



Florence and the war machine, p 1142

Lethal injections: no doctors should be involved

PERSONAL VIEW **Mike Weaver**

On 15 February the American Board of Anesthesiology, which certifies anaesthetists in the United States, stated that “anesthesiologists may not participate in capital punishment if they wish to be certified” (*BMJ* 2010;340:c2432). To me, a US anaesthetist practising in the United Kingdom but partly US trained, this statement would seem surreal if it were not so necessary. The death penalty is constitutional, and so is the use of a lethal injection to achieve it.

For years the American Society of Anesthesiologists has followed the American Medical Association’s advice in its clear opposition to physicians’ involvement in capital punishment. The association’s guidelines almost completely limit this involvement to certifying death. This guidance has not prevented some medical and nursing practitioners from taking part in the administration of lethal injections. The precise numbers involved are unknown, as participants are allowed to maintain anonymity. The most recent commentary from the American Board of Anesthesiology sends a very clear message to anaesthetists,

The use of lethal injection for capital punishment is, of course, not part of any medical domain. There is no patient; harm is done on purpose; and there is no consent

the public, and judicial authorities in the United States, and it goes well beyond simple guidance.

I can see how the idea of involving anaesthetists and other doctors in the use of lethal injection for capital punishment is attractive and logical to some. If execution uses lethal injection, why not make sure that venous access, timing

of drugs, and monitoring is done as humanely as possible? This could even be extended to finding a better combination of drugs. Possible drug options, drug combinations, and monitoring methods change as medical knowledge and practice develop. To this end, why shouldn’t clinicians with appropriate



FLORIDA STATE CORRECTION DEPARTMENT

No place for healthcare professionals

skills be both directly and indirectly involved?

The US surgeon and writer Atul Gawande interviewed nurses and doctors who had taken part in giving lethal injections to inmates condemned to death (*New England Journal of Medicine* 2006;354:1221-9). The stories are powerful and challenging. They should be read by anyone wishing to hold a view on this issue. These individuals care greatly about minimising suffering and take this role very seriously. They seem to be compassionate people. One doctor, a critical care specialist, had started out just monitoring the electrocardiogram for cardiac standstill. He was drawn into the process further at another execution when the technicians had problems achieving venous access. He was asked to help, and he did. In one patient with very difficult venous access he placed a central line. He had these skills; and the procedure went more smoothly because he was there. He had gone from being present as a “monitor” to providing important practical assistance. I suggest that any of us in these circumstances would have found it difficult to just walk away. This use of medical skills and knowledge could be seen as appropriate, even if unsanctioned by professional bodies.

But Gawande’s interviewees and other healthcare professionals who assist in capital punishment miss the point. The use of lethal injection for capital punishment is, of course, not part of any medical domain. There is no patient; harm is done on purpose; and there is no consent. So, no healthcare professionals belong here. The practice uses components of medical care and, in particular, anaesthetic practice to try to achieve unconsciousness and death. That is all.

If it were straightforward this issue would not exist, as healthcare professionals would not be needed. The problem is that it is clearly not that easy, can be messy, and causes suffering. A district court in California was concerned enough about this to rule in 1996 that there should be reasonable assurance that unconsciousness is achieved during the execution. The court ruled that only “a person with formal training and experience in the field of general anesthesia” could do this, putting anaesthetists in a difficult position through no fault of their own. The American Society of Anesthesiologists was concerned that its members might be asked to help with lethal injections. It sent out a newsletter strongly advising its members to be informed about this issue and to not help out (www.asahq.org/Newsletters/2006/08-06/guidry08_06.html).

The recent statement from the American Board of Anesthesiology goes much further, and all anaesthetists should welcome it (www.theaba.org/pdf/CapitalPunishmentCommentary.pdf). It provides additional protection for anaesthetists working in the United States. I worry that the statement cannot protect nurse anaesthetists, who also have skills in this area. Let us hope that their regulatory body will act soon. It remains to be seen whether the board’s bold move on certification and participation in capital punishment has an impact beyond public reassurance.

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REVIEW OF THE WEEK

Florence and the war machine

A clever revamp of an established museum about Florence Nightingale should switch a new generation on to her supreme contribution to modern health care, finds **Colin Martin**

Florence Nightingale Museum

2 Lambeth Palace Road, London SE1 7EW

www.florence-nightingale.co.uk

Rating: ******* ✨

The Florence Nightingale Museum in London reopened this month, the 190th anniversary of her birth in 1820. Located at St Thomas's Hospital, its exhibition area has been cleverly reconfigured by the Amsterdam based design practice Kossman de Jong. The three phases of Florence's life are presented in new "pavilions," inspired by her innovative hospital design, in which cross ventilated wards were housed in separate buildings linked by corridors.

The first pavilion, "The Gilded Cage," is a rose covered topiary maze, with recorded birdsong, representing her upper middle class upbringing in Derbyshire and Hampshire. Her long struggle to convince her family that nursing was a suitable occupation for an intelligent, well bred young woman is presented in episodes with *Girl's Own* type titles, including "Florence fights to nurse" and "Florence escapes the gilded cage." Although she had her parents' permission to study nursing in Germany, and then to become superintendent of a Harley Street nursing home for gentlewomen in 1853, Florence's moment came in 1854, when the disastrous medical conditions in the Crimean war were widely reported in Britain, particularly by *The Times*.

The second pavilion, "The Calling," demonstrates that chance favours a prepared mind. Florence's letter to the War Office offering her services crossed with one from Sidney Herbert, secretary of state there, seeking her help. Within weeks she departed for the Crimea with 38 nurses. The pavilion's exterior is glazed with colourful Turkish tiles; within it a central pile of wooden packing crates is surrounded by display cases, crisscrossed with wide webbing bandages. Recorded sounds evoke rats scuttling within the hospital walls at Scutari. Her

The new "pavilions" are inspired by Florence's innovative hospital design, in which cross ventilated wards were housed in separate buildings linked by corridors



Ode to a Nightingale: the library-like "Reform and Inspire" pavilion

achievements there resulted from her realisation that military hospitals needed to be properly managed (which she did), from her ability to organise much needed supplies and galvanise public support, and from her ability to work with others to improve sanitation and supply clean water. Only then did the death rate begin to fall.

The final pavilion, "Reform and Inspire," presents Florence's achievements during her remaining 54 years, when, as a semi-reclusive invalid, she lobbied for medical reforms and established nursing as a proper profession. Her 800 page *Notes affecting the Health, Efficiency, and Hospital Administration of the British Army* informed the report of the Royal Commission on the Health of the Army, which established four sub-commissions to implement its recommendations, largely hers.

As well as displaying historical documents and artefacts, the pavilions provide touchscreen interactive learning opportunities. I needed three attempts to answer the question "Could you take charge of a hospital?" by correctly identifying the four essential Crimean supplies requested by

Florence: soap, dressings, needles and thread, and shirts.

Interventions by three contemporary artists comment obliquely on Florence's life. Her sister Parthenope married the Liberal MP Harry Verney. A tree felled at the Verney country estate, Claydon, which Florence visited often, provided timber for a wooden garden bench carved with the text "On February 7th 1837 God spoke to me and called me to His Service." A film that follows a walking woman, accompanied by the sound of echoing footsteps, is projected within a wooden crate, poignantly evoking her 8 km nocturnal patrols through the

hospital wards at Scutari. A brass bed, its mattress covered with pages torn from *Notes on Nursing* and a 19th century biography of Florence, alludes to her half century of achievement after Crimea. It reflects her huge literary output, including 14 000 letters and 200 books, pamphlets, and articles written while campaigning on army medical reform, hospital design, nursing, and other health related issues.

The four boundary walls, enclosing the pavilions, display historical and modern photographs and ephemera depicting Florence's enduring legacy: a fully fledged nursing profession. She would have approved of an early 20th century advertisement for the official Guy's Hospital "probationers on trial" outfits, with its caveat, "No other type of uniform accepted." But the dust jacket for the 1960s novel *Tramp Nurse*—"She healed their bodies with her white hot passion"—would have amused neither Queen Victoria nor Florence. In 1849, having finally decided to remain single, she declined a marriage proposal from the politician and poet Richard Monckton Milnes. "Their marriage would have delighted her mother," notes the wall text, drily adding, "Neither knew about Milne's collection of erotica and interest in the Marquis de Sade."

Florence had many friendships with influential men, without any hint of impropriety, although Sir Harry Verney was lampooned as the member for Florence Nightingale, because of his avid parliamentary support for his sister in law's policies. Colin Martin is an independent consultant in healthcare communication, London cmpubrel@aol.com

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Review: Florence Nightingale—Iron Maiden (*BMJ* 2001;323:172)

Christmas 2008: Reappraising Florence Nightingale (*BMJ* 2008;337:a2889)

The cost of reading

A famous author who was also a doctor, Somerset Maugham, once wrote that he was so devoted to reading that he would rather read a train timetable than nothing at all. I understand this state of mind well. Once, in a hotel room in Los Angeles, I had nothing but the telephone directory and spent two hours happily reading it. I was most impressed by the number of private detectives (none called Philip Marlowe).

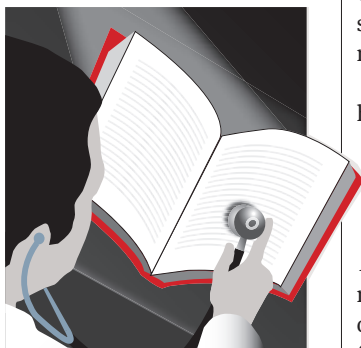
The other day I was on a train with nothing to read but a bookseller's catalogue, from 1960, of "Old Medicine and Science." This, too, I read happily for two hours. Ah, if I had only had the number of pounds then that I have now or that old books were the price now that they were then.

On average, antiquarian scientific and medical books now cost 60-100 times what they cost then, though if you buy from a love of monetary appreciation rather than from bibliophilia (or bibliomania) you must exercise discrimination.

On the one hand, *De Dissectione Partium Corporis Humani*, by Charles Estienne (a pupil of Sylvius, of the Sylvian fissure, and scion of a famous French printing family), would have cost you £300 (€350; \$435), but now it would cost you £30 000 at the least. Published in 1545, two years after Vesalius, it would have been published earlier but for legal problems. Estienne died in prison, sent there (according to various sources, and perhaps according to taste) for debt or heresy. Of course, for some, debt is heresy.

On the other hand, you might have bought H W Haggard's *The Lamae, the Halt and the Blind* of 1932 for £1 15s, whereas you could now easily buy it for less than £10: that is to say, you would have lost almost as much of your money

BETWEEN THE LINES Theodore Dalrymple



One doesn't acquire books for the monetary return—a bookseller will arrive after your death and offer your relict yardage, which is to say £5 per bookshelf yard

as if you held certain British bank shares (though you would at least have had the pleasure of the book meanwhile).

On yet another hand, I could have bought a very early edition (1644) of Descartes's *Meditationes de Prima Philosophia* at the nominal price of my copy of the catalogue (once owned by an irascible bibliophile, who angrily scribbled "should have 2 plates!" against Honoré Fabri's *Tractatus Duo: Quorum est de Plantis et de Generatione Animalium; Posterior de Homine*,

Paris, 1666), namely £6.

But, of course, one doesn't acquire books for the monetary return—a bookseller will arrive after your death and offer your relict yardage, which is to say £5 per bookshelf yard.

No, one wants to learn; and who would learn nothing from, say, two of the books for sale by the Swiss physician Samuel-Auguste Tissot, *Onanism, a Dissertation on the Diseases Caused by Masturbation and An Essay Incidental to Literary and Sedentary Persons?*

My favourite item, though, was *In Vino Veritas: Or a Conference betwixt Chip the Cooper, and Dash the Drawer (Being both Boozy)*, a pamphlet of 1698. An extract to whet the appetite, as it were, explains why the English prefer the fortified wines of Portugal to the unfortified wines of France:

"They have the body, that is strength, and that now a days pleases, for our People love to have their Heads and Stomachs hot, as soon and as cheap as they can."

Now does that remind you of anything, I wonder—for example, casualty on a Saturday night?

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MEDICAL CLASSICS

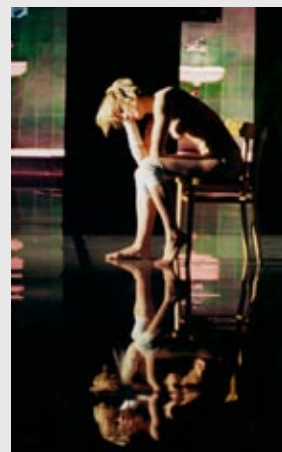
4.48 Psychosis Written by Sarah Kane

Published 2000

"I have become so depressed by the fact of my mortality that I have decided to commit suicide." The play *4.48 Psychosis* is a bleak, often angry examination of clinical depression and suicidal ideation. The playwright, Sarah Kane, was a key figure in the British "in-yer-face theatre" of the 1990s, which was characterised by provocative and confrontational writing and depictions of explicit sex and violence. Kane committed suicide in 1999 at the age of 28; *4.48 Psychosis*, her fifth and final play, was first performed almost 18 months later.

Kane had attracted controversy while alive. Her first play, *Blasted*, was described in the *Daily Mail* as a "disgusting feast of filth" for its surreal and disturbing imagery of male on male anal rape and eye gouging set in a Leeds hotel room amid a civil war—and for its unapologetic misogyny, racism, and homophobia. But now many critics celebrate Kane's contribution: each of her plays is an experiment in new theatrical form, challenging traditional naturalistic writing. Kane concluded this innovation by presenting *4.48 Psychosis* without characters, plot, or stage directions but as free text, in the form of diary entries, doctor-patient dialogues, longer prose, passages from self help books, and poetic dreams. Directors are free to present these words as they see fit.

A woman is mired in mental agony, full of self hatred, despair, and thoughts of self harm and death. Fragments of text merge in a relentless stream of consciousness that can be read as a conversation between the woman and her suicidal mind or as the voices of friends, family, lovers, doctors, and other patients: "I am a complete failure as a person." "But you have friends." "Take an overdose, slash my wrists then hang myself." "It's not your fault. You're ill." "My final submission. My final defeat."



A theatrical suicide note?

Doctors are viewed entirely unsympathetically: "I dreamt I went to the doctor's and she gave me eight minutes to live—I'd been sitting in the fucking waiting room half an hour." Lists recall symptoms, diagnoses, drug regimens, and their failure: "Lofepamine and citalopram discontinued . . . Delusional ideas—believes consultant is the antichrist . . . Fluoxetine hydrochloride, trade name Prozac, 20 mg, increased to 40mg . . . homicidal thoughts towards several doctors and drug manufacturers. Discontinued." Amid the horror, moments of dark humour and tenderness do little to lift the mood. "100 aspirin and one bottle of Bulgarian Cabernet Sauvignon, 1986. Severe stomach pain. No other reaction."

Kane reportedly often woke at 4.48 am in a depressed state, and it is simple to see *4.48 Psychosis* as autobiographical, a suicide note that Kane intended to be performed posthumously. Whatever the intention, and regardless of her subsequent action, Kane describes a harrowing and intensely personal battle with severe depression that is moving and unforgettable.

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Pain revisited

FROM THE
FRONTLINE
Des Spence



I upset many by asserting that the widespread use of strong opioids for pain in diseases other than cancer was a disaster in the making, after a doubling in the number of prescriptions in a decade (*BMJ* 2010;340:b5683). Since then I have immersed myself in the evidence, and I have come to only one certain conclusion: the pain community is well intentioned. But the process again makes me question the role of evidence based medicine. It was once touted to be our saviour, but its flaws are little understood, and “evidence” is given a primacy that is not warranted in clinical practice. Now the drug industry, seeing evidence based medicine as the new frontier of marketing, has realised the importance of controlling this evidence.

Evidence says that 20% of the population experiences chronic pain, but this defies common sense. This evidence is based on the unscientific definition that “pain is whatever the patient says it is,” an assertion so simplistic that it cannot be true. This is presented as absolute fact, however—an unmet need and the reason for more prescribing. “Evidence” shows that dependence and diversion to unlicensed use are low when opioids are used in non-cancer syndromes. But these definitions are loose, open to interpretation, and depend on the flawed science of self reporting, with huge reported variation in problems (*European Journal of Pain* 2007;11:490-518). “Evidence” also shows that people likely to become addicted can be screened out. Indeed, many problems are explained away by “pseudoaddiction,” another nebulous term that has

been added unquestioned to the scientific evidence lexicon.

Evidence supports the use of “validated questionnaires” for screening and scoring pain. Reducing pain to a collection of numbers allows the substitution of statistical for clinical significance. But questionnaire medicine belies a low specificity and a high rate of false positives; these patients are then prescribed opioids. Questionnaire culture is reductionist nonsense that dismisses experience and clinical judgment, offering phoney reassurance. Lastly, with a high reported prevalence and lifelong treatment, chronic pain is a pharmaceutical golden goose. With pharma’s power to commission research (commissioning bias), branded sustained release products now dominate the evidence base. These are gold plated products never tarnished by turning generic—an eternity of profit. This is no conspiracy theory but business.

I wish I could show the evidence for harm of opioid use in the United Kingdom, but I can’t. However, irrefutable data exists from another country that has also seen a similar rapid rise in prescribing. In the United States addiction to prescribed opioids is as big a problem as cocaine, and unintentional overdose kills about 39 000 US citizens a year (almost as many as die in road traffic crashes). These are but the visible tip of an iceberg of problems. We have an evidence based disaster in the making.

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A sometimes unhealthy coalition

DRUG TALES AND
OTHER STORIES
Ike Iheanacho



Mutual respect, tolerance, understanding, and support—these hallmarks of successful partnership will be sorely needed by the parties making up the United Kingdom’s brand new coalition government.

For lessons about how large coalitions work (or fail) where can we turn? Yes, there are other European countries and, at home, recent experience in the devolved Scottish and Welsh administrations. But useful examples also come from outside politics, including one so entrenched and dominant that it’s generally not recognised as a coalition at all.

Regulation of drugs in the European Union (and elsewhere) relies, in effect, on a coalition between the pharmaceutical industry and the drug regulators. Far from an antagonistic relationship of the governors and the governed, it’s better thought of as an interdependent union that ostensibly serves (the public and healthcare

professionals) through exerting power (decisions on whether and when products get to and stay on the market).

The need for this sort of set up isn’t seriously questioned. And the close and essentially harmonious working relations between what are two very different groups tell their own story. The overall impression is of orderly governance that reliably strikes the right balance between facilitating the advent of innovative drugs and safeguarding public health.

However, this seemingly rosy picture encourages dangerous complacency: not among the industry or regulators (who could, no doubt, produce reams of evidence of their diligence and efficiency) but among the supposed beneficiaries of their benign rule. Patients and, more worryingly, doctors tend to know little or nothing about the regulatory mechanisms for drugs. And, in general, they don’t engage much with the day to day work of the

regulatory coalition, leaving this largely free from the public and media scrutiny that other aspects of health care are subject to.

Is it so surprising then that the coalition sometimes agrees terms and conditions that seem to favour primarily their own interests? The result can be strikingly bad policies. For instance, how is the public good served by allowing some new drugs to be licensed solely on the basis of placebo controlled trials even when well established comparator treatments are available?

Ensuring that his new government functions well and focuses on the real needs of the population will be key priorities for our new prime minister. So should they be for another, much less obvious, coalition.

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