NO HOLDS BARRED Margaret McCartney

A wise doctor and a foolish prosecution

Dharmasena was concerned that the stitch reconstituted the patient's FGM, and—as reflective, thoughtful doctors should do—he sought advice

Wisdom is recognisable for its facets of fair judgment, experience, carefulness, and compassion—but also a degree of risk taking. The wise people I know make choices that are based on likely consequences. They consider all options but are also decisive. They are fair minded, having little ego to get in the way of what might be best for others. Wise people make good role models, although they most likely hate this. Shakespeare had it right: "The fool doth think he is wise, but the wise man knows himself to be a fool."

The risk taking is important; wise people are not interested in "covering their backs." The jury judging Dhanuson Dharmasena rapidly acquitted him as innocent against charges that he had committed female genital mutilation (FGM) in 2012 at a London hospital. His patient, whom he saw as an emergency in labour, had been subjected to FGM previously in Somalia. To deliver the child, Dharmasena had to make an incision, but it continued to bleed. To stop this he inserted one single suture and was called away to another emergency immediately.[1] He was concerned about what he had done, though, in case it infringed the Female Genital Mutilation Act 2003. This act states, however, that "no offence is committed by an approved person who performs . . . a surgical operation on a girl who is in any stage of labour, or has just given birth, for purposes connected with the labour or birth."[2]

Dharmasena was concerned that the stitch reconstituted the patient's FGM, and—as reflective, thoughtful doctors should do—he sought advice. The hospital held a "serious untoward incident" review, which should have realised that the patient should have been recognised as having had FGM well before she went into labour, allowing plans to be made before an emergency arose. The hospital referred the matter to the police, who contacted the Crown Prosecution Service (CPS), which decided to press charges against the doctor—the first such UK action.

But this was not a doctor intending FGM—rather, one dealing with an emergency situation and one who, wisely, had doubted his own actions and sought advice; if only a wise person in the CPS had realised that bringing the matter to court was a mistake.

A far bigger issue is that girls are being taken abroad from the United Kingdom to have their genitals cut—not only with the consent, but also by the organisation, of the people who are meant to care for them.[3] Why has the CPS yet to bring any prosecutions for that?

Margaret McCartney is a general practitioner, Glasgow
margaret@margaretmccartney.com

Cite this as: *BMJ* 2015;350:h815

IF I RULED THE NHS John R Ashton

We need a Public Health Act fit for 21st century

If I ruled the NHS, strengthened public health and primary and community care would go further than the currently fashionable talk of integration, to re-embrace housing and town planning and the "hidden lay healthcare system" that accounts for most care.

Other challenges I would tackle include bringing back robust local public health intelligence, no longer provided by the public health observatories, and a new approach to workforce development that recognises the importance of practical nursing and the reservoir of untapped young talent in our communities. It is lunacy to reject well qualified domestic applicants to medical school while plundering the output of schools in the developing world.

So, here are some of my solutions to the failures of the past 30 years. The Department of Health should be recast as a department of public health, with a secretary of state in the cabinet supported by a minister for the NHS and advised by a national director of public health, and with meaningful two way links to each other's government department.

We need a new Public Health Act to succeed the last principal one in 1936. This should provide a framework for policy, legislation, and action fit for the 21st century and committed to devolution. In any steps taken, the principles of structure following function and subsidiarity with additionality, in which local policy and action is the default position, should be paramount.

It is lunacy to reject well qualified domestic applicants to medical school while plundering the output of schools in the developing world

The democratic deficit of NHS governing bodies and the cloning of non-executive boards should be replaced by directly elected boards of health and hospital and other service providers. They should be provided with independent advice by local directors of public health, who would have the same independence of mind and voice as local financial auditors.

Nationally, I would review Public Health England's scope and purpose. The US public health service model of command and control, which influenced its origins, may have its place in public health emergencies such as bioterrorism, Ebola, or pandemic flu, but the principle of Occam's razor applies here: the starting point should be the most parsimonious list of functions needed in London to protect the public's health. In his *Five Year Forward View* NHS England's chief executive, Simon Stevens, acknowledged that the future of health depended on a radical upgrade in prevention and public health. This is refreshing, heady, and welcome stuff—if it is not yet another false dawn.

My final action would be to establish a national network of public service staff colleges to provide joined-up public service leadership, fit for the 21st century and encompassing all public services. These would be freed from the recent hegemony of private and commercial sector ideology.

John R Ashton is president, Faculty of Public Health
Johnrashton@blueyonder.co.uk

Cite this as: *BMJ* 2015;350:h616

thebmj.com

Read previous articles in this series at http://www.bmj.com/specialties/if-i-ruled-nhs

"This may hurt" may do harm

Open ended statements such as "You may feel something now" allow for patients' widely varying responses to stimuli and are less likely to invoke a nocebo reaction, says **Baruch S Krauss**

Procedural disclosure includes statements that warn the patient that something is about to happen, along with subjective descriptions of sensations that the patient may experience. Statements are either declarative ("I am going to give you some numbing medicine now"), descriptive ("You will feel some cold soap on your back"), or a combination ("I am going to do X, and you will feel Y"), and they can be expressed as either definite ("This will feel cold") or qualified ("You may feel some burning"). The content depends on the age of the patient, the type of procedure, and the expected response from the patient. Disclosures are based on the model that clinicians learnt in their training and the assumption that most patients will respond similarly to a given, and often potentially noxious, stimulus.

This assumption allows clinicians to make general statements as to what patients will, or may, experience with each procedural stimulus. However, this does not account for the wide range of individual responses (based on temperament, previous experience, coping style, and cultural tradition) that patients display in clinical practice, from no anxiety/pain response to severe distress.

The value of procedural disclosure is taken as self evident. It is assumed that disclosure is ethically the right thing to do; that it is accurate, does no harm, and benefits patients. Procedural disclosure differs from informed consent because it does not communicate the risk of an adverse event—rather, it outlines what sensations patients may experience, and it takes place after informed consent has been obtained. Unlike informed consent, procedural disclosure is a process learnt informally without an evidence based method or established rules governing the process.

Negative expectations may produce symptoms or worsen existing symptoms, studies on nocebo effects have shown[1-9]—allowing for inferences about how specific types of procedural disclosure communications can shape patient response. Telling patients that something will hurt is likely to increase their reports of pain. Videos of patients undergoing interventional radiological procedures show that warning them of impending pain or an undesirable experience results in significantly greater pain and anxiety than informing them with a neutral statement (for example, "What does it feel like?") or a

Calibrated and nuanced language is required for procedural disclosure to communicate truthful information that positively influences the patient's affective state while minimising negative responses

statement focusing on competing sensations (such as "cooling, tingling, or numb").[10]

Women receiving epidural or spinal anaesthesia who were randomised to "reassuring" words ("We're going to give you a local anaesthetic that will numb the area, and you'll be comfortable during the procedure") had lower pain ratings than those who heard "harsh" words ("You're going to feel a big bee sting; this is the worst part of the procedure").[11] Similarly, patients requiring intravenous catheter placement for surgery who received the communication, "I am going to apply the tourniquet and insert the needle in a few moments. It's a sharp scratch, and it may sting a little," reported higher pain scores than patients who were told, "I am going to apply the tourniquet on the arm. As I do this many people find that the arm becomes heavy, numb, and tingly. This allows the drip to be placed more comfortably."[12]

A recent study combined behavioural and neuroimaging data to consider how three different cognitive frameworks—expectations of analgesia, no analgesia, or hyperalgesia—modulated a fixed concentration of remifentanil on constant heat pain. Positive expectations doubled the analgesic effect when compared with no expectation, and negative expectation abolished remifentanil analgesia. Positive expectation was associated with activation of pain inhibitory regions in the brain; negative expectation was correlated with increased hippocampal and prefrontal cortex activity.[9]

Nocebo research

Nocebo research has shown that communications that elicit negative expectations have the potential to harm and that this effect is neurobiological.[9] Therefore, calibrated and nuanced language is required for procedural disclosure to communicate truthful information that positively influences the patient's affective state while minimising negative responses. Because patients may have individual, and often idiosyncratic, responses to procedural stimuli, it may not always be possible to match disclosure language to the patient's subjective experience.

Open ended statements, therefore, can be more helpful than firm predictions and can allow maximum latitude for individual responses without directing the patient towards a particular sensation or experience: "I am going to give you an injection now," instead of "This may hurt a little"; or "You may feel something now," instead of "This will sting for a moment"; or "You may be feeling some of the changes from the medication," instead of "This medication may make you dizzy."

It has been the accepted norm that formal training is not needed for clinicians to communicate procedural disclosure information. Although there is a method for, and training in, communicating a terminal diagnosis or poor prognosis (that is, compassionate delivery of information that tells the truth but does not destroy hope), no analogous training or method exists for delivering procedural disclosure information. Nocebo research highlights the need for such training and provides a framework for developing an evidence based method through the specific phrasing of information—one that avoids negative expectations without compromising the ethical standards of informed consent.

Baruch S Krauss is associate professor in paediatrics, Division of Emergency Medicine, Boston Children's Hospital, 300 Longwood Ave, Boston, MA 02115, USA; and Department of Pediatrics, Harvard Medical School, Boston, MA, USA
Baruch.Krauss@childrens.harvard.edu
Cite this as: *BMJ* 2015;350:h649