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Daniel K Sokol

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VIEWS & REVIEWS

Ethicist on the ward round

PERSONAL VIEW Daniel K Sokol

Not so long ago in the *BMJ* I quipped that most professional medical ethicists could not distinguish their “gluteus maximus from their lateral epicondyle” and suggested that such ethicists should undergo a short clinical attachment (*BMJ* 2006; 333:1226).

Soon after publication, a nephrologist kindly invited me to observe a ward round at his hospital. It proved to be a puzzling experience, not because the blood gases, creatinine levels, diagnostic tests, and myriad statistics recited by a junior doctor sounded like one of Mallarmé’s incomprehensible poems, but because, as the afternoon progressed, I noticed the patient-as-person fading behind this shroud of science. I felt comfortable with my consultant, my team with their dangling stethoscopes, the all-knowing computer wheeled by the bedside, and the timid patient, dwarfed by our confident crowd. Ethics seemed a million miles away.

This absence of ethics was most puzzling of all. I spend my days thinking, teaching, and writing about medical ethics, but there, in a group of doctors and with the patient before me, the subject seemed alien. “Think,” I urged myself, “what are the ethical issues here?”

My reverie would soon be interrupted: “Urine output . . . raised creatinine levels

My proximity to the patient, instead of highlighting the ethical components, obscured them

. . . metabolic acidosis . . . abdominal x ray.” Even in cases that I knew had obvious ethical dimensions, such as those involving futility and end-of-life decisions, I felt powerless to use ethical reasoning since I could not perceive the ethical issues with any clarity. It reminded me of a time when, intent on discovering a card magician’s method for a trick, I got so engrossed in his patter, in Sam Spade and the evil kings (a dramatic reference to the ace of spades and the four kings), that I forgot



to observe the subtle movements of the conjurer’s hands and body. Magicians, like doctors, are well aware that language can disguise reality, distracting the mind from the disappointing truth ahead, be it a palmed card or a grim prognosis.

My proximity to the patient, instead of highlighting the ethical components, obscured them. The incantation of scientific jargon, the outward confidence of the consultant and his team, the austere clinical environment, and the meekness of the patient all combined to give an air of certainty to the ritual. Ethics, this antithesis of science, had no place in this assured display. I could now see why some doctors and medical students found it so hard to appreciate the relevance of ethics to clinical practice. “Ethics and medicine are inseparable,” we tell our students, but up close the link is not so obvious. It may be easy enough to identify ethical issues in the classroom, but at a crowded bedside the task takes on added complexity and requires practice.

More recently, I attempted to fill the gaping holes in my medical knowledge by spending five weeks in a southern Indian hospital, observing the work of a rural surgeon. Again, I initially struggled to perceive the ethical elements. I was enthralled by the medicine, the ritual of surgery, the mesh, the corkscrew, and other instruments, the different kinds of suture material, the mattress and subcuticular stitches, the smells and sounds and

techniques. But as the days went by, as I saw more surgeries, it became easier. I learnt to zoom out of the medical and focus on the social and ethical dimensions. These more uncertain, fuzzy elements of the healing endeavour began to emerge from the mass of clinical information.

As my ethical gaze slowly sharpened, I reflected on the surgeon’s kind hearted paternalism and the submissiveness of patients; the considerable influence of relatives in decision making; the prevalence of disclosures that were “economical with the truth”; the limited importance of confidentiality in this communal setting; the perfunctory nature of obtaining consent; the ethical implications of treating illiterate and medically unsophisticated patients; the financial and emotional costs of surgery to poor families; the responsibilities of sleep deprived surgeons and anaesthetists towards their patients, their colleagues, and themselves; the difference a few words of comfort can make in times of pre-operative fear; the role of humour and camaraderie in the theatre; the wisdom of using mobile phones when operating; the extreme difficulty of speaking your mind when offence may result; the proper relationship between culture and ethical norms; and many other issues that were initially as invisible to me as the card magician’s sleights. I was not merely thinking about clinical ethics, but actually “doing ethics,” in real time with flesh-and-blood patients.

The first step to moral action is moral perception, since an ethical problem can seldom be resolved if not first spotted. For teachers of medical ethics, developing this skill in students should be a priority and the most critical place to do so is at the bedside. Suturing an orange in a lab and suturing a uterus in a caesarean section are quite different activities. The same holds true with studying ethics in the lecture hall and “doing ethics” on the wards. The aseptic first is a poor approximation of the messy second. Daniel K Sokol is lecturer in medical ethics and law, St George’s, University of London daniel.sokol@talk21.com

Solzhenitsyn and the
mindset of doctors on
a cancer ward,
p 673



REVIEW OF THE WEEK

The alcohol industry: taking on the public health critics

The thriving alcohol industry wants its products associated with health and happiness—and is pulling out all the stops to defeat its critics, **Michael Farrell** finds

The worldwide alcohol industry is flying high. With economic growth, changes in lifestyles, and the erosion of traditional customs and mores in many developing countries, the commercial production and consumption of alcohol has been booming. New competition within the industry has seen unparalleled growth, especially in the Asia Pacific region. And the party has only just begun. Some marketing organisations predict major growth in the cognac, whisky, and other spirits niches as Chinese markets continue to expand. The one cloud on the horizon is the public health sector. The alcohol industry wants to learn and avoid the mistakes that other industries have made; thus it has examined carefully the current state of the tobacco industry, the ever tightening regulation of smoking in public places, and the falling prevalence of smoking in developed countries.

The industry has been keen to emphasise that alcohol is not a drug, that it confers benefits and pleasures, and that it should be thought of primarily as an aid to recreation and possibly as beneficial to health. The industry's second main message is that a small number of people experience major problems, unfortunately, but the vast majority do not. What the industry fears is any control of the overall level of alcohol consumption. Public health advocates are focusing on strategies aimed at reducing the total consumption of alcohol, and the industry's key aim is to promote overall consumption, albeit responsibly.

As part of a sophisticated public relations process the industry has established the International Centre for Alcohol Policy, which is supported by Allied Domecq, Asahi Breweries, Bacardi-Martini, the Brown-Forman Corporation, Coors Brewing Company, Diageo, Foster's Brewing Group, Heineken, Molson Breweries, and SAB Miller. It is based in Washington, DC, and led by Marcus Grant, a former World Health Organization expert on alcohol. The industry is determined to shape the public health debate and to protect its interests. To this end the centre has sought partners in varied parts of the public health field to endorse its position.

This central stated aim of the book—one of whose editors is Marcus Grant—is to argue that population measures alone are inadequate in combating alcohol related problems. The industry has for decades conducted an intensive lobbying campaign against population based measures to reduce consumption by increasing taxation

or restricting access to alcohol. The industry argues that these measures don't suit different cultures and contexts and may not be relevant to those individuals and groups who are at risk of problems from drinking.

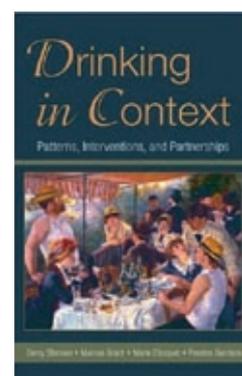
The book has an interesting section on the problem of illicit distilling in some developing countries, and it has a good review of the specific harms related to such activity and the problem of estimating overall levels of consumption where it exists. However, this section has virtually no mention of the growth in the commercial production of alcohol in some of these countries and doesn't cover particular alcohol related problems in such countries or the concerns being expressed by community advocates.

The book challenges any emphasis on population measures to reduce alcohol consumption, and to this end it aims specifically at WHO's global burden of disease project, which cites alcohol as a major contributor to mental and physical disease in developing countries. It predictably seeks to invalidate the broader public health perspective on estimating the overall burden of disease that is related to alcohol.

The book's final section makes a sophisticated case for partnership between industry and the health sector. However, at no stage does it explore the dangers of the industry using non-governmental organisations to pursue its interests covertly. This latest exercise has hooked in the International Harm Reduction Association, which has been advocating controversial and liberal policies concerning illegal drug use, emphasising the human rights of drug users and promoting harm reduction strategies to help prevent the transmission of HIV among injecting drug users. It is ill judged for the association to be linked to this lobbying exercise of the alcohol industry, and the best interests of the organisation are poorly served by the association of its executive director, Gerry Stimson, with this book. The harm reduction movement needs clear blue water between itself and the alcohol industry.

Despite its breadth of references and considered exploration of some topics, such as underage drinking and drink driving, this book chiefly serves the purposes of the global alcohol industry and offers little to those wishing to tackle the unrestrained growth in global alcohol consumption that is predicted for the coming decade.

Michael Farrell is reader in addiction psychiatry, Institute of Psychiatry, King's College London m.farrell@iop.kcl.ac.uk



Drinking in Context: Patterns, Interventions, and Partnerships

Eds Gerry Stimson, Marcus Grant, Marie Choquet, Preston Garrison

Routledge, £31, pp 264
ISBN 978 041 595 4471

Rating: ★☆☆☆

The alcohol industry has been keen to emphasise that alcohol is not a drug and that it confers benefits and pleasures

Running with the pantomime horses

FROM THE
FRONTLINE
Des Spence



After four children a man can lose his figure. I would smile with resignation at the predictable comments: “You’re looking well!” (translation: “Aren’t you fat!”) But most days I was lucky to have time to brush my teeth, let alone fret about my body mass index or go to the gym. Anyway, the exercising class exercised me. It was demanding, unrealistic, and never satisfied with my explanation that simply resting might be sensible. The accessories were ridiculous: orthotic insoles, straps, isotonic fluids, food supplements. Jogging from one specialist physiotherapist to another, each giving an unlikely but grand sounding diagnosis and equally grand bill. Seemingly intelligent people were reduced to believing in the unscientific voodoo that much of sports medicine is.

But I took the plunge. Never underestimate the power of sibling rivalry: my brother had starting running. For 30 minutes I rummaged in the bargain buckets of sportswear websites. My finger hovered, hesitated, and then clicked. The discounted running shoes arrived the next day, and I joined the exercise bores.

At first I ran each time for 15 gut-wrenching minutes, praying that I might die. Five times a week, in the margins of the day: early morning and in the evening darkness. Dim I may be, but determined I certainly am. The time crept up, to 20, 30, and then 40 minutes.

With indie rock in my earphones, the miles slipped by. I splashed through puddles, loving the rain, wind, cold, and solitude. I dodged dogs and drunken local youths, and still I plodded on.

My kids did a double act. “Dad’s gone mental obsessive,” said my daughter, and my son twirled his finger at his temple. “Bonkers, man,” they told everyone. I endured a swollen ankle and chronic hip pain, but through the pain I pounded on. One Saturday morning I sped faster and faster up a hill, with the rising sun. Trumpets blasted: I had my Rocky Balboa moment. God, it was good to be alive.

With my previously plum shaped face now a wrinkled prune, I smile in resignation at the predictable “Are you all right? You look sick.” But exercise is an elixir of life, a treatment with a number needed to treat (NNT) of one to help prevent obesity, mood swings, cardiovascular disease, osteoporosis, and many other modern ailments. Medicine—with all its polypills, distorted risk, huge NNTs, and undebated treatment paradoxes—collapses on the starting line. So last Sunday was the Great North Run, my number 37 474—in the paddock with pantomime horses. Never mind: I am glad to be on the stage of life, not sitting in the dark watching the action, occasionally scrambling on the floor for sweets.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk

A different perspective

THE BEST
MEDICINE
Liam Farrell



We have peace now in Northern Ireland, which is a good thing—although it’s ironic that the deal could have been done 30 years and thousands of lives ago and was originally scuppered by the very people now in power. There is an unpleasant lesson here: in any negotiation, you need the extremists on board. They’re the ones who can make the deal stick, as no one can accuse them of selling out without losing, for example, their thumbs.

I was aware of this bitter pill when we introduced an appointment system. Appointment systems were then viewed with suspicion, undermining the right of every patient to queue, the queue being not just a line of people but something much greater: a never ending social event, the ordinary person’s forum for complaining about life in general and the health service in particular. Abolishing it

was a sign that the liberal socialist elite was at its clandestine work again.

Mrs Magee turned up every day around 10 am; she considered this a human right, and waiting for more than a few minutes only further augmented her cherished sense of grievance. If you asked whether a glass was half full or half empty, she’d reply, “What’s in the glass? And by the way, I’ve an awful sore throat; I want an antibiotic. And my leg’s giving me the jip. What about an x ray?”

Mrs Magee was my Hamas, my Taliban. I knew that if she could be courted and seduced, the battle was won; if not, a mob with torches and pitchforks was just around the corner.

On the first day of the new system I processed the early patients with robotic (yet deeply empathetic) efficiency. When Mrs

Magee arrived, usually as welcome a sight as blood in my stools, I was beaming at the door and tap dancing with delight.

“You are like a breath of spring, whispering of the joys to come while deep in the heart of a long yet lustrous winter, Mrs Magee,” I rhapsodised, my feelgood factor bursting out all over. “Come into my parlour, have a cup of tea, maybe a few little fruit cakes. Or what about some fresh scones hot off the griddle, and perhaps a foot massage as well?”

Mrs Magee cast a cynical eye over the vast emptiness of the waiting room and drew her own conclusion, my snark becoming a boojum.

“Not very popular, are you?” she said.

Liam Farrell is a general practitioner, Crossmaglen, County Armagh William.Farrell@528.gp.n-i.nhs.uk

Doctor-anarchists in class war

There is no more distinguished a writer in Britain today than J G Ballard, who was briefly a medical student but gave up to become a writer. He was born in Shanghai in 1930, but was interned in a Japanese camp there in 1943. Having previously lived the comfortable life of the rich and privileged expatriate in a poor country, he became sensitive as no one else in contemporary letters to the fragility of our well ordered existence.

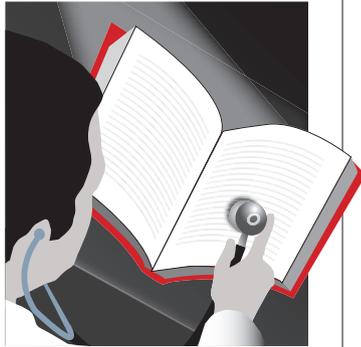
Many of his books record the barbarism that lies just below the surface of our apparently civilised conduct, and that our highly technological society favours because of its tendency to isolate us emotionally from one another. Ballard is the prophet of social pathology, particularly among the educated middle classes: the vile behaviour of middle class football supporters, for example, would not surprise him in the least.

It is irrational, no doubt, but I feel some personal connection with Ballard because my grandfather, a doctor, was in Shanghai at the time that Ballard was in the camp.

Doctors figure prominently in Ballard's fiction, as if he somewhat regretted not having become one. But the doctors of his dystopian novels do not behave better than others—far from it; and the fact that they so frequently behave badly, or at least not well, is symbolic of how fragile the author thinks that their ethical standards are, and therefore (since doctors are generally so highly regarded by the rest of society) how fragile all ethical standards are. We should not forget that many Japanese and German doctors committed some of the most sadistic atrocities of all.

Ballard's novel, *High-Rise*, has several doctors as characters: a lecturer in physiology at a medical school, a psychiatrist, some neurosurgeons, and a gynaecologist. The book is typical of his dystopian genre. The high-rise of the title is one of

BETWEEN THE LINES Theodore Dalrymple



Ballard is the prophet of social pathology, particularly among the educated middle classes

four 40-storey apartment blocks built in the docklands area of London (as the novel was first published in 1975, the very location is an instance of Ballard's uncanny prescience).

The residents of the new development, all of the professional classes, start a war against each other of a class nature (the higher the floor you live on, the higher your social status). Eventually there is total anarchy. Everything is vandalised, the services cease to work, garbage

accumulates everywhere, the walls are covered in graffiti, and the residents raid one another for food and eat each other's pet dogs. Almost every element of the horror is visible today, in less extreme form, and so we cannot just dismiss the author's vision as morbid or ridiculous.

Pangbourne, the gynaecologist, is among the worst characters in the breakdown of order. Rich and successful, he lives on the highest floor, the 40th, and has led a raid with women acolytes to the lower floors, capturing "a cost-accountant from the 32nd floor with a bandaged head, and a myopic meteorologist from the 27th." Pangbourne playfully asks what should be done with them:

"Pangbourne turned to his guests [the captured men]. 'I rather like Flying School. Did you know we've been running a flying school here? No—?'"

"'We've decided to offer you some free lessons,' [acolyte] Anne Royal told them.

"'One free lesson,' Pangbourne corrected. 'But that's all you'll need. Isn't it, Anne?'"

"'It's a remarkably effective course.'

"'Solo first time, in fact.'"

Then they fix some papier maché wings to the "guests," preparatory to throwing them out of the window.

Which of us has never met a Pangbourne?

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

Cancer Ward By Aleksandr Solzhenitsyn

First published 1968

The semi-autobiographical novel *Cancer Ward* is set in a cancer hospital in the Soviet province of Uzbekistan in the late 1950s. Like Solzhenitsyn, the main character, Oleg Kostoglotov ("bone chewer") spends some years in the Gulag, is sentenced to perpetual exile in Kazakhstan, becomes ill with cancer, is treated in a cancer clinic, and makes a good recovery. The book describes the profound effects that the experience of labour camps, exile, and then cancer can have on an individual.

Cancer Ward is meant to be understood as a political allegory—tumours kill, so how can a country survive with "growths" like labour camps and exiles? The ward, with its heterogeneous mix of patients from different ethnic groups and social backgrounds, reflects to a certain degree Soviet society. There are fierce debates on, for instance, social origin. The opportunistic apparatchik Rusanov, who has made a successful career out of denouncing friends as well as foes, prides himself on his proletarian forebears. Kostoglotov booms at him in response that even if he, Rusanov, had 10 proletarian grandfathers, if he were not a worker himself, he wouldn't be a proletarian.

What is much less well known than the allegorical dimensions of *Cancer Ward* is the psychological realism of the portraits of both patients and staff. We see how being admitted to the cancer ward is like being sent to the Gulag. In both cases there may be a loss of status, loss of individuality, and loss of a future perspective. We see how cancer can isolate sufferers from even their closest relatives and friends, how some patients

become anxiously preoccupied and constantly check their bodies for physical changes, how they sometimes come to think that it is no longer they but the tumour that is in charge, and how they may feel as if they were dead.

Solzhenitsyn has an equally good understanding of the mindset of the doctors. The main purpose of

the ward round is to improve the morale of the patients. Euphemisms, vague formulations, and downright lies are routine tools of the trade. The doctors rarely say what they think—until they sit down together later and "the general impression of improvement and recovery was completely exploded." One patient who has not responded to treatment is simply ignored by the doctors. Patients are discharged before they can die in order to improve the clinical statistics—no palliative care here. In individual consultations with patients some of the doctors are more honest, and even show natural kindness, rather than mere professional kindness. When Ludmila Dontsova, the lead oncologist, becomes ill with cancer, she does not want to know anything about the details of her condition, treatment, or prognosis.

Cancer Ward is not only a forceful indictment of political abuse, but an insightful and cogent study of the psychological reactions of both doctors and patients to life threatening illness.

Paul Crichton, consultant psychiatrist, London
paulcrichton@doctors.org.uk

