From the Editor

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On the use of human tissue after death

Suspicion and mistrust inevitably follow lack of involvement and misunderstanding. This is exactly what has happened in relation to storage of various human organs following the debacles of Bristol and Alder Hey, revealing a yawning gap between professional sincerity and a public not in possession of the salient facts. The gap was exacerbated by media reporting ('scandalous', 'shameful', 'macabre') accompanied by political outbursts ('the worst disaster to befall the NHS').[1] Trust in the medical profession was considerably damaged. What can now be done to restore confidence and trust?

An informed public would not now dispute the need for the study of human anatomy and pathology, and every medical student of our generation undertakes dissection of parts of the human body. It was not always so. Pope Boniface's decree of 1300 (De Sepultris) effectively banned study by human dissection over time.[2] Yet dissection of cadavers gradually evolved: Durer, Michelangelo and Leonardo da Vinci were all anatomists. The studies of Vesalius (1514–1564) corrected errors in Galen's theory of anatomy after more than a millennium, and in Bologna during the sixteenth century, public anatomy demonstrations demonstrating God's wonderful creation took place during carnival. Paintings of human dissections, for example Rembrandt's *Anatomy of Dr Nicolaes Tulp*, or the seventeenth century anatomical tables demonstrating nerves, arteries and veins in our own library,[3] have always been in the public domain. And the Royal College of Surgeons' Hunterian Museum, established with the 13,000 specimens collected by John Hunter (1728–1793), has always been open to the public.

Pathology museums have existed for centuries: our own hospitals and medical schools may hold around 105,000 specimens, and there are probably more than 282 million specimens similarly stored in the USA.[1] Human remains are also kept and exhibited in 132 out of 146 public museums in England, with up to 500 items in any one of them.[3] They have been openly viewed by the public of many generations. The debate on the future disposal or return of these specimens, discussed on pp 465–7,[3] is at present confused and inconclusive.

Individual 'scandals' can too readily influence public opinion. The disgraceful body-snatching episode by Burke and Hare in 1827 led to public distrust of anatomists, while more than a century and a half later the behaviour of a single aberrant pathologist (Professor Dick van Velzen at Alder Hey) added to present-day mistrust of the medical profession, and in particular of pathologists. It is now incumbent on us to restore confidence in the profession both by a process of public education and by our own understanding of the public's need for appropriate modification of consent procedures and legislation. The Anatomy Act of 1832 following the Burke and Hare episode actually enhanced anatomical vitality in Britain during the remainder of the nineteenth century.[2] The Human Tissue Bill, designed in response to transgressions by a very few individuals and currently passing through Parliament, has been much improved as a result of the concerns expressed by this College and others. However, fears about the legislation's potentially harmful impact on medical progress persist – and not without reason. Indeed, there is already evidence that post-mortem examinations have decreased by approximately 80%, with a growing tendency to restrict examination only to specified organs, which may in part be the consequence of adverse public perceptions, as well as increasingly complex consent procedures. These important developments are discussed on pp 417–23.[4]

Both the public and the medical profession have been shocked by the events surrounding the storage of human tissues. Now it is vital to improve public understanding of the issues, while at the same time addressing the need for greater openness by doctors

in the twenty-first century. The British Association for the Advancement of Science and the Royal Society are themselves addressing the problems of perceptions of science through their recent Science Communication Conference,[5] and this College is engaging the public through its Patient and Carers Network. The existing legal framework governing ownership and disposal of human tissue was discussed in detail in a previous issue of *Clinical Medicine*.[6] It is clear from every viewpoint that new legislation is required, but it should avoid the adverse effects of overregulation denounced by Baroness O'Neill[7] and the lawyer Lord Phillips[8] as further diminishing trust in the professions. One hopes that common sense and trust will in the end prevail.

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The European Working Time Directive and professionalism

The acquisition of professional attitudes by example and training has always been a hallmark of medical education, and they are of sufficient importance to be assessed in the future by the 360 degree appraisal of doctors. Most doctors act with professional commitment to their patients, attending them at awkward times during unsocial hours or at night without question. Their willingness to do so has to a large extent assured the continuity of care so crucial to understanding patients and delivering the highest standards of medicine. But now the European Working Time Directive (EWTD), introduced into the UK on 1 August 2004, with worthy and important intentions to reduce tiredness amongst hospital doctors, has at least two serious side effects. Firstly, it actively inhibits (and polices) conscientious doctors from attending sick patients if they have already worked their fixed number of hours, which seriously damages attempts to maintain continuity of care. Secondly, there will be an inevitable decrease in direct clinical experience.

This College has worked energetically and constructively to reduce the potential damage to clinical care ushered in by the EWTD. Its proposal of a 'cell of ten' (or at the very least eight) junior doctors needed to provide adequate cover has been accepted by government as a model of good practice.[1] Furthermore, new ways of reinforcing continuity of care in order to benefit patients have been widely discussed, and the College has recently published standards of good practice to assist doctors and managers in this crucial aspect of clinical care.[2] Indeed, doctors at the Royal Free Hospital have devised new approaches which look promising (see pp 427–30).[3] It is still the case, however, and much publicised, that some Trusts could not meet all the requirements of the EWTD by 1 August 2004 simply because they have insufficient numbers of medical staff, and full implementation would lead directly to increased risks for patients.

The alacrity of the British Medical Association (BMA) in advertising its readiness 'to support overworked doctors who decide taking legal action[4,5] is therefore astonishing. Although a trade union has a responsibility to support its members when asked to undertake illegal rotas, the BMA's public enthusiasm belies an understanding of the genuine difficulties facing many Trusts in maintaining safe care and upholding professional practices. This stance represents another nail in the coffin of professionalism in medicine, so strongly defended by this College[6] in its role as guardian of standards, and seemingly disregarded by our trade union, the BMA. This attitude unfortunately adds credence to Professor Raymond Tallis' prediction that doctors are becoming 'deprofessionalised, sessional functionaries, robotically following guidelines'.[7]

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PETER WATKINS