



Time to get streetwise: why medical ethics is in need of doctors

Daniel Sokol

BMJ 2006;333:1226-
doi:10.1136/bmj.39055.658762.59

Updated information and services can be found at:
<http://bmj.com/cgi/content/full/333/7580/1226>

These include:

Rapid responses

12 rapid responses have been posted to this article, which you can access for free at:
<http://bmj.com/cgi/content/full/333/7580/1226#responses>

You can respond to this article at:
<http://bmj.com/cgi/eletter-submit/333/7580/1226>

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top left of the article

Notes

To order reprints follow the "Request Permissions" link in the navigation box

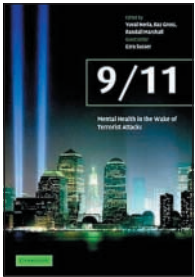
To subscribe to *BMJ* go to:
<http://resources.bmj.com/bmj/subscribers>

reviews

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS

9/11: Mental Health in the Wake of Terrorist Attacks

Eds Yuval Neria, Raz Gross, Randall D Marshall

Cambridge University Press,
£60, pp 674
ISBN 0 521 83191 1
www.cambridge.org

Rating: ★★★★★

Are We Ready? Public Health since 9/11

David Rosner, Gerald Markowitz

University of California Press,
£10.95/\$16.95, pp 210
ISBN 0 520 25038 9
www.ucpress.edu

Rating: ★★★★★

Terrorism's primary target has always been the psyche, not the body. Destruction of life and property is simply its vehicle for inflicting broader, long-lasting harm to the mental health of populations. The 11 September 2001 terror attacks in the United States were no exception to this centuries old principle. However, their nature and scope were without precedent on American soil, and have exerted a singular impact on the research and practice of disaster mental health. The influence of the attacks on this nascent field receives worthy treatment in *9/11: Mental Health in the Wake of Terrorist Attacks*, which attempts to document and critically examine the wide ranging mental health response.

In the book, leading researchers offer candid, behind the scenes insights into their own efforts in conducting mental health studies in the wake of 9/11. Vividly described profiles of large scale mental health interventions after 9/11, such as New

York City's project liberty and the Pentagon's operation solace, offer remarkable examples of ingenuity and collaboration and contain heartbreaking stories of trauma and loss. To their credit, the editors offer constructive critiques of these post-9/11 programmes for their lack of embedded research methodology and evaluative rigor, and their book cogently argues for greater use of evidence based mental health interventions after mass trauma. Refreshingly, the book's contributors freely—and vigorously—critique each other's chapters (one contributor refers to another's perspective as “dangerously naïve,” for example). Such exchanges reflect the growing pains of disaster mental health, a rapidly developing field that appears to lack consensus on relevant exposures, outcome variables, research methodology, evaluation design, and implementation practices.

In this spirit of open feedback, it is worth noting that ethical considerations in post 9/11 disaster mental health research merit more coherent, dedicated discussion than they receive in this volume. While the book's emphasis is understandably New York City focused, it inadequately addresses the unique post-9/11 mental health response challenges of smaller communities with fewer resources. Many of its chapters redundantly open with the same research data presented in a nearly identical context.

However, these modest shortcomings do not reduce the book's overall relevance to our understanding of community level mental health response challenges in the wake of terrorism and other disasters. It offers an important contribution to the disaster mental health literature.

Five years on from the terror attacks and a second book also documents how it affected and altered health services, this time from the perspective of public health.

Are We Ready? Public Health Since 9/11 considers how 9/11 and an ensuing series of anthrax laced letters shoved the American public health system on to centre stage in a new role as first responder. Health department workers now stood shoulder to shoulder with law enforcement personnel, as “incident command” and “Category A agents” permanently joined the public health lexicon. Unprecedented federal funding for bioterrorism preparedness also raised new questions about the primary roles that the public health infrastructure can—or should—have.

These tensions of institutional identity are at the core of David Rosner's and Gerald Markowitz's “contemporary history” on the

part terrorism has played in redefining the boundaries of public health in the United States. Their extensive interviews with public health leaders at the local, state, and federal levels yield an insightful story of shifting priorities and challenges in the days, months, and years since September 2001. The book is divided into three chapters, each covering a separate jurisdictional level and a distinct interview time frame: New York City public health officials in the immediate aftermath of 9/11 and anthrax, state health department leaders within two years of the attacks, and federal public health officials three years after the attacks. The resulting narrative is rich in unflinching detail. It includes local public health heroism, risk communication failures, state budget shortfalls for public health, and a controversial national small-pox vaccination campaign in 2003. Woven throughout are fundamental philosophical questions about the “militarization” of public health in the years since 9/11 and the value of “dual use” applications for bioterrorism funding.

The authors allow readers to generate their own conclusions in response to the question their book's title poses; this decision is laudable. My criticisms rest primarily in the book's missed opportunities in exploring the challenges faced by local health departments. The authors' exclusive use of New York City's perspective on local public health in the immediate aftermath of 9/11 and anthrax, while critically relevant, is too limited in time and space. Given the maxim that “all disasters are local,” their treatment would have benefited greatly from a variety of local health department perspectives throughout the United States, not just in the immediate aftermath but in the months to years following 9/11 and the ensuing anthrax attacks. A more diverse set of public health workforce perspectives than just those of senior management would have enhanced the book's value as a contemporary history.

As the authors acknowledge in their preface, they completed this book before Hurricane Katrina, a transformative event for disaster preparedness in the United States. While this is an obvious gap, the book none the less provides an instructive look at a critical and redefining chapter for the American public health system.

Daniel Barnett instructor, environmental health sciences, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA
dbarnett@jhsph.edu

Items reviewed are rated on a 4 star scale
(4=excellent)

PERSONAL VIEWS

Time to get streetwise: why medical ethics needs doctors

On my office wall hangs *The Conjuror*, a painting by the 15th century Dutch artist Hieronymus Bosch. On the right side of the canvas, a conjurer holds a small ball between his fingertips. On the other side of the table a gowned spectator, bent over like a hunchback, stares idiotically at the small ball. Behind the spectator, hidden from the stares of the diverted crowd, the conjurer's accomplice is stealing the spectator's purse.

Like the spectator in Bosch's painting, the modern medical ethicist is at risk of losing something of considerable value. By focusing so closely on the little ball—the purely philosophical aspects of medicine (such as the meanings of autonomy)—the ethicist too easily ignores the broader context in which these issues arise. The combination of abstruse theorising and ignorance of practical medicine alienates the very people the ethicist is trying to help.

To be of any use to practitioners, armchair bioethics, which tends to tackle issues in a contextual vacuum, must make way for a more streetwise form of bioethics in which conceptual analysis is coupled with an awareness of clinical reality.

One way for ethicists to appreciate the realities of their chosen subject is by reading or conducting empirical, social science research. Although the popularity of combining philosophical medical ethics and empirical research is increasing, such research is so far limited (*Journal of Medical Ethics* 2006;32:240-5). How can ethicists find out what it is like for a junior doctor to be "on nights"? How can they really understand

the chaos and confusion of a crash call? In the first academic article I published, I criticised medical students for failing to stand up to consultants who asked them to perform intimate examinations on unconsented anaesthetised patients (*Journal of Medical Ethics* 2004; 32: 612.) Today, I am more sympathetic to the precarious situation of medical students whose future jobs may depend on a good reference from their consultants. I am not so sure my conclusion was helpful.

In the absence of empirical studies, streetwise ethicists should either be medically savvy or collaborate with practising medics. Currently, there are too few ethicists with medical degrees, and there is too little collaboration between ethicists and doctors. Ethicists working on issues of clinical ethics should actively seek the help of practitioners in the field, and similarly practitioners who identify ethical issues in their work should flag these up to ethicists as potential areas of joint research.

I believe it is this gulf between theory and practice that is in part responsible for the dismissive attitudes of many clinicians towards academic medical ethicists. Few things exasperate healthcare professionals more than an ethicist's evident ignorance in matters medical. The aspiring streetwise ethicist can reduce the gap by reading first hand accounts of "doing medicine": Richard Selzer, Lewis Thomas, Jonathan Kaplan, Max Pemberton, Atul Gawande, and other medical writers offer insights into life in medicine. Conversations with healthcare workers about their practice and its challenges can also enrich an ethicist's under-

standing of medical reality. There is also room, in the expanding medical ethics literature, for a book on "medicine for the medical ethicist" that would include instructions on how to read patients' notes; list common acronyms, medical conditions, and medications; describe key procedures (lumbar puncture, central line, and so on); and explain the role of each healthcare worker in the team and the structure of hospital management. Although such a book would undoubtedly be helpful to the armchair ethicist, it is only a first step towards "streetwise bioethics."

In a recent article (*Journal of Medical Ethics* 2006; 32:617-8), John Freeman, a hospital doctor, laments "the distance that they [philosophers] have, in general, maintained from the bedside fray, from the individual decisions that are so often made." Doctors, as seasoned decision makers and experts in clinical medicine, patient psychology, and ward logistics, have much to contribute to the field of academic medical ethics. As the discipline becomes more specialised, there is a real danger that interested clinicians, who may not possess the requisite PhD in medical ethics, will avoid contributing to scholarly debates in medical ethics. This impending split between clinicians and ethicists will be a great blow for medical ethics, for it will widen the gap between theory and practice and lead to discussions of interest only to a handful of academic medical ethicists. As an applied discipline, medical ethics should strive to address the real life issues of healthcare professionals. This requires active collaboration between clinicians and ethicists.

A few decades ago, all medical "ethicists" were practising doctors. Their medical expertise, however, was not always matched by either wisdom or analytic competence. Today, although well versed in moral theory and occasionally graced with wisdom, most professional ethicists have no clinical training and would be unable to distinguish their gluteus maximus from their lateral epicondyle. As I hinted elsewhere, ethicists dealing with issues in clinical ethics could undergo a short "clinical attachment" (much as aspiring medical students do) to acquire some basic first hand knowledge of life on the wards (*BMJ* 2006;332:1399.) This attachment could form part of the training for non-medical PhD candidates in clinical ethics. Only then will the ethicist look away from the enthralling little ball and notice that something of great value is being ignored.

Daniel Sokol lecturer in ethics, Keele University
daniel.sokol@talk21.com

Few things exasperate healthcare professionals more than an ethicist's evident ignorance in matters medical



Detail from *The Conjuror* by Hieronymus Bosch c1450-1516

It's about sex, but not sexy enough

I am writing this to coincide with my last day working in a busy community family planning clinic in north London. For those who feel they have a messianic mission to change the world, such as eradicate HIV or malaria in sub-Saharan Africa, they need not look any further. Why not work in an inner city family planning clinic closer to home and help eradicate unplanned pregnancies and chlamydia? I guarantee a working environment that could be compared with a remote village in a low income country: short staffed and poorly paid, with clinic users travelling long distances and queuing for hours. And yet most clients are grateful to be seen and the staff go home feeling pleased, knowing that they have done something for humanity. The pay also makes you feel as if you are working for a charity.

So why am I leaving? Same reason as everyone else—I feel demoralised and undervalued.

Public health, including health promotion and prevention of diseases, has come to the forefront of UK health policy in the last couple of decades, since the publication of the government's strategy document *The Health of the Nation* in 1992. The government now has a minister for public health, and, more recently, the white paper on public health policy, *Choosing Health*, extols the virtues of the old adage "prevention is better than cure." It focuses on reducing health inequalities, smoking, obesity, sexual health, mental health and wellbeing, and sensible drinking.

Despite publicity about investments "earmarked" for *Choosing Health* priorities, much of this funding has been used to save many primary care organisations from financial meltdown. We are also seeing a relative disinvestment in contraceptive services across England. The current emphasis on the chlamydia screening programme and achieving the 48 hour target for accessing genitourinary medicine (GUM) services reduce funding available for contraception, making it literally the poorer relation to GUM.

A census of the current workforce in the UK, by the Faculty of Family Planning and Reproductive Health Care (FFPRHC; www.ffprch.org.uk), shows that the specialty needs more consultants and training posts to fill many lead clinician vacancies. Many family planning services have been staffed by sessional doctors like me: general practitioners who want to maintain their skills and value a different working environment. But as the pay increasingly falls below that of

general practice, it is not surprising to see a sharp decline in the number of sessional doctors since 1999.

Apart from decreased access to contraception and other well women services, current undercapacity in sexual and reproductive health has other implications. Doctors wishing to obtain the diploma of the Faculty of Family Planning (DFFP) report difficulty in accessing practical training. Furthermore, the National Institute for Health and Clinical Excellence's recent recommendations on training for long-acting reversible contraception (LARC) mean that contraceptive services often have to make a difficult choice between training doctors and running a service.

Contraceptive services in the UK are the envy of other high income nations. Unlike in many countries, including Australia and the United States, contraception and access to abortion services are free and confidential on the NHS, albeit with a range of waiting times; more importantly, young people do not need to inform their parents to obtain contraception and abortion services.

Judging from the current funding allocation by primary care organisations, family planning and contraceptive services are not as worthy of attention as information technology, management consultants, cancer, and children's services; nor does the new GP contract provide the incentive to give quality contraceptive care. While organisations such as the FFPRHC and fpa (formerly Family Planning Association) continue their campaigns to keep sexual health on the national agenda, lead clinicians of services have to battle hard to maintain staff morale, and keep their services open, free, and accessible.

So if you ask why rates of unplanned pregnancies and abortion remain high, my answer is simple: it's about sex, but not sexy enough—contraception and sexual health services are undervalued. Until we get serious commitment from ministers to prioritise and fund contraception and sexual health services properly, there will be more staff leaving the service and vacancies left unfilled. We know from experience that once the staff leave and a service shuts, replacing them would be a challenge and a service would be lost forever.

Richard Ma *general practitioner, London*
richard.ma@btinternet.com

Competing interests: RM is a member of the Department of Health Contraceptive Services Group and a council member of the Faculty of Family Planning and Reproductive Health Care.

SOUNDINGS

Pills with a doughnut hole

When Zhou Enlai was premier of People's Republic of China, from 1949 to 1976, he was asked about the impact of the French Revolution, and reportedly replied that it was too early to tell. The same can now be said about the Medicare Part D Drug Benefit. Passed some two years ago by the then Republican controlled Congress, it represents an interesting experiment of the government providing drugs through the private sector to stimulate competition and contain costs.

Under the provisions of this benefit, available to Americans over the age of 65 years, several competing companies offer plans at a cost of roughly \$26 per month. Patients are responsible for a small co-payment for each prescription up to a total of \$2400; then there is a gap between \$2400 and \$3850 when the patient has to pay for everything; and beyond that the plan covers all costs except for a small percentage.

Patients are allowed to use most large pharmacies "in the network." There is a formulary of approved drugs, divided into tiers. To encourage use of generic drugs, most of them are in tier one and require a small co-payment, perhaps \$6 per month per prescription. Most brand names and certain expensive drugs are in tiers two and three, with larger co-payments, about \$28 and \$70 per month, and with some drugs requiring prior justification and authorisation. Certain avenues are available for those who cannot afford the premiums or the co-payments. Some of the inexpensive generics available over the counter (such as loratidine) do not seem to be covered and may drive prescribers to more expensive items. But perhaps the most striking characteristic of the scheme is its complexity.

Then there are critics on the left, still enamoured of a totally government administered health system in which the government negotiates directly with the drug companies. They are also concerned about the "doughnut hole," the gap between \$2400 and \$3850 when 100% of costs must be paid by patients or shifted to state or local authorities. On the right there are concerns about yet another entitlement to swell the federal deficit. But in the first year, government expenditures were \$30bn instead of the estimated \$43bn, attributed by supporters of the scheme to the benefits of competition. Clearly, as with the French Revolution, it is still too early to tell.

George Dunea *attending physician, Cook County Hospital, Chicago, USA*