

BMJ BLOGS Andrew Burd

Bring back the white coat

Helen, a delightful medical student from the University of Aberdeen in Scotland, has been staying with us for an elective. All overseas students are asked to provide their own white coats, and our visitor from the United Kingdom told us that she had to borrow a white coat from a Hong Kong friend.

“There are no more medical white coats in the NHS.” This was a passing comment on the morning rounds, but it certainly stimulated a lot of discussion. I have just forked out a relatively hefty sum to buy a fitted white coat with designation, name, and specialty carefully embroidered above the pen pocket, as have several other team members. We like our white coats in Hong Kong. We wear them with pride, and many buy their own and wash them. So what is the problem with white coats in the UK?

The *BMJ* ran a piece in 2004 (*BMJ* 2004;328:57) that caught my eye. A senior registrar in general practice predicted the death of the white coat on the grounds of elitism, as the white coat no longer held the respect it once did. The BBC also reported on the dying of the white coat and

caught the mood of doctors and patients.

The death itself was rather drawn out, and this reflected the ongoing war between the medical profession and the management. The managers wanted to disempower doctors, and to do so they had to attack their status. And this was done insidiously with government led targets. Targets that were all to do with politics and very little to do with the practice of medicine. Perhaps there is an element of wishful thinking in this, but I witnessed the plummeting of morale among surgical colleagues in the NHS in the latter half of the past decade.

So when the white coat died in 2007, what was the reason? Infection. The BBC and Associated Press both reported that doctors in the NHS would no longer wear white coats. They are an infection risk.

What absolute nonsense. White coats do not cause infections. It is the sloppy, careless, dirty, demoralised people who wear them who cause infections. I wear a white coat; I wash my hands between patients; and I wear a mask, gown, and gloves when dressing a wound. It is a clean white coat.

But in the UK, I have a sneaking feeling that this was the final battle in the war between the medical profession and the management. It smacks of collusion for both sides to agree that the white coat should go for the same reason. A reason that is so startlingly insincere.

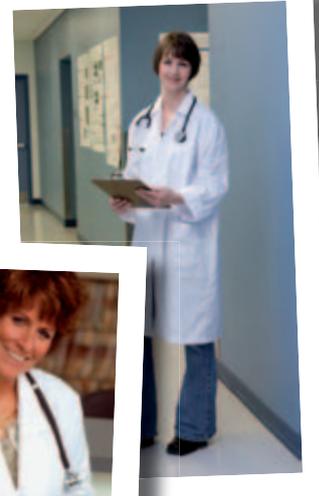
Rise up: re-take the initiative and elegantly and proudly re-drape the white coat around your shoulders. Doctors in the UK: buy your own white coats; get at least three. Wear them with pride and get back to work. Next issue to push into the past: the European Working Time Directive.

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BMJ blog readers have been commenting on this blog.

Keith Slater says, “Your points are eloquently made and entirely correct. So many of the pointless initiatives and directives we now suffer at the hands of management result from edicts without a grain of evidence to support them.”

► Read the full version of Andrew Burd’s blog and others at www.bmj.com/blogs



White coats: the discussion continues

Andrew’s blog was also discussed on doc2doc, BMJ Group’s global online clinical community:

Deb_D: “A cross sectional study by Wong et al. (*BMJ* 1991;303:1602-4) found bacterial contamination of white coats by *Staphylococcus aureus*, particularly in doctors of the surgical specialities. Maybe the doctors can wear white coats during interview and remove it during examination. This way, the risk of transmission of infection is reduced. Many doctors whose coats were contaminated were also found to be carriers of *S aureus*. Infection may nevertheless be transmitted, even if white coats are not worn.”

bungeejump: “I’m glad white coats are no longer worn. I find them hot and restrictive and used to hate wearing one while they were still in use when I was a medical student. Surely the patient’s perception and respect towards you as a doctor is

based on your manner, conduct, and skill, and not whether you have a big white jacket on?”

DrS: “When you work in a special care baby unit, where the standard room temperature is 25 degrees or higher, surely white coats are a risk to health—through the risk of overheating doctors!”

Elsewhere on doc2doc, Oliver Ellis discusses *Gattaca*, Andrew Niccol’s 1997 film, where genetic screening is done in seconds by the entry barriers in offices. Which other sci-fi fictions are now medical fact? Have your say at <http://bit.ly/d8FePa>.

Max Allen is concerned that the proposals put forward in the NHS white paper for England, and the bureaucracy the paper generates, will rob general practitioners of their clinical role. Will the role of the chemist become more medical, he asks.

► Visit <http://bit.ly/bxGHZz> to discuss.

ETHICS MAN Daniel K Sokol

When is restraint appropriate?

All practicable and less invasive alternatives, such as persuasion and de-escalation techniques, must first have been exhausted

I have encountered the issue of restraint three times in recent months. The first came in my involvement with a Ministry of Justice committee examining the use of a new pain compliance technique in young people in secure institutions. The committee was set up after the *Observer* ran a front page story detailing violent restraint techniques and the tragic deaths resulting from their use.¹

My second encounter with restraint was in an ethics committee meeting. The patient, who had severe learning difficulties, needed dialysis. Without it she would die in weeks or months. The problem was that she became extremely distressed when undergoing dialysis. The clinicians decided that restraint would not be in her best interests.

Finally I came across a case that appeared in May 2010 before the Court of Protection, which makes decisions in relation to people who lack the capacity to make the decisions themselves. The patient was a 55 year old woman who needed an operation to treat an endometrial adenocarcinoma.² Despite her fear of needles and hospitals she had agreed to the operation in the past but consistently failed to turn up for treatment. The judge ruled that it would be appropriate, if persuasion failed, for a consultant anaesthetist to go to her home and put some midazolam in her drink and to restrain her while she recovered after the operation.

For some people restraint is so repugnant a prospect that it should never be used. It is, they say, a violation of a person's autonomy and an infringement of their dignity. Restraint is indeed a violation of a person's autonomy of action. The restrained individual cannot move even though he or she wants to. Often it is also a violation of autonomy of will, defined by Raanan Gillon as "the freedom to decide to do things on the basis of one's deliberations."³ Sometimes,

however, the situation is more complex. Did the 55 year old patient with endometrial cancer want the operation or not? She agreed to it at first, but when the moment of truth came she refused. Which of her incompatible views is the most deliberated: the agreement or the refusal? In "Ulysses contracts," named after Ulysses' instructions to his crew not to untie him from the mast come what may, the autonomous patient agrees to be restrained should he or she later refuse treatment. Restraining the patient thus becomes part of respecting autonomy.

Ulysses contracts are rare. Restraint usually requires the violation of autonomy. It can be violent, and there is, inevitably, a risk of harm. In the "nose distraction" technique, now no longer used in young offenders' institutions, the "restrainer" strikes the child underneath the nose with the ridge of the hand. It is easy to get wrong. The restrainer could hit too hard or in the wrong place, causing a nose bleed, a broken nose, and psychological harm. This risk of harm must be justified. One justification is to protect others from harm. The *Observer* article talks of the use of brutal techniques on "unruly children." Imagine a large, muscular, irate 17 year old, an improvised weapon in hand, fighting viciously with another teenager; "unruly" is too weak a word. It is easy to dismiss the use of restraints as barbaric and undignified, as remnants of the bad old days when it was undoubtedly abused, but such an outright dismissal ignores the realities on the ground. When a boy has his teeth embedded in another boy's neck, these arguments lose much of their appeal.

Another consideration is the risk of harm to the restrained individual. The risk of the restraint must be balanced with the risk of not restraining. One of the key roles of the Ministry of Justice committee was to identify and assess all the risks and harms,



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physical and psychological, of a new restraint technique. This also included an analysis of the potential harms on the restrainer. The nose distraction technique, for example, left the restrainer's hands perilously close to the young person's teeth. Only then can a proper evaluation of the pros and cons of restraint be made. In the case of the dialysis patient the risk of non-restraint was an earlier death than if dialysis was imposed. The clinicians, however, deemed that the profound psychological harm of forced treatment, coupled with the practical difficulty of administering dialysis and enforcing adherence between sessions, outweighed the benefit of a prolonged life.

Whether in a secure institution, a hospital, or in the community the use of restraint should be a last resort. It is often barbaric and undignified. It generally does violate autonomy and cause harm, sometimes very serious harm. All practicable and less invasive alternatives, such as persuasion and de-escalation techniques, must have been exhausted. The restraint must be effective, its benefits must outweigh its harms, and those performing the technique must be adequately trained. Measures to deal with adverse outcomes must also be in place. In the case of the woman with endometrial cancer, for example, the anaesthetist would need to anticipate the possibility of oversedation and breathing difficulties. If appropriate, post-incident counselling should be offered to the restrained and the restrainer. The hard question is not whether restraint is ever appropriate but in what circumstances it is appropriate.

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References are on bmj.com

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