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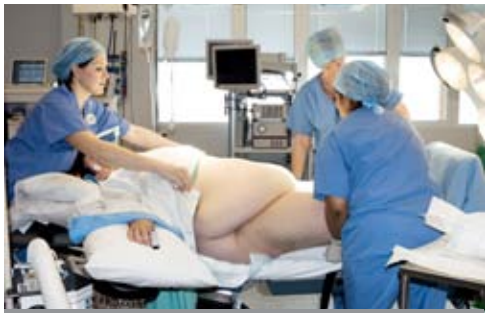

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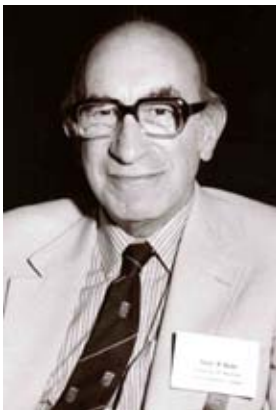
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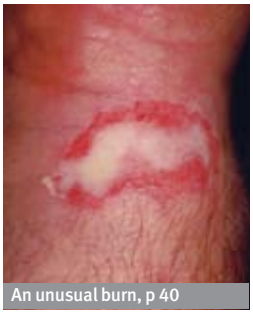
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PICTURE OF THE WEEK

The Arthritis Research UK Garden at the 2013 Chelsea Flower Show. The garden, designed by Chris Beardshaw, is in three sections, representing the personal journey of a patient with arthritis: from confusion, represented by the shady Veiled Garden, to knowledge, represented by the open and formal Lucid Garden, to warmth, openness and confidence as the patient learns to manage the condition, represented by the Radiant Garden (pictured).

RICHARD JANE (www.richardjanephotography.com)

RESPONSE OF THE WEEK

It is extraordinary how little there is written about the 'emotional labour' of care in relation to doctors. Menzies Lyth's famous work looked at the social defences used to protect nurses from the burden of emotional involvement—separating care into parcels for different nurses to deal with medications, washing, observations, etc. In the same year (1959) Balint used the term 'collusion of anonymity' to describe the manner in which doctors could claim responsibility for their organ of interest, but none would take responsibility for the patient.

Increasing specialisation, working time directives, financial contracts, and disease pathways all act as social defences. Combine this with the head-in-the-sand approach that typifies the medical profession's attitude to its own subjectivity and involvement with care and you can see why compassion is so endangered.

Jonathon P Tomlinson, GP, London, UK, in response to "How to encourage compassion" (*BMJ* 2013;346:f2049)

MOST SHARED

Helping patients to die well
Seeing double: the low carb diet
Are MOOCs the future of medical education?
Orlistat: should we worry about liver inflammation?
Measles and stroke show why healthcare must innovate

BMJ.COM POLL

Last week's poll asked:
"Should governments introduce plain packets for cigarettes?"

72% voted yes
(total 1002 votes cast)
BMJ 2013;346:f3069

This week's poll asks:
"Should we sequence everyone's genome?"

Head to Head:
Yes *BMJ* 2013;346:f3133
No *BMJ* 2013;346:f3132
Vote now on bmj.com

EDITOR'S CHOICE

Too many labels

Being in hospital doesn't simply put patients at risk of further illness and early readmission; rather, it is itself an abnormal health status associated with physiological and psychological stresses

"Is that really the right title?" asked a colleague at a recent editorial meeting, spotting this week's Personal View on the list of forthcoming articles. See what you think. In "Admission to hospital could be considered a disease," Hugh McIntyre argues that being in hospital doesn't simply put patients at risk of further illness and early readmission; rather, it is itself an abnormal health status associated with physiological and psychological stresses (p 28). This is echoed in the editorial by Shaun D'Souza and Sunku Guptha (p 8). They define frailty as a dynamic condition associated with sudden profound decompensation secondary to a stressor, and find no good evidence that admission or readmission to hospital is reduced by changes in community care for frail older people. McIntyre suggests that we label hospitalisation as a disease, monitor and study it more closely, and focus on its prevention and treatment.

McIntyre's concept seems analogous to institutionalisation. Is that syndrome listed in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), I wonder? If I had $199 (£131, €155) to spare I could look it up in the latest edition, DSM-5, which was published last week. Jonathan Gornall reviews the background to this highly controversial tome and interviews its main detractors and defenders (p 18). Shitij Kapur, dean of the Institute of Psychiatry at King's College London, says that critics "can find all the faults with DSM but are totally naive about the total mess that the diagnosis of psychiatric disorders used to be about 40 years ago . . . What you called schizophrenia in New York wasn't schizophrenia in London, and we have made a huge transition since then." The next transition, hopes Thomas Insel, director of the US National Institute of Mental Health, will reflect the biological basis of mental disorders much more closely. But we may be onto DSM-10 by the time the institute's biomarker focused, Research Domain Criteria project bears fruit.

For good medical practice, we need tests that answer a specific question with a reasonable prospect of useful results, counsels Frances Flinter in this week's Head to Head debate (p 16). It's hard to argue against that. She also argues that possessing the technical ability to do something new doesn't justify going ahead with it, especially in an ethically complex area like whole genome sequencing in healthy individuals. Flinter believes that it has nothing to offer clinically at the moment because most of the data it generates are meaningless. John Burn disagrees. We can have a whole genome for the price of a family package holiday, he explains, and there's scope right now for cheap, fast genotype panels in some frontline care settings. But are we ready for "a mixed economy of stored whole genomes"—and the labels that will come with it? Not if this means dumping heaps of molecular uncertainty on patients, families, and their carers, concedes Burn.

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