"When a brown consultant is appointed over a white candidate, no one thinks that he or she got the job because of skin colour"
Kinesh Patel, p 428

Should pregnant doctors work in termination of pregnancy clinics?

PERSONAL VIEW **Megan Millward**

I found clinic days as a foundation year 2 (F2) doctor strangely satisfying. After three months of on-calls in obstetrics and gynaecology, running between emergency department and labour ward, I was ready for some clinic time. I was also seven months pregnant and getting round, heavy, and tired. Imagine my confusion when I was assigned to repeated sessions of the weekly termination of pregnancy (TOP) clinic. On questioning the rota coordinator on the appropriateness of this decision (imagining that someone may have overlooked my rapidly swelling gravid uterus), I was told that as most of the other doctors had conscientiously objected I was the only junior doctor available for those weeks.

Discussions with doctors in other fields and with non-medical friends and family only heightened my unease about being a pregnant doctor consulting on and certifying terminations. In my experience most junior doctors don't want to get involved with terminations, even when they are pro-choice. Most of those I spoke to were objecting to the work not because of strong religious or personal beliefs but because the system allowed them to object, without question, thereby avoiding an emotionally awkward clinic. My family did not realise that doctors could refuse to perform certain clinics or tasks. My lay friends were under the impression that if a medical procedure is safe and legal, and if you are qualified to provide the service, it would be unprofessional to refuse.

Most junior doctors don't want to get involved with terminations, even when they are pro-choice

Reactions of patients in the TOP clinic to my pregnant appearance varied. When I started in the clinic most patients did not notice or comment—perhaps because of their own internal conflict or because they didn't want to start a tricky conversation. More commonly,

partners or parents of patients would politely ask me questions about my pregnancy after the patient had left the consulting area to get undressed for the examination. However, as I progressed through my third trimester, whenever I moved from sitting doing paperwork to standing in my full gravid glory I was often asked by patients, with a confused, guilty look, "Are you pregnant?"

I had run the TOP clinic three months earlier in my pregnancy, and I was surprised that, other than the incredibly competent nurses and specialist counsellor, you were pretty much left to your own devices. In a general gynaecology or antenatal clinic you have to run even the most obvious decisions by the consultant. I was amazed that I seemed to be making serious, life changing decisions, virtually unsupervised. The TOP clinic was "sensitively" hidden in some clinic rooms behind theatre, but it seemed to be hidden from most of the middle grade and consultant staff as well. The clinic was cancelled if a junior doctor was not available. They had only an out of date information folder as back-up. I began to wonder whether the clinic was unashamedly ignored rather than being just discreet.

I think that doctors who conscientiously object to such clinics need to consider who is left to perform in their place

Don't get me wrong: I found the clinics a good learning tool, especially as I plan to become an obstetrician one day. I realise that as more women become doctors the traditional role of the male obstetrician and gynaecologist will become a thing of the past. This will be even more likely if termination clinics become nurse led, as has been proposed.

After a bit of research, I found that GMC guidance states that personal and religious beliefs must be set aside if they compromise the care of patients (www.gmc-uk.org/guidance/personal_beliefs_and_medical_practice.asp). I believe that some of the patients I saw for a termination of pregnancy appointment experienced care that was less than ideal as a result of an emotional dilemma spurred by my pregnant appearance. I think that doctors who conscientiously object to such clinics need to consider who is left to perform in their place. Is it appropriate for patients to see a pregnant doctor for their termination of pregnancy appointment? Is it suitable to have an obvious reminder of the alternative consequence when patients are already facing a difficult decision? Pregnancy is a familiar sight in society, and some may argue it is inevitable that some patients will be seen by a pregnant doctor. Why then is it common for efforts to be made to arrange ultrasonography sessions for women wanting an abortion separate from routine antenatal scanning?

Next time you object, think about your patients and who they may see instead. The clinic may be awkward for you, but you might just learn something.

Megan Millward is an F2 doctor, Bristol
doctormillward@gmail.com

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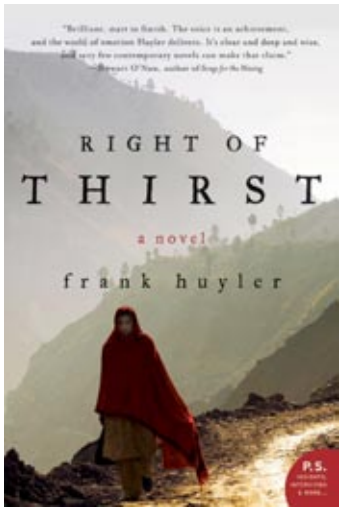
REVIEW OF THE WEEK

The unknown patients

A novel by a US emergency doctor about escape from "the empty rhythms of career and success" to a foreign land and unfamiliar patients impresses **Brodie Ramin**



Right of Thirst
Frank Huyler
One World Publications, £11.99, pp 384
ISBN: 978-0061687549
Rating: ★★★☆

A tiny girl, Homa, is at the heart of this graceful novel by Frank Huyler, a US emergency doctor. We learn very little about her world, the mountains of an impoverished Islamic country. We see only for an instant her family, her home, and the life set out for her. But we witness in great detail the moment when Charles Anderson, a US cardiologist volunteering in her land, amputates her foot with only simple instruments in a makeshift clinic.

Right of Thirst, Huyler's third book, is based on a real life event. As a medical student in the early 1990s Huyler trekked through the mountains of northern Pakistan. On his way down from the mountains a group of villagers asked Huyler to see a young girl with a crushed foot. Like Homa, she needed an amputation, which Huyler could not provide. The young medical student offered to transport the girl to the city, but the offer was refused. The girl was carried on her brother's back into her dark mud house, an image that has remained with Huyler. This girl's tragedy was witnessed and her story shared, but she remains, like so many others, an unknown patient—a lost life whose death goes unremarked. Any physician or nurse who has worked with poor people in poor countries will have known such a patient, and the memory will be terrible.

What draws physicians to such work? In *Right of Thirst* Dr Anderson travels to the mountain encampment in this Islamic land, modelled on Pakistan, to escape his life in America. The death of his wife has disrupted the reassuring but empty rhythms of career and success that he has built for himself. While visiting the head of his department Dr Anderson notices his CV open on the desk, a document that "spoke to decades of blind, relentless work" as a cardiologist and a thousand sleepless nights away from his family. He expects to lose himself in work "in a foreign land, freed from the burden of the familiar." But the ghost of his wife haunts his journey, as does the absence of his son and his own absence as a father.

Most of the time the doctor and the motley group wait for the refugees to arrive at the camp. When will they come? How many will there be? Are there enough supplies? They spend a negligible amount of time improving the lives of the local people. They hold a single clinic for the local village in an orchard of apricot trees.

The cardiologist sees an old man, "his heart, a jumble of clicks and murmurs, skipping and leaping, and then his lungs, full of crackles, wet and heavy and thick." He gives him diuretics; and when the man returns some days later, looking vastly better, Dr Anderson knows that he "won't be better for long."

The cardiologist sees an old man "his heart, a jumble of clicks and murmurs, skipping and leaping, and then his lungs, full of crackles, wet and heavy and thick"

Beyond the medicine the book explores the minefield that is military humanism. To be able to operate in the remote mountainous region the group depends on the logistical support of the local military. The power of the military is embodied by General Said, who arrives suddenly one day in his massive Russian helicopter. He charms and intimidates in equal measure. The book elaborates the theme that collaborating with the military to provide medical care is neither morally nor logistically simple. Captain Rai, the group's military attache, is caught between his dual roles as officer and coordinator of the relief operation, and the strain is evident throughout the novel.

Dr Anderson wants to guarantee Homa a healthy existence. He wants to use his wealth to shield her from her fate, the fate of the refugees, the fate of her village. Huyler uses fiction to create a new life for the young girl he could not help. Until the end, Anderson believes that he has the right to wield that power. He wants to save at least one of the unknown patients; he does not want to be left with that terrible memory.

Brodie Ramin is a family medicine resident, University of Ottawa
bramin@toh.on.ca

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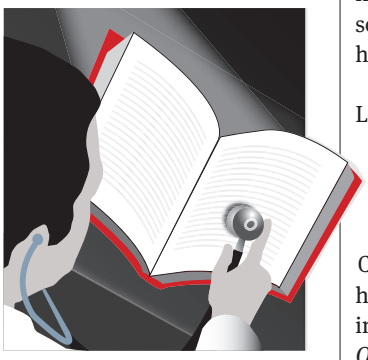
What draws physicians to such work? In Right of Thirst Dr Anderson travels to the mountain encampment in this Islamic land, modelled on Pakistan, to escape his life in America

Ill feelings

BETWEEN THE LINES
Theodore Dalrymple



There are few better evocations than in *One Hand Clapping* of how the distress caused by a disease can persist for half a century

John Middleton Murry (1888-1957), a famous though not universally loved man of letters in his day, is now remembered mostly for having been the husband of Katherine Mansfield, the New Zealand born short story writer and literary disciple of Chekhov. Their marriage was a difficult one: they got on better when they did not live together and communicated mainly by letter.

Soon after Mansfield's death from tuberculosis—for which, in desperation, she had sought treatment first from the Russian physicist Manoukhian, who bombarded her spleen with x rays until she was ill from it, and then from Gurdijeff's mystical Institute for the Harmonious Development of Man, where she died—Murry married Violet Le Maistre.

Le Maistre could have been Mansfield's double: she wrote stories and cut her hair in the same style as Mansfield. When, like Mansfield, she received a diagnosis of tuberculosis she exclaimed to Murry, "I'm so glad. I wanted you to love me as much as you loved Katherine—and how could you, without this!"

Murry was not altogether sympathetic. He wrote in his diary, "How tired I am of listening to that cough of Violet's. It seems to vibrate upon my spine." This may be contrasted with Mansfield's graphic words about her own cough in her notebooks: "I cough and cough and at each breath a dragging boiling bubbling sound is heard. I feel that my whole chest is boiling. I sip water. Spit, spit, spit. And I can't expand my chest—it's as though the chest had collapsed. Life is—getting a new breath. Nothing else counts."

No doubt many an attendant on many an invalid has felt like Murry, but few have committed their thoughts to paper knowing them to be inglorious, to say the least.

It was Murry's habitual self absorption, combined with an abstract love of humanity, that led some people to regard him as Pecksniffian.

Murry's son by Le Maistre, also called John Middleton Murry (1926-2002) but more often known as Colin, became a writer himself. He recounts in his autobiography, *One Hand Clapping* (1975), how, being thought susceptible to tuberculosis, he was allowed hardly any contact with his mother, by contrast with his sister, who was a year older than he and not regarded as susceptible. She, whom Murry senior regarded as Mansfield's daughter in some vague spiritual way in spite of being biologically Le Maistre's, was therefore allowed more contact with her mother.

The doctors arrived at their conclusion because John junior failed to thrive in his first year; this was still the age of what one might call medical ex cathedrism. Their fiat was to have a lasting effect on Colin: "For the better part of 40 years I cherished the belief that my mother had died when I was 2 years old. Only in this way could I explain to myself why I had only one memory of her."

Moreover, since Le Maistre's tuberculosis was diagnosed shortly after Colin's birth, he believed that his father, who never really got on well with him, subconsciously blamed him for his mother's disease and death five years later.

I am not sure that this is true; John senior was quite capable of emotional distance without such a cause. But still there are few better evocations than in *One Hand Clapping* of how the distress caused by a disease can persist for half a century.

Theodore Dalrymple is a writer and retired doctor

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MEDICAL CLASSICS

Every Good Boy Deserves Favour

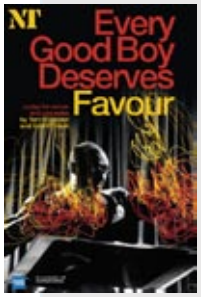
A play by Tom Stoppard **Published in 1978**

In February 2008 Roman Nikolaychik, a parliamentary candidate for the opposition Other Russia party, was detained without explanation in a psychiatric hospital, laments Tom Stoppard in the latest foreword to his play written three decades before.

"Would a Soviet doctor put a sane man into a lunatic asylum?" the head of the hospital asks Alexander, the protagonist of Stoppard's play. If he admits madness, his doctor has promised that he will be discharged and can see his son again. But Alexander's only diagnosed pathology is to have publicly criticised the state. He knows that he is sane, and his conscience won't allow him to lie.

Every Good Boy Deserves Favour, a mnemonic for the notes on the lines of the treble clef, is about the medicalisation of dissent: the abuse of psychiatry to silence and hide political prisoners. "Your opinions are your symptoms," Alexander's violin-playing psychiatrist tells him. "The idea that all the people locked up in mental hospitals are sane while the people walking around outside are all mad is merely a literary conceit, put about by people who should be locked up."

Set in the former Soviet Union of the 1970s, Stoppard's playful but stinging short script begs questions about who decides what constitutes mental ill health; how states choose to deal with people who deviate from their ideals; and how through orthodoxy and hierarchy doctors can become complicit in politics at the expense of medicine.



Alexander shares a cell with a genuine patient: Ivanov thinks that he is the conductor of an orchestra that he is permanently leading. He can hear it all around him. He plays the orchestral triangle, which he wears around his neck. Subtitled "for actors and orchestra," this play is rarely seen because all the musicians in Ivanov's imagination are needed on stage to perform André Previn's purpose written score. And Ivanov's orchestra is also an essential part of the physical drama.

Alexander is a writer who has been transferred to a civilian mental hospital after going on hunger strike. His detention is the result of protest against the treatment of other writers and activists who have been interned in labour camps and psychiatric prisons. He remembers, "I was given injections of aminazin, sulfazin, triftazin, haloperidol, and insulin, which caused swellings, cramps, headaches, trembling, fever, and the loss of various abilities, including the ability to read, write, sleep, sit, stand, and button my trousers."

Stoppard and Previn were inspired to devise *Every Good Boy Deserves Favour* by Vladimir Bukovsky, a real dissenter who exposed to the West the use of psychiatric imprisonment and forced treatment of him and other political prisoners in the Soviet Union of the 1960s. Bukovsky went on to write *A Manual on Psychiatry for Dissidents*. "Let me give you some advice," Ivanov tells Alexander near the start of the play, "Number one: never mix music with politics. Number two: never confide in your psychiatrist. Number three: practice!"

Richard Hurley, assistant magazine editor, *BMJ*
rhurley@bmj.com

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A friend in need

FROM THE FRONTLINE
Des Spence

He offered me a cigarette. "It's only bloody ophthalmology; you could get the whole course on a postage stamp." We both laughed drunkenly. But at 3 am I sat bolt upright, letting out a gasp. I leapt to my desk and opened my "pocket guide" to ophthalmology. The exam was at 9 am. This wasn't revision, because I hadn't ever opened the book before. Unblinking and wide eyed I poured knowledge into my hungover, short term memory, praying like only an atheist can that I might pass. Six hours later I met my red eyed friend filing into the exam: "That's a bloody big postage stamp." Neither of us smiled.

We need our medical friends to share experiences of pain, unworthiness, guilt, and anger. We're ordinary people from whom others expect the extraordinary, so we often retreat into the comfort of professional friends, and many of us marry other doctors. At parties we huddle together to inhale and puff on the medical chat, conversations closed to others. But this can make us insular and is sometimes mistaken for arrogance by others. Worse still, it makes our children pretend to yawn. The pressure of medicine runs the risk of taking interesting, intelligent, and lively people and making them introspective and dull.

So we need to keep our medical friends close but our non-medical friends closer, because they give us important perspective: an honest view of the profession from the outside; different takes on health care; insight into why people aren't happy with the NHS; and an opportunity to defend and explain what we do, if we can.

Non-medical contact also helps us to accept the responsibilities of being a doctor when we realise just how awful it is to be a lawyer or accountant—because the grass is rarely greener. It is hard to whine about our pay and conditions when our non-medical friends lose their jobs; we appreciate what we have. But most of all we need smoking, besmocked artists, bored bankers, cynical teachers, and bonkers builders as friends so that we might sometimes find escape from the seriousness of what we do. There's more to life than you can fit on the back of a postage stamp.

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

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Positive discrimination is still elitist

STARTING OUT
Kinesh Patel

Imagine a profession filled with ageing white men, men of great power and sometimes great wisdom, with many years of experience. Some used their power to appoint other white men to replace them. And some used their power inappropriately because they didn't like anyone who wasn't white like them.

Not all were bad, but there was a conspiracy of silence covering all this up until the whole house of cards fell down.

I'm talking not about medicine but the police. Last week the conviction of the corrupt Metropolitan Police commander Ali Dizaei made all the newspapers' front pages. He had been criticising the police for years, claiming that they were racist. However, paradoxically at the same time he was taking advantage of their targets for numbers of officers from ethnic minorities in high ranking positions and accelerating his own career. Meanwhile he was engaged in what could euphemistically be called "shady dealings."

Had he been white, would he have been allowed to continue like this for so long? Would his relentless promotions have carried on? It seems far fetched. Medicine was in not such a dissimilar position years ago, yet it has acquitted itself remarkably well. Of course, there have been problems, but any wholesale change in the composition of any institution is bound to be met with some resistance.

So why the difference? Are doctors intrinsically better people than police officers? Probably not. One thing is certain: until now medical recruitment has not been subject to the same vogue for political correctness as in the police. When a brown consultant is appointed over a white candidate, no one thinks that he or she got the job because of skin colour.

However, is that likely to be true in the police? People will naturally suspect the next high flying ethnic minority police officer as perhaps having reached that position because of his or her ethnicity. And they may well be right, which in turn breeds more resentment. But it does meet the tick box quota: another target met, and another great success for bureaucracy.

In medicine we could have had quotas for women, south Asians, and countless other groups who were minorities in the past. But those calls were resisted, with the unpredictable result that many of the former minorities are now satisfyingly over-represented as a result of their own merits and nothing more.

So it is galling to hear repeated cries to combat elitism by introducing quotas to increase the numbers of the last minority in medicine: those who have underperformed academically. For the grim reality is that a meritocracy is just as elitist, by its very definition, as any other form of selection.

Kinesh Patel is a junior doctor, London
kinesh_patel@yahoo.co.uk

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