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BMJ blog: Bushra Azam on doctors fasting over Ramadan

The reality is a global medical cultural problem: a catastrophic regulatory failure of doctors' behaviour
Des Spence, p 51

PERSONAL VIEW **Zohra Ismail Panju**

Patients who fast in Ramadan need better health advice

Ramadan is the lunar calendar month in which Muslims spiritually and physically "cleanse," which includes abstaining from food and drink between dawn and dusk. This year Ramadan will be observed between 19 July and 18 August. Being Muslim, this was a tradition I grew up with, and aside from new diagnoses of diabetes presenting during this time, resulting from dehydration or blood glucose derangements exacerbated by fasting, I had never considered the medical implications.[1 2]

In my more youthful years, Ramadan fell in winter, and late sunrise and early sundown meant that you really only missed lunch. Islam prioritises health above all else so it always seemed clear that you fasted if you could, and if you couldn't then you didn't. It was only when I began a general practice rotation last year that I saw that the situation is often less clear cut, and religious fasting has the potential to adversely affect health.

The practice at which I was based served a predominantly Muslim demographic, and most of my patients were fasting in August. The most common problem was poor drug management. Often patients would omit doses in fasting hours or, worse, not take their drugs at all. Some patients didn't understand the need for their drugs, and taking them was a low priority. Others were confused about how to adjust timings; these patients thought that omeprazole, for example, was a 9 am drug that wouldn't work at another time. And some patients, even if they understood the purpose of their drugs and the times they could be taken, had to overcome the hurdle of needing polypharmacy, with complex drug regimens.

More shocking were the patients who fasted when it would clearly have an adverse effect on their health. I was prepared for elderly patients attempting to fast or patients with diabetes who might try their luck but not for the 24 week pregnant woman who merrily told me that she was fasting. I thought that she might not understand the adverse effects that fasting for long periods of time of up to 18 hours may have on her baby, but even after we discussed the situation and I had emphasised the importance of her baby getting adequate nutrition in this period of rapid growth, she insisted she continue to fast and explained that she had done this while pregnant before.

DAN KITWOOD/GETTY IMAGES

Clerics will advise people not to fast if it is not in the best interest of their health . . . doctors must target mosques when sharing advice about fasting to ensure that religious rulings are based on up to date information

I found her response surprising and since have reflected on the reasons people fast when advised not to. In addition to patients failing to understand the health implications of fasting, they may feel under pressure from their peers not to be different. Also they may not want to accept that they are too ill or too old to fast.

Fasting in Ramadan can extend beyond oral intake of food and drugs. Some patients include in their fast a prohibition on the unnatural extraction of bodily fluids—for example, giving blood. In addition, Muslims are restricted from having intercourse during fasting hours, and many women decline vaginal examinations or swabs being taken. One patient even refused to attend physiotherapy for pelvic floor exercises on this basis.

So what can doctors do? Resources for patients on how to adjust drug doses and timings while fasting are lacking. Websites mainly tackle drug management in diabetes, and there is little advice available for other patients, particularly those who need complex polypharmacy. Drug reviews with a pharmacist or doctor before Ramadan might promote patient education and preparation for the fasting month, and help to avoid drug omissions. Guidance on which patients should avoid fasting requires an evidence based approach. Research into the effect of fasting on different populations, for example, pregnant women, is lacking. Regarding investigations and managements that patients think would compromise their fast, it is important to discuss the need and urgency of each of these and ultimately to negotiate the best times or dates for them to be carried out.

Patients seek advice about fasting from doctors, with reference to their health, and from clerics, with reference to religious rulings, and they consider both to determine what is in their best interest overall. Clerics will advise people not to fast if it is not in the best interest of their health; therefore, doctors must target mosques when sharing advice about fasting to ensure that religious rulings are based on up to date information. This can be in the form of patient leaflets, talks, or health workshops. I have highlighted only a few of the issues experienced by patients during Ramadan, but they show the importance of educating and preparing our patients for fasting.

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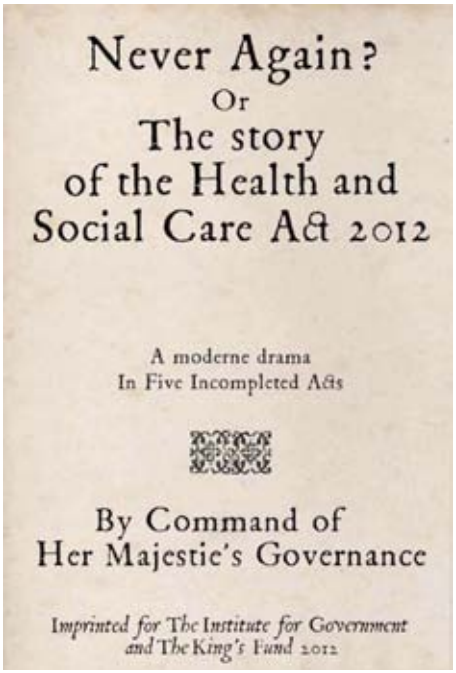
REVIEW OF THE WEEK

NHS reforms caught in the act

The story of how England's Health and Social Care Bill came to be conceived and passed is pure drama, finds **Nick Seddon**



Never Again? The Story of the Health and Social Care Act 2012

Nicholas Timmins

The King's Fund and the Institute for Government, pp 148

Download for free at www.kingsfund.org.uk/publications/never_again.html

Rating: ★★★★

"And let me speak to th'yet unknowing world / How these things came about," says Horatio at the end of *Hamlet*, seeking to make sense of the "accidental judgements" and "casual slaughters" through the act of storytelling. It is to this dramatic tradition that *Never Again?* appeals, with its mock-Jacobean frontispiece describing it as a "moderne drama In Five Incompleted Acts." In fact this is a conceit, for it's a work describing public policy making rather than fiction, but the narrative is unusually captivating. It tells the tale of how the Health and Social Care Bill—the most controversial piece of NHS legislation in over two decades—became law, and tries to ensure that lessons are learnt for the future.

The protagonist, the man with whom this legislation is uniquely identified, is the health secretary, Andrew Lansley. Just weeks after Cameron promised "no more top-down reorganisations," Lansley launched in July 2010 arguably the biggest restructuring the NHS had seen in its 63 year history. Many felt he did so without telling anyone what he was up to. Actually, as Timmins reminds us, Lansley's early speeches show that he had been testing out and refining most of the policies for many years—and a genealogy can be traced back through the "market-like" NHS reforms introduced by both New Labour and the preceding Conservative administration. The surprise lay in the fact that while the white paper plans were evolutionary in concept they were revolutionary in how they were to be implemented.

Not only would family doctors take over the commissioning of NHS care, for instance, but the entire superstructure of the NHS (special health authorities and primary care trusts) would be abolished. The received wisdom is that this was all Lansley's doing, but Timmins marshals extensive research and interview material to compose a different picture. This will make for uncomfortable reading for Liberal Democrats, who have at times tried to distance themselves from the plans. It was the hurried horse-trading over the coalition's "programme for government"—cooked up in Downing Street in May 2010, largely by Oliver Letwin, the Tories' policy guru, and Danny Alexander, Nick Clegg's key adviser—that reshaped Lansley's blueprint and paved the way for GP commissioning to become not voluntary but compulsory.

Much of the rest is a matter of public record—the introduction of the bill into parliament, its tortuous passage, the "listening exercise," open divisions in government, the Royal Assent of the bill, with 2000 amendments making it look like something designed by Heath Robinson—though Timmins' analysis is particularly dextrous and nuanced. Without the Liberal Democrats there would have been much less fertile ground within government for opponents to sow the seeds of their dissent. Without them, the bill would have undergone fewer amendments. And yet, in another twist to the coalition tale, without their votes the legislation would not have passed and Lansley would have no bill at all.

Politics is all about communication, and the coalition never had a story to tell. If "narrative" is an unfashionable word in politics, good politics requires a clear definition of the problem and an explanation of how the policy will fix it. For years, the Tories, especially, have struggled to resolve the contradictory urges to change the service but, in the spirit of detoxification, to say they weren't going to change it. That the 550 page bill was terribly complicated made matters worse. "You cannot encapsulate in one or two sentences the main thrust of this," said the health minister Simon Burns. In this vacuum, simple messages cut through, such as the mock eBay site set up by Unison to "sell off" the NHS.

The past is prologue, the reforms have just begun, and if the forecasts are right there'll be little money for the NHS for the next decade, which means that more changes are inevitable

Earlier this year, the *BMJ* stated in a joint editorial with *Health Service Journal* and *Nursing Times* that "we must make sure that nothing like this ever happens again" (*BMJ* 2012;344:e709); but there is another version of "never again"—the health secretary's. Over the past 20 years there has been on average a reorganisation—or re-disorganisation—every two years. Although Lansley claimed that he "could have done most of this without the legislation," it is clear that he viewed legislation as a way to complete and make "permanent" two decades of reforms. But that requires the act to be a success, which in turn depends on how success is measured: if success, like beauty, is in the eyes of the beholder, it seems unlikely that this will be the top-down reorganisation to end them all.

Never Again? combines extensive research, forensic analysis, a gripping plot, and elegant writing. Take a close look at the 10 lessons for politicians and policy makers in the conclusion: in a centrally funded system you can't take politicians out of the running of the NHS; have a story to tell about reform; develop workable plans and don't go quiet on those plans before an election or misrepresent them; build constituencies of support, and so on. The past is prologue, the reforms have just begun, and if the forecasts are right there'll be little money for the NHS for the next decade, which means that more challenges and changes are inevitable. This first history of the coalition's NHS reforms is essential reading.

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BETWEEN THE LINES **Theodore Dalrymple**

One million war deaths

Walt Whitman (1819-1892) was the poet of romantic, democratic individualism, or possibly even of egotism. His most famous poem, after all, is *Song of Myself*, which opens: "I celebrate myself, and sing myself . . ." Another line, of the kind of which there are many, is: "I exist as I am, that is enough . . ."

Whenever, therefore, a patient complained to me of lack of self esteem, thoughts of Walt Whitman rose inexorably in my mind. In fact, the deepest experience of his life was serving for three years as a volunteer nurse to the wounded of the US civil war. At the outbreak he wrote an exultantly pro-war poem that starts: "Beat! beat! drums!—blow! bugle! Blow!" and ends: "Let not the child's voice be heard, nor the mother's entreaties, / Make even the trestles to shake the dead where they lie awaiting the hearses, / So strong you thump O terrible drums—so loud you bugles blow."

Though Whitman never lost his faith in the justice of the Union cause, his experience, attending the wounded, changed his tune somewhat. In his poem *The Wound-Dresser*, he wrote: "On, on I go, (open doors of time! open hospital doors!) / The crush'd head I dress, (poor crazed hand tear not the bandage away,) . . . (Come sweet death! be persuaded O beautiful death! / In mercy come quickly.)"

During the war Whitman kept an occasional diary, published as *Specimen Days* (1882). Here is his description of his first sight of a war hospital, dated 21 December 1862:

> *Begin my visits among the camp hospital in the army of the Potomac. Spend a good part of the day in a large brick mansion on the banks of the Rappahannock, used as a hospital since the battle [of Fredericksburg]—seems to have receiv'd only the worst cases. Out doors, at the foot of a tree, within ten yards of the front of the house, I notice a heap of amputated feet, legs, arms, hands, etc . . .*

Whitman felt that he was most useful not in changing dressings, but in bringing comfort to the dying, whom the surgeons and nurses had abandoned as beyond help. Whitman did, however, praise the surgeons:

> *I must bear by my most emphatic testimony to the zeal, manliness, and professional spirit and capacity generally prevailing among the surgeons . . . I never ceas'd to find the best men and the hardest and most disinterested workers, among the surgeons in the hospitals . . . Unfortunately, they were let down by disorganisation: Scores, hundreds of the noblest men on earth, uncomplaining, lie helpless, mangled, faint, alone, and so bleed to death, or die from exhaustion, either actually untouch'd at all, or merely the laying down and leaving them, when there ought to be means provided to save them.*

Since Whitman estimated the deaths in the civil war to number a million, three quarters of whom (said he) died from neglect, this was no small matter. Of course, Whitman was neither a statistician nor an epidemiologist; his figure for the number of dead is doubtful, and how many might have been saved by the means technically available is a matter of conjecture. But he says he paid more that 600 visits to military hospitals in Washington (which in 1865 had more patients—70000—than the city had had inhabitants 15 years before), so it is unlikely that he was wholly mistaken.

Theodore Dalrymple is a retired doctor

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I must bear by my most emphatic testimony to the zeal, manliness, and professional spirit and capacity generally prevailing among the surgeons

Whitman: comfort for dying soldiers

MEDICAL CLASSICS

Buddenbrooks

By Thomas Mann; first published 1901

A patient complains about pain in various parts of his body. Finding no physical explanation, we might diagnose fibromyalgia. Our professional predecessors had to be more imaginative, however, and might have decided that all the nerves in the left side of the patient's body were too short. When medical nomenclature was a less internationally agreed convention and more the result of the individual physician's creativity, this diagnosis may have seemed as plausible as the next.

Thomas Mann (1875-1955) is one of the greats of German literature and was awarded the Nobel prize in 1929. Mann is best known in the medical world for his depiction of patients with tuberculosis in *The Magic Mountain*, and had a keen eye for symptoms and described them with eerie accuracy.

This book charts the gradual decline of an eminent merchant family throughout four decades in the mid-1800s. This is set against a backdrop of the changing social and political reality of the 19th century, which saw a more ruthless type of capitalist emerging. Mann himself came from a merchant family, rich in wealth and traditions, whose younger generation preferred a literary or artistic path to that of the bourgeois businessman. The family's decline is paralleled by the various ailments suffered by the younger generation, real and imaginary, and in describing these, Mann may well have given us one of the earliest descriptions of fibromyalgia.

Christian Buddenbrook, the hapless younger brother of the head of the family, has several complaints throughout his life. The worry that he might not be able to swallow his food bothers him from childhood, but it is as an adult that he develops the condition that prevents him from doing any productive work. This periodic pain, all down his left side, he shares in great detail with his unsympathetic family.

You can almost picture the quietly exasperated physician running out of medical wisdom, one day crying out, "All the nerves in your left side are too short!" With this diagnosis Christian now feels he can legitimately give up a business career and seek distraction among his bachelor friends at his club and the theatre.

In German literary criticism, Christian is diagnosed as having the rather esoteric cenesthopathic schizophrenia. Presumably, this is because he admits to having hallucinations. This happens only once, however, and Buddenbrook has a weakness for Swedish punch. The character of Christian Buddenbrook was modelled on the author's uncle, Friedrich Mann.

The retreat behind a diagnosis will have been seen by most doctors in real patients. While sometimes patients are relieved by a diagnosis because, even if there is no cure, they feel that their mystery has been solved, others will use the diagnosis as a justification to revel in their disability and shy away from the demands of the world. Which makes you wonder whether naming a condition can, at times, prove counterproductive.

Poor Christian marries a woman of dubious reputation in the end, much to the displeasure of his remaining family, mainly because she sympathises with him when he feels ill. It does not work out, though, and his new wife soon has him committed to an asylum. We will never know for sure exactly what it was that plagued him. But among the various diagnoses proffered, fibromyalgia seems as good as any.

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FROM THE FRONTLINE **Des Spence**

Don't just blame big pharma

GlaxoSmithKline has been fined $3bn (£1.9bn; €2.5bn)[1]—this follows other recent fines of drug companies: Merck,[2] AstraZeneca,[3] Johnson and Johnson,[4] and Pfizer,[5] reflecting a cultural problem across the industry, now allegedly all in the past. These fines come after decades of claims of manipulation of research, suppression of data, off-label promotion, excessive hospitality (gifts in all but name), expert panels paid bloated fees (educational mercenaries), withdrawal of dangerous drugs, disease mongering, payments made to advisory groups and charities, constant political lobbying, feeble and inept regulation, patent extensions, the absolute control of medical education, omnipresent threats of litigation, and massive profits. But this is just business, like banking, and all businesses seek control and influence and use all resources and avenues available to them to do so.

Like-minded corporations work together, but not as formal cartels, because that would be illegal. This is the global and eternal culture of business. Blame may be gratifying but is too simplistic to have much value, and this is an essential industry doing untold good.

Medicine's greatest weakness is its culture—authoritarian, hierarchical, deferential, and therefore easy to control through a few powerful individuals

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Big pharma must accept more regulation, and do it publicly, and put its house in order. However, problems of excess will be seen again because health makes perfect business, better even than basic utilities. Part science, part religion, and emotional in a way that water will never be, no one can resist the lure of medicine and medicines. The health benefits of branded drugs are easy to understand in a way that wealth distribution never will be. So even tough talk and beefed-up regulation will ultimately be undone; governments and the public forget, and anger always dissipates. The temptation to invent a condition, promote and spread it, manipulate data, lobby governments, and control the media will return because profit always distorts even the most robust corporate governance. This is the cycle of temptation, unweathered by millenniums of human attempts to change it. And doctors are open to manipulation too: medicine's greatest weakness is its culture—authoritarian, hierarchical, deferential, and therefore easy to control through a few powerful individuals.

There is an obvious solution—doctors. If we didn't accept hospitality, refused lecturing fees and expenses, used self directed learning, let go of any sense of our own sense of entitlement, learnt to be respectful rather than deferential, and gave scepticism a bash instead of naivety, then there might be a chance of change. The reality is a global medical cultural problem: a catastrophic regulatory failure of doctors' behaviour. Where is the medical leadership?

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THE BIGGER PICTURE **Mary E Black**

Winners and losers

Bodies, bodies everywhere—each one the kind of specimen you wish had been on display during anatomy tutorials in medical school. Wearing unforgiving Lycra sportswear or nothing but a strategically placed hockey stick, it seems as though every Olympian is getting his or her kit off for charity or to promote a perfume. Step aside effete supermodels: aspirational physiques now come in all (but still clearly well honed) shapes and sizes. Bodies that function differently, with parts missing, malfunctioning, or replaced, are marketable. Prosthetic legs have a patina of glamour and a keen high tech following. I cheered when I saw the Paralympic and Olympic line-up for Team GB in their kit, and I cheered again when my daughter was presented with a sporting achievement award by a local Paralympic superstar. That was a smart choice: who would not be impressed by a toned, dedicated swimmer with partial hemiplegia?

We can argue about the money spent and dispute the economic benefits of the games. We can hold strong opinions about some of the sponsorship deals. We can express little interest in elite sports or international competition. We can grit our teeth, ready for traffic gridlock in London. What we cannot do is ignore the magnificent spectacle of the world collaborating on such an incredible scale.

In one short, glorious burst, lifetimes of practice and commitment will be tested, and there will be a few winners and many losers. Regardless of ability or preparation, medals may be decided by a single event: one minor injury, one missed cue, one bad day out of thousands of good ones. In sport the cull is exact and brutal, but athletes understand this. They accept that their best might not be good enough—somebody might be better, more talented, or luckier.

I would like to buoy my children's spirits on dark days with that hoary fairy tale that we are all winners, but I would be lying

I would like to buoy my children's spirits on dark days with that hoary fairy tale that we are all winners, but I would be lying. In life there are always winners and losers. So I tell them this: work with what you have. Train and train hard. Then go for it. Medals may or may not follow. Let the games begin.

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