggest employer. You can see why. Grierson and Alexander set out to exalt working men. Doctors and nurses were nice middle class people who did not need propaganda to glorify or educate them.

Pity, but it's not too late. Both those units were created in times of austerity. Now that the NHS is the only surviving relic of Britain's socialist past, its faceless leaders should ensure that its heroic workforce is immortalised on DVD. *Brief Encounter* could celebrate the 5 minute appointment system, and a biopic about the endless succession of health secretaries could be called . . . well, *Inglourious Basterds* is too obvious, but perhaps Tarantino could be persuaded to do some pro bono directing.

The GPO Film Unit was subsumed into the Central Office of Information, which, its website says, "is the Government's centre of excellence for marketing and communications" and "is given annual ministerial targets to achieve." Say the word, minister. And if a Scots accent is still needed for voiceovers, I'm available.

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