



“Integrative medicine’ ... the most insulting, misleading, and nonsensical rebranding yet”
Margaret McCartney, p 160

The killing of doctors in Iraq must stop

PERSONAL VIEW Nisreen A Alwan

On 29 March 2011 Professor Mohammed Alwan, dean of Al-Mustansiriya Medical School in Baghdad and my uncle, was assassinated. A bomb was planted in his car and exploded as he got in after leaving his medical practice. He was a distinguished academic and surgeon who was respected by his students, and he was a fellow of the Royal College of Surgeons of England. Within a week, another clinical academic from the same institution—Dr Zaid Abdul Munim, head of research at the molecular department—was killed with a similar technique.

These are not isolated incidents. Assassinations and kidnapping of Iraqi doctors, academics, and scientists are now part of everyday life in Iraq, particularly in Baghdad. This phenomenon started after the 2003 US led invasion of the country. One study estimated the combined rate of violent event (death, kidnapping, and threats) among specialist doctors in Iraq in 2004-7 to be 3.7%, and the rate of violent

death at 1.6% (*Social Science and Medicine* 2009;69:172-7). There seems to be a systematic targeting of the brightest, most distinguished, and most highly regarded doctors and scientists. The Spanish Campaign against the Occupation and for the Sovereignty of Iraq (Iraq Solidaridad) listed the names and affiliations of 314 university academics assassinated in Iraq since 2003. Other sources, such as the Iraqi Medical Association, report a higher figure of about 500. As a consequence, the people whom Iraqis desperately need to help rebuild their country are fleeing in fear for their lives and their families' safety.

Before 2003 Iraq's higher educational system, including medical training, was still well regarded despite years of repression on the part of the regime, neglect, and international economic sanctions. Currently, medical training is suffering enormously in Iraq, with students and academics facing daily threats and junior doctors leaving without proper training and

leadership. According to the 2008 Medact report on Iraq's healthcare, about three quarters of doctors, pharmacists, and nurses have left their jobs since 2003, with half of them leaving the country. About 9000 doctors remain to serve a population of 28 million people, a ratio of only six doctors to every 10 000 citizens, compared with 23 to every 10 000 in the United Kingdom (www.medact.org/content/violence/MedactIraq08final.pdf). This has resulted in rapid deterioration of the already strained healthcare services by rendering health facilities, acute and primary care, short of staff. The health situation in Iraq is not showing any improvement. The mortality rate for people aged 19-59 is soaring, at 222 per 1000 adults, compared with the global average of 176 and the regional average of 188 (www.who.int/gho/countries/irq).

Why has this brain drain been happening for the last eight years? And who is responsible? Unfortunately, the Iraqi government has displayed neither authority nor effectiveness in protecting Iraq's brightest minds. The killers are not being brought to justice and therefore are not deterred from committing more crimes. In the early years after the 2003 invasion, the perpetrators were more or less known as terrorist and extremist groups. However, now the picture is fuzzy, and it is hard to attribute these criminal acts to a particular group or ideological front. Most of those assassinated did not have any political affiliations or activities. The reasons for the killings are

The reasons for the killings are unknown; but these actions can only benefit those who want Iraq to continue drowning in a sea of corruption and civil war

unknown; but these actions can only benefit those who want Iraq to continue drowning in a sea of corruption and civil war.

This problem needs collective action from Iraqis inside and outside the country. International and national medical and scientific organisations must join forces to raise awareness and condemn these atrocities. For example, the Brussels Tribunal has started a campaign and a petition aimed at stopping the assassinations of Iraqi academics (www.brusselstribunal.org/Academics.htm). The first step to tackling this problem is to establish a fair, transparent, and effective legal process of enforcing justice.

Doctors such as Professor Alwan are what the medical profession really stands for. While most of us do our jobs in safe and supportive environments, they risk their lives daily in settings in which honesty, integrity, and hard work are sometimes punished with death. I salute the doctors and scientists of Iraq for fighting every day for what they believe.

I thank Zaed Z R Hamady, academic specialist registrar in general surgery, Leeds Teaching Hospitals NHS Trust and graduate of Baghdad Medical School, 1996

Nisreen A Alwan is a clinical research fellow and specialist registrar in public health, University of Leeds and a graduate of Baghdad Medical School, 1998 n.alwan@leeds.ac.uk

Cite this as: *BMJ* 2011;343:d4467

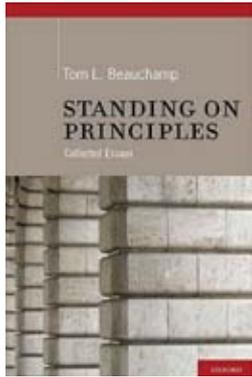


A Baghdad hospital. Three quarters of Iraqi doctors, pharmacists, and nurses have left their job since 2003

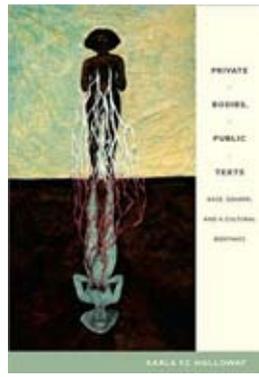
REVIEW OF THE WEEK

Lost in medicine's moral maze?

Julian Sheather considers two books that exemplify two approaches to bioethics—one abstract and philosophical and the other practical and evidence based



Standing on Principles: Collected Essays
 Tom L. Beauchamp
 Oxford University Press USA,
 £32.50, 320 pages
 ISBN
 9780199737185
 Rating: ★★★★★



Private Bodies, Public Texts
 Karla F C Holloway
 Duke University Press, £14.99,
 256 pages
 ISBN
 9780822349174
 Rating: ★★★★★

During the 1970s some of those who thought more deeply about medicine and its role in society began to register a gathering sense of unease. Doubts about the capacity of the moral tradition of medicine—loosely, the Hippocratic tradition—to respond adequately to the ethical challenges confronting it started to emerge.

The sources of this unease were diverse. Rapid developments in medical technology gave rise to novel ethical dilemmas that soon exhausted the explicatory reserves of that ancient injunction *primum non nocere*—first, do no harm. Social and political changes in Western societies also led some to doubt the authority of medicine. The increasing egalitarianism of post-war Western societies meant that people began to question the automatic deference paid to professionals. Medicine's largely unquestioned social contract—the belief that it should be at liberty to act in the best interests of patients—began to look more like condescension. Beneficence began to be recast as unwarranted paternalism. And in the United States there was the Tuskegee syphilis study.

Between 1932 and 1972, in Tuskegee, Alabama, the US Public Health Authority conducted a clinical study into the natural progression of syphilis among a group of African-American sharecroppers who thought they were being treated for so called bad blood. Not only were the participants deceived as to the nature of the study, but when penicillin was identified as a cure, they were deliberately left untreated. Scientists conducting the study also prevented the participants from seeking treatment elsewhere.

In 1972 the story finally broke and in response to the ensuing outcry, the US government set up the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Staff philosopher and coauthor of the

ensuing Belmont report was Tom L. Beauchamp. Now better known as the coauthor of *Principles of Biomedical Ethics* and intellectual sponsor of the so called four principles approach to medical ethics, he went on to become one of the most influential figures in the emerging discipline of bioethics. In the 1970s, in Beauchamp's view, a "need arose for moral norms that could guide investigation of prevailing clinical and research practices . . . Frameworks drawn from moral philosophy suggested that bioethics could be given universal and principled foundations as well as practical methods of inquiry." It was to that need that Beauchamp's work was directed.

As bioethics grew, two linked if countervailing impulses could be identified; impulses reflected in the two books here under review. On the one hand the search, exemplified in Beauchamp's marvellous collection of essays *Standing on Principles*, for a unifying theory or basic framework of understanding. Drawing heavily on moral theory, it asks what it is that we are doing when we make moral judgments in medicine and whether, and on the basis of what criteria, those judgments are justifiable.

Such an approach, heavily indebted to philosophy, tends inevitably toward abstraction and to the investigation of paradigmatic dilemmas: when, for example, might it be proper to override a patient's autonomous interest in confidentiality to disclose information to protect another person from harm? The essays in *Standing on Principles* consider many of bioethics' core concerns. Starting with an account of the writing of the Belmont report, these essays take in a history of informed consent, lay out in exemplary clarity the four

principles approach, and explore the meaning of autonomy and paternalism, the distinction between killing and letting die, as well as taking issue with the foundational use of the concept of personhood in moral philosophy. The book is a marvellous reprise of a lifetime's engagement by a major practitioner with some of our most challenging contemporary moral dilemmas.

Tending in the opposite direction to Beauchamp's runs the impulse, strongly in evidence in Holloway's *Private Bodies, Public Texts*, to move away from abstraction, and to embrace the practical, the contingent, and the concrete. Bioethics stepped rapidly beyond early concerns with the prevention of egregious harms in medicine and medical research to answer complex questions in clinical practice, social policy, regulatory structures, and the possibility of moral obligations to non-human animals and to the environment. It also called into question the adequacy of the construct of the abstract choosing individual, the autonomous self, so beloved of philosophers. Holloway attempts to return individuals to their so called deep social context, and specifically in this instance—Tuskegee puts in another appearance here—to explore the ways in which race and gender figured, or were written out of, early constructions of autonomous choosing selves in bioethics.

In Holloway's view, "the public controls of race and gender are so robust that private individuation is rarely an opportunity for those whose identity falls within these social constructs." Unlike Beauchamp's struggle to identify and refine the basic assumptions of bioethics, Holloway's work is explicitly interdisciplinary, drawing on literature, literary theory, and legal studies in search of what she describes as a "theory of cultural ethics." Many of Holloway's preoccupations, though, remain political ones.

The wrongs that she considers are the political wrongs of unjust discrimination, and there are times when the average intelligent reader might wonder whether the dense weave of the writing obscures rather than reveals its topic and whether the coining of an entirely new theoretical field is the best way to address the deep injustices she so passionately addresses.

In one of his final essays, Beauchamp asks whether ethical theory has a future in bioethics. Although the tide in bioethics is probably moving away from the four principles—despite their enduring popularity in medical schools—both these books remind one, in different ways, of the vital need for conceptual clarity when dealing with issues of such profound human significance.

Julian Sheather is senior ethics adviser, BMA
 jsheather@bma.org.uk

Cite this as: *BMJ* 2011;343:d3617

BETWEEN THE LINES Theodore Dalrymple

The physician's progress

There was a time when medical history was written as the story of the gradual ascent of knowledge to our glorious present; this was known as the Whig interpretation of history. Obviously it had its limitations (it was mainly written by retired doctors), but it turns out that all other interpretations have their limitations too.

In his amusing book *Quacks: Fakers and Charlatans in English Medicine*, the non-medical medical historian Roy Porter consistently minimises the difference between what in the 18th century was called “the faculty” (that is to say the regular practitioners armed with a *bona fide* medical degree) and the irregulars: the mountebanks and the charlatans. After all, says Porter, is there evidence that the treatment of the faculty was more effective than that of the quacks? Near the end of the book he writes, “There was far greater convergence between the activities and attitudes of regulars and quacks than either side allowed, or than historians have been primed to perceive.”

Well, yes and no. As it happened I read John Huxham in tandem with Porter. Huxham (1692–1768) was a regular physician who discovered nothing, in the sense that there is no Huxham's disease, Huxham's law, or Huxham's sign; it can even be said that he missed a golden opportunity to discover the cause of an epidemic. Yet, though he discovered nothing, and his results with his patients were probably little better than those of the veriest mountebank, yet when one reads



[Huxham, above] missed a golden opportunity to discover the cause of an epidemic

him one cannot but respect the diligence, rationality, and devotion with which he investigated the causes of epidemics.

Huxham was a Devon man who studied at Leiden and received his degree from Rheims. He returned to England to practise at Plymouth; in his *Observations on the Air and Epidemic Diseases: from the year MDCCXXVIII to MDCCXXXVII Inclusive* one finds an immense accumulation of meteorological data, which he tries to relate to the prevalence of epidemic diseases. January 1728, for example, was “a very rainy, moist Season, for in this Month fell no less than 6 inches, of Rain, an immense Quantity!” The state of public health was as follows: “From the Beginning of the Month Coughs and Catarrhs were frequent, oftentimes attended with a troublesome Tumor of the Fauces, and slight Fevers commonly. Rheumatisms and Squinzies up and down; great lowness of spirits and frequent hysteric Paroxysms every-where.”

We may smile at the naivety of this, but it is a serious, if unsuccessful, attempt to interrogate nature by a rational method completely different from that of, say, an itinerant seller of nostrums. So it's not surprising that, *pace* Porter's faintly disguised sneers, progress depended upon the faculty and not upon the quacks.

Huxham's missed opportunity came in 1724. Fourteen years later he published *A Small Treatise on the Devonshire Colic which Was very Epidemic in the Year MDCCXXIV*. He described how, in the cider season, many people were seized with intestinal colic, palsies of their arms and hands, peripheral anaesthesia, and unconsciousness and seizures from which they died. He attributed this to the acid in the apples rather than to the lead of the vats in which the cider was kept. “That the long continued Use, shall I say? Or Abuse of this Apple Drink was the Cause of this Disease I doubt not, for I saw no one seized with it, that abstained . . . Nor did it attack people of the better Sort, who lived elegantly, for they despising cheap Things, scarce ever tasted the Apples . . .”

It was Sir George Baker (1722–1809) who, during the height of Georgian quackery, proved that it was the lead in the vats that did it.

Theodore Dalrymple is a writer and retired doctor
Cite this as: *BMJ* 2011;343:d4422

MEDICAL CLASSICS

Father Damien: An Open Letter to the Reverend Dr Hyde of Honolulu

By Robert Louis Stevenson; first published 1890

In 1889, Robert Louis Stevenson made a seven day visit to a leper colony on the small Hawaiian island of Molokai. It was a harrowing and deeply moving experience. Stevenson interviewed many people about a Belgian Catholic priest known as Father Damien, who spent the last 16 years of his life among the lepers, improving their conditions by helping to build cottages and a chapel, as well as ministering to their spiritual and medical needs. Eventually Father Damien contracted leprosy himself, dying at the age of 49, one month before Stevenson's arrival.

In the following months Damien's fame spread; there was talk of a monument, perhaps beatification. But some Protestant missionaries were unhappy, and later that year a letter from a Reverend Dr C M Hyde in Honolulu to a clerical friend was published in a church newspaper. Hyde wrote that Damien's achievements had been exaggerated, that among other faults he was a coarse, dirty, bigoted peasant and had brought leprosy and death upon himself because of “impure relations with women.”



Father Damien himself got leprosy

When Stevenson was shown the letter he was incensed and in a single day wrote this long response to Hyde. In it he reminds Hyde they had met before, and that Hyde had never been to the colony. He agrees that Damien did have failings: what makes him angry is Hyde's hypocrisy and inability or refusal to see Damien's virtues. “Damien was *coarse*. It is very possible. You make us sorry for the lepers, who had only a coarse old peasant for their friend and father. But you, who were so refined, why were you not there to cheer them with the lights of culture?” Yes, Damien was bigoted, but “his bigotry, his intense and narrow faith, wrought potently for good and strengthened him to be one of the world's leaders and exemplars.” As to his immoral behaviour: how did Hyde know? No one else had mentioned it, and if it was a rumour how low was Hyde for repeating it? (An official inquiry later showed the allegation had no foundation.)

Stevenson published the open letter knowing his attack could bring a libel suit. But Hyde shrugged it off as the work of a bohemian crank and Stevenson later himself wrote that he had been rather hard on him. But the little book endured as a minor classic in which we see Stevenson's non-judgmental attitude to human foibles and his willingness to defend the unjustly accused. And Damien's spirit still lives on in those doctors and aid workers in today's trouble spots who risk their lives in following their calling.

Barry Newport, sessional general practitioner
barry.newport@yahoo.co.uk

Cite this as: *BMJ* 2011;343:d4417

The scam of integrative medicine

FROM THE
FRONTLINE

Margaret McCartney



There's been a shift in the world of alternative NHS medicine. I know, I know, alternative so called medicine is only medicine that doesn't work: so how come it's still chumming up with our evidence aware NHS? It's not, you see, called "alternative" or even the giveaway "homoeopathic" medicine any more. Keep up: it's now called "integrative medicine," which is the most insulting, misleading, and nonsensical rebranding yet.

So the Royal London Homoeopathic Hospital is now the Royal London Hospital for Integrated Medicine. In Glasgow, it has become the Centre for Integrative Care. Bristol calls one of its clinics the Integrated Centre for Health. You get the idea. As we have come to realise, homoeopathy is placebo, and rather than closing the places down they have tried to corner what does work—listening and spending time with patients—as their new specialism. The new moniker, said Dr David Reilly, clinical director at the Glasgow centre, is "reflecting its development work in creating new models of care especially in long term conditions, with an emphasis on person centred, individualised therapeutic relationships aimed at helping people enable their own strength and self care."

Does this mean that doctors listen to patients; try to work out what would help and what would be acceptable to them; and encourage, support, and plan for the future? Instead of these being core attributes of normal good care, integrative

care is attempting to lift these essentials away from the norm and into their special realm, spiced with placebo pills and acupuncture, which inject the consultation with inherent untruths.

It isn't fair that professional, compassionate care is seen as something of a specialist competency to be available only to those who consort with non-evidenced based medicine. Interest in the whole person is what good doctors have always had. Creating a new brand of integrated care almost accuses those of us in normal medicine of aiming for something different. If only we had the resources to spend more time with patients and we were allowed to treat people's concerns with professionalism and evidence rather than the will of the government's general practice contract. Then everyone might have a chance to benefit from professional medical care, not just a few willing to suspend their disbelief.

Integrative doctors, come on. Ditch the homoeopathy; get rid of your reiki. Come back to discover the necessity, richness, and vitality of evidence. Find fulfilment in the honest human values shared in the relationship between doctor and patient. Help us get rid of politics in the consulting room, abet us in ripping up the general practice contract, and let's all help all of our patients.

Margaret McCartney is a general practitioner, Glasgow

Cite this as: *BMJ* 2011;343:d4446

Des Spence is away.

A tale of two hospitals

THE BIGGER
PICTURE

Mary E Black



My daughter's classmate, a 16 year old with a torn knee meniscus, was admitted to hospital the night before planned surgery in Belgrade, Serbia, and sent to bed in pyjamas. Her operation was cancelled; to keep her place on the waiting list she was admitted to hospital for a week. After a successful procedure under general anaesthetic she was confined to hospital for a further five days and was eventually allowed home on crutches.

My 85 year old mother, a retired doctor with ocular lens implants, bilateral hearing aids, arthritic knees, and the odd episode of angina, was admitted as a day case to an NHS hospital in Kent for a complex tendon reconstruction to her dominant hand. She sat for several hours in a noisy, busy waiting area in her ordinary clothes. After a successful procedure under general anaesthetic she was, exceptionally, kept in for one night, transferred to a local hospital for

two days' care after the operation, and then returned to her own house. Preoperative assessment by an enablement team triggered two home visits a day for help with personal care, to be reviewed in three weeks for further need.

Serbia continually wastes hospital beds (and patients' time) and does not yet have an output based hospital payment system that would provide incentives for the rational use of beds; that process has just started. In contrast, the NHS aims to discharge patients as soon as possible, sometimes too soon. The UK press abounds with tales of elderly and disabled people with limits imposed on their care packages, frail patients spending nights on hospital trolleys, and breakdowns in planning discharge from hospital. In Serbia there is no such discussion because hospital services are "one size fits all"; home care packages do not exist;

and families take up the slack—or else elderly and chronically ill people spend endless periods lying around, and even dying, in hospital beds, with nowhere else to go. Once Serbia has funding based on outputs this can be questioned; home based care might then be developed and funded.

In Serbia there was no debate about the harm done confining the 16 year to bed or whether by occupying that bed someone else had to wait longer for care. In the UK there was a presumption of fitness until formally tested and proved otherwise. There is a debate, although we may not agree with the range or quantity of service options. My daughter's friend went quietly nuts confined to bed but had no choice; my mother was angling to get home as soon as possible but also had no choice.

Mary E Black is a public health physician, Belgrade, Serbia drmaryblack@gmail.com

Cite this as: *BMJ* 2011;343:d4421