Read the review on p 715 and join the discussion on doc2doc

Assisted suicide: a substitute for a caring doctor?

PERSONAL VIEW **Brian Livesley**

The 97 year old dying man I was visiting on a hospital ward emitted a piercing scream of pain. I discovered that his intravenous fluids had been stopped, his catheter also unexpectedly removed, a "nil by mouth" notice had appeared by his bedside, and his scream was due to the pain of attempting to pass concentrated and infected urine while he was left unattended. Informed negotiation with the ward sister allowed correction of the deficits and his physical discomfort. When he returned home the causes of his recurring emotional and physical misery were correctly diagnosed, explained to him, and eased by his general practitioner, who also talked to his daughter. He was able to relax and, with his fears assuaged, enjoy relevant and amusing conversations with his daughter and visiting friends over the next few days until, in their presence, he passed away comfortably.

A gentle and easy death, "euthanasia," is something all rational people desire. Unfortunately the term has been hijacked to mean death actively induced by a lethal draught or injection. Today the call is for assisted suicide; but this cry for help often arises out of fear or panicking desperation and occurs because suffering—physical and psychological—is not relieved. One of the problems is that clinical professionals, for all their expertise, can be at a loss about what to do and turn a blind eye to patients' difficulties. This paradoxical behaviour is the result of at least three factors: the virtual absence today of those life threatening epidemic diseases that previously gave doctors experience with dying patients; the easy availability of the diagnostic and therapeutic techniques associated with high technology medicine, among which ignorance about palliative care can be hidden; and the failure to pause at the bedside to listen to patients' anxieties—while forgetting that seeking or offering to induce death with a lethal injection when a person has unrelieved symptoms overlooks the important and simple question of why the symptoms remain unrelieved.

Regrettably, medical interventions that ignore patients' needs, including that of being left in peace, enable advocates of assisted dying to present themselves as the only people who now care

One of the key remedies lies in updating clinical education. Universities, collegiate bodies, and NHS trusts must each accept and monitor their responsibilities. After all, bedside professionals need to have a basic knowledge of cardiac resuscitation; and it is just as essential that they are trained to at least the same degree in palliative care. What is needed is the ability to impart confidence to dying people, and their relatives and friends, while at the same time relieving immediate anxieties and promoting effective care. Slowly and surely this should reduce the panic about dying which has heightened the call for legalised euthanasia.

The public interest factors in favour of and against prosecution for assisted suicide, produced by Keir Starmer QC, the director of public prosecutions (www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html), contain sound statements with no erosion of the present law; but in my opinion we must constantly oppose those who strive to legalise assisted suicide. Perhaps we have forgotten the historical background to the medical murders committed for reasons of social engineering or eugenics and that these also started from small beginnings. Indeed, in the words of the eminent US law professor Yale Kamisar, "legal machinery initially designed to kill those who are a nuisance to themselves may someday engulf those who are a nuisance to others" (*Minnesota Law Review* 1958;42:969-1042), as it has in the recent past.

Thirty five years ago a medical student stated: "We come to clinical medicine with humanity, and after three years they have educated it out of us" (*Age & Ageing* 1974;3:49-53). Is it reasonable to suggest that this is why things have not changed? Do medical schools and royal colleges lag behind in ensuring that standards of personal medical care at the bedside are adequate? Has the General Medical Council, with its publicly stated ethos of "ensuring good medical practice," been silent about this matter for too long? Is the University of Bristol the only one now giving, and not merely promising, a practical educational lead in "medical humanities" (in its intercalated BA) that will be carried to the bedside?

BSIP MAYSPL

Do medical schools and royal colleges lag behind in ensuring that standards of personal medical care at the bedside are adequate?

Today, in endeavouring to keep people alive, medical training has produced too many high tech oriented clinicians who are unable or unwilling to recognise when a patient is dying and requires palliative care. Regrettably, medical interventions that ignore patients' needs, including that of being left in peace, enable advocates of assisted dying to present themselves as the only people who now care.

Brian Livesley is emeritus professor in the care of the elderly, Imperial College London
brian.livesley@doctors.org.uk

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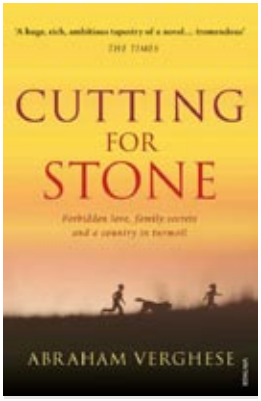
REVIEW OF THE WEEK

Opening up the past

The doctor and author Abraham Verghese has been tipped for the literary big time. **Richard Villar** is impressed by his new novel but finds the surgical scenes overegged



Cutting for Stone
Abraham Verghese
Vintage, £7.99, pp 560
ISBN: 978-0099443636
Rating: ★★★☆

In this byte sized, internet driven era it was with some reluctance that I began this 560 page novel. I started late one Friday night, fully the sceptic, but within a matter of a few pages this book hit me. I read, read, and read, at times fascinated, at times impressed, on occasion horrified and revolted. *Cutting for Stone* is a page turner in the true sense of the word. Be warned before you start.

I have never met Abraham Verghese, professor of medicine and senior associate chair at Stanford University School of Medicine, but he comes across as a thoughtful man as his story weaves its web of love, death, conflict, betrayal, and minute medical detail. The tale moves largely between Ethiopia and the United States in an astonishingly expert way. The bulk of the plot takes shape in Missing, an Ethiopian mission hospital surrounded by political and military chaos. The conjoined male twins Marion and Shiva appear early in the novel, the offspring of a British surgeon (Thomas Stone) and an Indian nun (Sister Mary Joseph Praise). That said, the descriptive evidence of conception between the two is fleeting, appearing as a distant memory well into the story, which surprised me in a novel that held no punches when it came to medical and surgical detail. Perhaps the words, "She dispassionately cleaned his uncircumcised member, then flopped it to one side and attended to the wrinkled and helpless-looking sac beneath," explain something about the descriptive skills of the author.

However, it was this level of detail that troubled me. There am I, the committed surgeon, ostensibly able to withstand all manner of horrors. Yet I found myself at times nauseated by Verghese's descriptions of disease, misery, and surgical technique. He was almost like the physician trying to make his point that surgeons are troubled creatures whose only response to intraoperative stress is to throw instruments across the operating theatre.

Verghese was almost like the physician trying to make his point that surgeons are troubled creatures whose only response to intraoperative stress is to throw instruments across the operating theatre

Life simply is not like that. Often I wondered whether a non-medical reader would understand the fine detail, while I remained troubled throughout that such detail was detracting from an otherwise fine story. Again, try this for size, which appears early in the book, as Verghese describes the twins' caesarean delivery, a procedure that resulted in the death of the mother: "Just as Hema feared, there was a lateral tear in the uterus. Blood had filled the broad ligament on one side. That meant that once she got the babies out, she'd have to do an emergency hysterectomy, no easy task in pregnancy, what with the uterine arteries being tortuous, thickened, and carrying half a liter of blood a minute. Not to mention the massive blood clot shimmering in the light, growing before her eyes and gloating at her like a smiling Buddha." I have not seen too many smiling Buddhas in my own practice, but Verghese's point is perhaps made.

After their birth Marion and Shiva's troubled father disappears, leaving the twins with a deep sense of abandonment. They are brought up in Missing by Ghosh and Hema, two doctors who do much to point their two charges towards a medical career. Yet, bonded by birth and profession, betrayal rears its head in adulthood as Shiva makes love to Genet, the girl with whom Marion has become emotionally obsessed, the girl who, Verghese later suggests, may have given Marion hepatitis B.

Verghese's characterisations are excellent. Relax as you read and you can almost sense the key players in the room beside you. The eventual reunion between son (Marion) and father towards the end is a description that is second to none. The breaking into his father's apartment to leave a small memento of their past, the desire to inflict verbal punishment for all that had gone before, and the full confession and description by Stone of events desired but unmentioned earlier in the book are brilliant.

The climax of the novel centres on the transplantation of a liver from Shiva to Marion, the recipient procedure being performed by Stone, the estranged father. Yet whether I can believe that an ageing father would in reality either wish or be able to undertake such an operation on his own son is another matter. I doubt it. The initially successful transplantation then turns to disaster as Shiva dies from a massive bleed into his brain, leaving Marion the survivor and the narrator of this complex tale. This final twist seems all too sudden. Within three pages Shiva had gone from laughing with his brother to a brain dead state requiring his ventilator support to be discontinued, his demise eased by intravenous morphine with the approval of his brother. We live in a far fetched world, but that far fetched? Again, I doubt it.

Yet despite these anomalies *Cutting for Stone* was an exceptional read, as evidenced by the much fingered and now tattered cover of the paperback version I was sent. Do read it today, but on an empty stomach, to withstand some of the gorier descriptions. I doubt you will regret it. This, Verghese's first novel, is clearly the start of something big. Watch for that name; you will see it many times again, I am certain.

Richard Villar is consultant orthopaedic surgeon, Wellington Hospital, London rnv1000@aol.com

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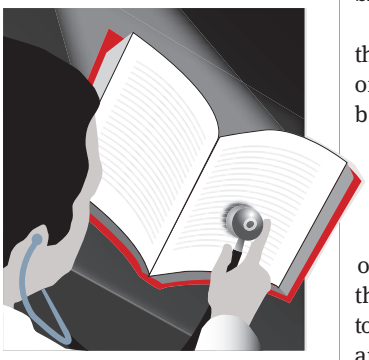
The fine art of the surgeon

BETWEEN THE LINES
Theodore Dalrymple



Bell was not only an anatomist and physiologist of the greatest distinction . . . but a talented artist, and his oil sketches of the injuries sustained by soldiers in the Peninsula war and at the battle of Waterloo show him to have been a deeply humane man

Perhaps because they treat the body as a machine and see more than most of the grim side of human life, doctors, it used to be thought, were particularly liable to atheism. Whether or not this is so epidemiologically speaking, four of the eight authors of the Bridgewater Treatises defending the notion of a divine designer were doctors.

The Bridgewater Treatises were written in accordance with the terms of the will of the Right Honourable and Reverend Francis Henry, Earl of Bridgewater, who died in 1829, each treatise to be by a recognised scholar to illustrate "the Power, Wisdom and Goodness of God, as manifested in the Creation . . . as for instance the variety and formation of God's creatures."

The four doctors who wrote the treatises (which the anatomist John Knox derisively called "the Bilgewater Treatises") were John Kidd (1775-1851), professor of medicine at Oxford and the first physician there to abandon the wig; William Prout (1785-1850), the discoverer of gastric hydrochloric acid and coiner of the term "convection"; Peter Mark Roget (1779-1869), who invented a form of slide rule and later wrote his immortal thesaurus; and Sir Charles Bell (1774-1844), of Bell's palsy, Bell's nerve, and the Bell-Magendie Law.

Bell's Bridgewater treatise was titled *The Hand: Its Mechanism and Vital Endowments as Evincing Design*. Although he accepted the extreme antiquity of the world, he thought that species succeeded one another by periodic extinction rather than by gradually developing into one another (an idea that was clearly present when he published the second edition of his book in 1833). He also thought that function and purpose determined anatomy. Although, once enunciated, the idea of natural selection seems so obvious as to be almost a tautology, it did not occur or seem obvious to Bell, who was a very brilliant man.

Bell also thought that pain was evidence of a beneficent deity because a sense of pain was necessary to the survival of creatures. Without the possibility of pain they would do things fatally harmful to themselves. This was an argument that Dr Johnson had rejected three quarters of a century earlier; although a believer in a beneficent deity, Johnson said that the deity could have made creatures invulnerable if he had so wished.

It wasn't because Bell was unacquainted with pain that he had a rather optimistic view of it. He was not only an anatomist and physiologist of the greatest distinction—his book on the musculature of facial expression was and is the greatest work on the subject, much praised by Darwin—but a very talented artist, and his oil sketches of the injuries sustained by soldiers in the Peninsula war and at the battle of Waterloo (recently published in a beautiful book by the Royal College of Surgeons of Edinburgh) show him to have been a deeply humane man. He depicts not only the injuries but the individuals who suffer from them. His pictures are like those of Goya, but with more pity than rage.

The editors of the book of Bell's paintings, Peter Starling and Michael Crumplin, tell us, however, that Bell was not a particularly successful operative surgeon, at least in the military context. His amputations had an almost perfect rate of failure, with a mortality rate of between 86% and 92%, far higher than the average. I prefer to think that he took on only the most hopeless cases: for of his greatness in all his other fields of endeavour there can be no doubt.

Theodore Dalrymple is a writer and retired doctor

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ROUND TABLE

Risk: The Science and Politics of Fear

Dan Gardner **Published in 2008**

When you suggest that there is a big or a small risk of an event occurring, how often do you really explain what you mean? More fundamentally, how often do you know what you mean? As the journalist Dan Gardner points out in his incisive book, the "gut" and the "head"' can estimate risk in different ways.

In his deconstruction of several recent scare stories Gardner outlines some of the major drivers of the response of individuals and society to risk. One is the human tendency to form a narrative from sequential events no matter how tenuous the connection. Studies of emotive and memorable cases such as a child abduction or terrorist attack have reported widespread change in behaviour irrespective of the actual risk involved. The influence of affect, culture, and political persuasion are also well described here.

The unifying theory that Gardner returns to is that our minds have developed over hundreds of thousands of years to protect ourselves by an instinctive survival response—our "gut" feeling—but this over-rides any rational sense of danger that our "head" might detect. Therefore we may be less well adapted to living in the information age in which perceived threats are innumerable and can travel round the globe in milliseconds. The second, familiar, and often maligned driver is the role of the media. Gardener suggests however, that we consider who or what the media actually are. In this age of blogs, phone-ins, and "expert" opinion we are all part of the media, as much producers as we are consumers.

Another major challenge he delineates is the varying degree of literacy and numeracy among health professionals as well as the public. Many medical students and doctors whom I know struggle to reconcile absolute and relative risk reduction.

And then there is self interest. At times there are reasons why we may decide to magnify the perception of risk to reinforce our own agenda. This is, of course, bread and butter for politicians and advertising companies, but the culprits are perhaps more diverse than you might imagine. Gardner illustrates one heated correspondence in which an epidemiologist who asked questions of a skin cancer awareness raising campaign was accused of being "pro-cancer."

Gardner's book essentially asks how we can communicate more effectively with one another. Many specialist academic fields have responded to this challenge by appointing "professors of public understanding." As health professionals we should all be professors of public understanding. Gardner argues that it is possible by such discourse to learn lessons from each scare story and, rather than fearing the next one, perhaps learn to live more comfortably with risk.

Keith Taylor, general practitioner, Bute Medical School, St Andrews, Fife **kct1@st-andrews.ac.uk**

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Round Table is an occasional column focusing on a current book, film, or TV programme that *BMJ* readers might wish to discuss in our online forum, doc2doc. To submit an idea email Rebecca Coombes (rcoombes@bmjgroup.com)

Doing our duty

FROM THE FRONTLINE
Des Spence

I don't know why I listen, because it instantly raises my blood pressure. Radio 4's *Today* programme clicks on at 6.30 am. General practitioners are the foot soldiers of medicine, with our commanders in distant war rooms planning the next big push on disease. We generally do their bidding, fearing that we would be shot by the General Medical Council as mutineers if we didn't. So when a medical general announces new research on high blood pressure I hold my breath. This time, the unqualified sound bite is that patients with isolated readings of high blood pressure should be considered for treatment even if blood pressure returns to normal on subsequent visits—"episodic hypertension"—with a call to review national hypertensive policy. I pull the duvet over my head and feel like deserting my post.

Already an estimated 30% of people have been conscripted into the hypertensive army. We see many more patients with 2-3 isolated raised readings, but if the blood pressure returns to normal we free them to be well, using defunct terms such as "white coat hypertension." So I know I shouldn't go against the generals but should just salute and do as I am told. However, the consequences and the horror of such a change in policy cannot be countenanced: the number forced to be "patients" would be vast. So in the grim glare of the fluorescent strip in the health centre dugout I trawl over the *Lancet* paper in question (2010;375:895-905).

Firstly, this is not new research, as has been suggested, but a rehashing and modelling of old data never intended for this purpose. The statistical modelling is complex; this excerpt gives a flavour: "We created a further transformation: variant independent of mean proportional to SD/meanx, with x derived from curve fitting." How this statobabble translates to individual patients is anybody's guess. Consider also that many of the data are 30 years old, the patients were from high risk groups, the confidence intervals are wide, and the data are observational and retrospective.

Perhaps this research is valid but it is certainly complicated, convoluted, based on assumptions, and open to confounding. Also, the incidence of cardiovascular illness and especially stroke is greatly reduced, with an 80% fall in stroke over the past 40 years, so the absolute benefit from treating even conventional definitions of hypertension has also fallen. Therefore the results can't be extrapolated into today's patient population.

There should be no change in policy until a prospective study has been designed specifically to look at and to define the population with "episodic hypertension." Only then should we change practice. Our generals should be careful about going over the top with statements or we may send yet another generation across the no man's land, to be ensnared in lifelong treatment.

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

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Search for the hero inside

THE BEST MEDICINE
Liam Farrell

"I love the smell of naproxen in the morning," said the grizzled veteran, surveying the flames and inadvertently disclosing his day job as a pharmaceutical adviser. "Smells of . . . economy—and bendroflumethiazide," he continued, starting to ramble pointlessly, "That's cheap and all, just the kind of drug a commie pinko would take. ACEs, they're more the American way."

Another fireman came dashing up.

"There are people trapped on the first floor," he shouted at me enthusiastically. "But you can't go in there: it's far too dangerous; you'd be risking your life."

"Yes, absolutely, no problem," I said. "There are NICE guidelines for this kind of situation, which I cannot transgress. In case of fire, they clearly state, always take the advice of the experts. I'll just wait here then, shall I, while you chaps establish a perimeter, break down the doors with hatchets, get the hoses and ladders going, look macho, pose nude for charity calendars, and do your thing."

The firemen appeared rather discomfited by this response. Briefly at a loss, they looked from me to the fire, then back to me.

"Don't even think about it," said the first, gamely trying again, "It's an old house made of wood, there's an oil tank in the basement, the roof is unstable and could go anytime, and the stairs are on fire and they mightn't bear your weight. It's a death trap."

The crowd had seen it on television; they knew the drill. "Don't go in there, you crazy fool," they cried, "You'll only get yourself killed; it's madness, you'll never make it out alive."

The sense of expectation was suffocating, noblesse oblige and all that, and eventually I cracked, "seeking the bubble reputation even in the cannon's mouth," storming though the front door, racing up the stairs, heaving all available bodies onto my shoulders, stopping briefly to check my hair in a mirror.

"For a moment there I thought we were in trouble," I deadpanned, then leapt out the window after accessorising with a convenient baby (for theatrical purposes), grabbed from an unqualified lay person. One far fierce hour and sweet, the crowd was ecstatic, and I handed the baby to a shadowy American Christian adoption agency, discreetly palming the fee.

"Look after the little mite," I said, by now utterly in thrall to the stereotype, "I gotta go back, there may be more babies in there."

Liam Farrell is a general practitioner, Crossmaglen, County Armagh
drfarrell@hotmail.co.uk

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