

ETHICS MAN **Daniel K Sokol**

Crouching tiger, hidden surgeon

Why in surgery is there such a neglect of training in ethics?

Cast your eye down the list of delegates at any course in medical ethics. You will find represented a wide range of specialties: the usual batch of general practitioners and anaesthetists, intensivists, psychiatrists, oncologists, junior doctors, and even the occasional radiologist and pathologist. Yet there is one species of doctor that is as rare as the Siberian tiger: the surgeon. I must confess that my eyes light up when I see a surgeon on the list, and I scan the room hoping to catch a glimpse of the rare animal. When I see one in the flesh, he (for it usually is) tends, surprisingly, to be shy, crouching towards the back of the classroom or lecture theatre. More often than not he is an older creature. Without his tools and instruments, without his mask, exposed and alone, the surgeon in the ethics course has ventured into a foreign habitat.

The Royal College of Surgeons offers an extensive menu of training courses, from the cheerful “drawing for surgeons” to the bone chilling course on the Ilizarov method. Although a course exists on legal issues in surgery, there is no course on surgical ethics. Several royal colleges, including those of the general practitioners, pathologists, obstetrics and gynaecology, paediatrics, and psychiatry, have established their own ethics committees. There is no such permanent committee for the surgeons.

Some of the surgical textbooks I consult on the library shelf have a few pages devoted to the law of consent, but ethics is notable by its absence. At surgical conferences oral presentations on the subject are rare. I was mightily surprised when, scanning the programme of the forthcoming 14th European Congress on Neurosurgery, the last of the 42 topics was “ethics in neurosurgery.” In my excitement I submitted an abstract in support of the brave surgeon who must have raised the idea to puzzled looks at a meeting of the scientific committee. As I was doing so, my wife, a neurosurgical trainee, commented that this particular session would not be overflowing with delegates. No matter. A soliloquy is better than silence.

Surgery is a field brimming with ethical issues: a patient refuses lifesaving surgery on religious grounds or is the victim of an intraoperative error; another has been harmed by a previous doctor but knows nothing of it or has a tumour that is operable but high risk; and yet another mistakenly believes that the operator will be a consultant. There is also the sometimes tenuous link between properly informed consent and that signature on the consent form.

Incise deeper and you will find the surgeon who wants to try a new technique, the surgeon who adds his or her name to publications for no other reason than hierarchy, who is “economical with the truth” with patients and family, whose hand is unsteady or whose judgment is impaired, whose tendency is to overtear patients, or whose bedside manner borders on the discourteous. And what of the well intentioned but brash trainee who is unaware of his or her limits, the ethics regulating the proper relationship between the surgeon and the anaesthetist, or the ethics of operative scheduling and triaging, in ordinary times and in emergencies? And let us not forget the military surgeons, whose contributions to the art cannot be overestimated but whose ethical dilemmas are no less acute. The ethical issues are not visible on the radiologist’s scan, nor palpable deep in the recesses of the iliac fossae, nor graspable like a bowel clamp but are nevertheless there, as real and important as the potent gases of the anaesthetist.

Why there should be such a neglect of ethics training in surgery is unclear. I hope surgical readers will forgive me for suggesting the possibility of an irreverent attitude towards formal ethics education in surgery. Some of the older tigers may hold the attitude that junior surgeons learn ethics by copying their seniors and betters, that the ethics of surgery will enter the trainee like the absorbable sutures of the patient. Raanan Gillon, an emeritus professor of medical ethics, encountered such a type when he expressed his desire to study



“**The surgical community would benefit from a closer examination of the ethical issues in surgery. A one day course in surgical ethics and law, the occasional session in conferences, the odd presentation at the weekly departmental meeting ... That is all**”

for a PhD as a junior doctor in the 1960s. His consultant replied, in an incredulous tone, “You can’t *study* medical ethics!” The main danger of the osmosis theory is that it can perpetuate bad habits, carefully developed over years of unethical conduct.

Another possibility, equally uncharitable, is that the decision makers in the surgical community, whose own training perhaps contained little ethics teaching, believe that there are few ethical issues in their specialty or that the issues are dealt with adequately in the Royal College of Surgeons’ helpful booklet *Good Surgical Practice*. Alternatively they may think that these ethical issues are handled perfectly well at present and there is no need for change. “Seek and ye shall find” is the obvious response.

Talk to surgical trainees in private and they will soon complain about publications and presentations. “What about something on ethics,” I usually suggest, “perhaps an audit or a case report on an ethically interesting case?” Their response is that this would be received by their colleagues as enthusiastically as the wrong instrument in an operation. If my observations reflect the wider reality, the surgical community would benefit from a closer examination of the ethical issues in surgery. A one day course in surgical ethics and law, the occasional session in conferences, the odd presentation at the weekly departmental meeting, and a word of encouragement at the mention of ethics. That is all. The rest will follow. Surgical ethics may not be very fashionable, but it is a central part of the practice of surgery. In 100 years’ time the Ilizarov method will be confined to the history books, but surgical ethics will endure.

Daniel K Sokol is honorary senior lecturer in medical ethics, Imperial College London
daniel.sokol@talk21.com

Competing interests: DKS is a member of the Royal College of Surgeons’ working party on laryngeal transplantation, is co-director of the applied clinical ethics course at Imperial College London, and is married to a surgeon.

Cite this as: *BMJ* 2011;342:d3591

bmj.com

Previous columns by Daniel K Sokol are available on bmj.com

MEDICINE AND THE MEDIA

An early warning for Alzheimer's disease?

A website purports to help users identify the extent of their cognitive impairment, but **Margaret McCartney** advises caution before paying for the recommended supplements

The *Daily Mail* reported on 14 May that scientists were trying to create tests to detect Alzheimer's disease early and that one, "the new Cognitive Function Test, which has been devised by Oxford University scientists, can be taken online in the comfort of a person's own home." It continued, "The test, which is free to take, follows a landmark Oxford University study published last year which credits a simple vitamin pill with cutting brain shrinkage linked to Alzheimer's by up to 500 per cent" (www.dailymail.co.uk, 14 May, "15-minute online test for dementia: DIY memory quiz detects early signs of Alzheimer's in people as young as 50").

The report goes on to say that the test, "which can be found at foodforthebrain.org, has three sections which use computer-based tasks and games to test different components of memory. Those who are believed to be at risk of Alzheimer's are advised to have a blood test and given a letter to take to their GP."

The website claims that the "detectable, pre-clinical phase of Alzheimer's disease presents as mild cognitive impairment [MCI]." It states, "The specificity of the CFT [cognitive function test] is not yet clear, ie, individuals may score poorly due to aspects other than MCI, such as medication, depression, acute infection and other factors. However, based on the pilot, it appears that CFT is sensitive to MCI." The pilot study described by the web-

site involved 50 volunteers, and it says that "a full description of the pilot and analysis will be available on this page by 1st July 2011"—that is, six weeks after the publicity for the online cognitive test. No numerical information about the rate of false negative or positive results is included on the website. In the "frequently asked questions" section, people who have an "at risk" result are told that "it is advisable to follow up your CFT with a homocysteine test . . . take the test in 6 months' time and see if your results improve or not. If they improve you should have no cause for concern."

People with a "disappointing test result" are told that "either the test has identified that you may have mild cognitive impairment, in which case you may wish to follow the guidance on the results page, or there was another problem with the test," and the authors go on to list various internet connection problems. General practitioners are likely to be given letters from the Food for the Brain website printed by patients who have taken the test. The sample letter provides a clue to the enterprise (<http://bit.ly/md0HvB>). It reads, "To the General Practitioner for Patrick Holford . . . Your patient has completed the Cognitive Function Test . . . This is a validated screening test for those aged 50 and above, designed to test early cognitive impairment . . . Given that the progression from the first sign of cognitive impairment to Alzheimer's disease may take up to 30 years, early screening and preventative action is imperative . . . There is now a substantive body of evidence, referenced below, that an individual's plasma homocysteine level is a reliable indicator of risk for cognitive impairment and Alzheimer's disease, that it correlates with both the rate of brain shrinkage



and memory decline, and, most importantly, that these may be reversible by supplementing amounts of vitamins B6, B12, and folic acid not achievable by diet alone. Homocysteine testing is also available privately, as a home-test from www.yorktest.com."

Even if your score indicates a "very low risk," you are still recommended to take a self test for homocysteine from the same company. The letter from Food for the Brain to the general practitioners expected to mop up the fallout offers five references in support of its claim (see bmj.com).

Patrick Holford, who describes himself as a "nutritionist" and chief executive officer of Food for the Brain, told me, "We, the charity, deemed the evidence to have become substantial enough to warrant the launch of our Alzheimer's prevention project . . . the primary

A Cochrane review in 2008 concluded that folic acid with or without vitamin B12 did not have an effect on cognition in healthy elderly people and people with dementia

aim of which is to encourage early screening of cognitive function from age 50, followed by homocysteine testing." Food for the Brain's adviser, the pharmacologist David Smith, told me that the online test is "not a diagnostic test, and there is no definitive outcome; it simply tells the user about their cognitive status. Hence there is no false positive or negative rate." He went on, "My personal judgment is that it might in fact be unethical not to offer a person with high homocysteine the chance to lower it and slow the shrinkage of their brain and possibly slow their cognitive decline."

However, a Cochrane review in 2008 concluded that folic acid with or without vitamin B12 did not have an effect on cognition in healthy elderly people and people with dementia; it did, however, recommend more work, because in one study "long-term use appeared to improve the cognitive function of healthy older people with high homocysteine levels" (*Cochrane Database Syst Rev* 2003;4:CD004514). However, this review did not include a large randomised controlled trial in *JAMA*, published the same year, that found that vitamins lowered homocysteine concentrations but without a cognitive effect (2008;300:1774-83). The study also found a higher rate of depression in the treated group.

Holford's face appears on a range of supplements, sold through the Totally Nourish website (www.totallynourish.com), which says "there's not much about health that Patrick Holford doesn't know." The Brain Bio Centre, a clinic in London, which advertises its appointments with Holford on the Food for the Brain website, says, "Typically, over a year, most patients spend between £600 [€680; \$985] and £1100 on consultations and tests" as well as £2-3 a day on supplements. Patients deserve better evidence first.

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

Cite this as: *BMJ* 2011;342:d3732

LOBBY WATCH **Jane Cassidy**

The College of Medicine

What is it?

The College of Medicine, which launched in October last year (*BMJ* 2010;341:c6126), aims to promote holistic medicine in the NHS. Its president is Graeme Catto, former president of the General Medical Council. Its vice president is Ian Kennedy, an expert in medical ethics whose review of children's health services for the Department of Health for England was published in September (*BMJ* 2010;341:c5129).

Some of the college's senior figures were also involved in the Prince of Wales's complementary health charity, the Foundation for Integrated Health. The foundation closed last year after police launched a theft, fraud, and money laundering inquiry. George Gray, its finance director, was charged with the theft of £250 000 [€280 000; \$405 000] and is currently serving a three year prison term.

None of those helping to run the new college were involved in the police investigation. A report in the *Guardian* newspaper quoted a spokesman for the Prince of Wales as saying that the prince was aware of the college but had no official role.

What agenda does it have?

The college is campaigning for the acceptance of "an integrated approach to health" among doctors, scientists, and patients. Its philosophy involves taking into account patients' beliefs and personal circumstances and helping patients look after their own health. Projects and services it singles out for praise include the Bristol Homeopathic Hospital, the complementary therapy service of the Christie Hospital, Manchester, and the maternity acupuncture service of the Whittington Hospital, London.

At its first annual conference last month its chairman, Mike Dixon, said that the government's NHS health reforms were not enough. "It's time for a revolution—a complete paradigm shift," he said.

What does the government think of complementary medicine?

Last year the government rejected calls from the parliamentary science and technology select

committee to withdraw homeopathic remedies from the NHS (*BMJ* 2010;341:c4073). Decisions on funding homeopathy will continue to be made by general practitioners and primary care trusts.

Where does it get its money from?

The college is expecting to receive a cash boost from a star studded Royal Albert Hall charity concert taking place next month. The concert's organiser, Jacky Paice, is wife of Ian Paice, the drummer of the rock band Deep Purple. Her twin sister is married to the former Deep Purple keyboard player Jon Lord, and the heavy metal legends will be headlining the concert on 8 July.

Other prominent rock musicians billed to appear in the "Superjam" event include Rick Wakeman. Superjam 2011 is expected to be the biggest fundraiser to date organised by the charity the Sunflower Jam, which works with the College of Medicine.

The college is putting together initiatives to train doctors and nurses in complementary medicine, said Ms Paice, founder of the Sunflower Jam. She describes herself as having practised as a healer, working in clinics to help people.

Past Superjam concerts have raised thousands of pounds to fund complementary therapists or "healers," as they are described on the event website, to work with children in NHS cancer wards.

This year the actor Jeremy Irons is offering a free four night stay in his Irish castle home as one of several luxury prizes to be auctioned at the concert. Irons regularly hosts the event, which launched in 2006 when almost £100 000 was raised to fund complementary therapists at University College Hospital, London. Money raised at subsequent events has continued to fund therapists in paediatric oncology units at University College Hospital and other hospitals.

Alternative treatments for children who have cancer, offered alongside NHS treatment, can have incredible effects, said Irons. "So what we're trying to do is to sort of nudge gently the NHS, through training programmes, through the College of Medicine. We hope to be working with Great Ormond Street Hospital, but these things take time to get in place," he said.

As well as benefiting from the proceeds of the Superjam event, the college is to raise funds by offering various categories of membership, along with educational courses, events, and publications.

Jane Cassidy is a freelance journalist
janeccassidy2@googlemail.com

Cite this as: *BMJ* 2011;342:d3712

FROM BMJ BLOGS

Martin McShane: Director's cut

A year on from the election I was beginning, tentatively, to believe I could tell that story. I was presenting to a group of our senior managers on Monday. I was repeating the story about the challenges health systems face worldwide, the fact that we had clearly identified the major themes we are tackling to meet that challenge. I was contextualising how the reforms and our approach would meet those challenges. I explained how developing and supporting clinical leaders in general practice was an opportunity we were seizing, as it built on the approach we have had since we were established over four years ago. I talked about the absolute need to deconstruct the PCT and build structures that delivered the changes in a professional and managerial mindset necessary to deliver the changes in behaviour so vital to maintaining quality, and how we would track and feedback implementation and the impact of those changes. I set out the timeline and the ambitious aspirations we have set. They have heard it before but telling and re-telling a consistent story is necessary to support successful transformation.

And then, later in the week, the prime minister gets up and I hear him say, "Whoa. The mental construct you have is not quite right. Let's not rush this. Let's involve more people and do consensus commissioning. The story we have told needs to change." Meanwhile, elsewhere, at the same time, GPs were at a Pathfinder meeting where they were being told "push ahead harder, faster with the construct we have been working with since last year."

Martin McShane is the director of commissioning and QIPP for the newly formed Lincolnshire PCT Cluster.

Read this blog in full and others at bmj.com/blogs



Deep Purple: cash boost for the college