

### Bioethics in the clinic: Hippocratic reflections

By Grant R Gillett. Johns Hopkins University Press, Baltimore 2004. 328pp. \$45.

Grant Gillett is an active neurosurgeon; unusually, he is also a professor of biomedical ethics. This book comprises a series of essays, his reflections on Hippocratic precepts. In the first chapter he describes the return of a young man's body to a Maori family for burial; they are outraged when they learn that the brain is missing (still with the pathologist – shades of Alder Hey!). As a New Zealander he understands and sympathises with their response. This leads him to consider the foundations of a common universal ethical system that takes into account different cultural beliefs and practices.

A section on informed consent explains why he once said he did not believe in it. It turns out that he actually does, but it has to be properly based, not lip service to an ethico-legal requirement; full information must be given and the patient must share in the process of decision, not simply acknowledge agreement with whatever has been recommended. One cannot fault this, nor his assertion that one should listen to the patient if one really wants to know what the preference is. Chapters on clinical trials, on medical misadventures (mishaps and errors) and the orthodox/alternative medicine debate add little to an already extensive literature. In 'The endings of life' he provides a good explanation and description of the distinction between persistent vegetative state (PVS) and the locked-in syndrome. He is in favour of ensuring a dignified death for victims but, despite a lengthy discussion, does not resolve the problem of deciding when life ends. The concept of brain death is still strongly opposed by many medical ethicists. He fails to address the argument that withdrawing treatment disregards the possibility of late recovery in PVS (unconvincing examples of which have been published), and there is no mention of reports of continuing cerebral function or, more accurately, activity in PVS. I raise these points not because I disagree with his view, but the longstanding controversy about these aspects is at the core of ethical disagreements about ending life. In his discussion of embryos I liked his analogy of a painting – to destroy it while it is only a few brush strokes on a canvas is a lesser thing to do than when it is complete. Respect for the embryo, which governs one's treatment of it, grows as it nears its potential for independent existence. Admittedly, there are some who firmly believe that life starts at the moment of conception and that full respect should be accorded to it from the start. I don't know how one deals with this contention; it is a matter of faith.

I found this a hard book to read – and harder to review. It is written in a rather formal style with occasional coy excursions into slang – 'buy into', 'spill the beans', 'get a life', 'nuff said'. His attempt to reduce ethical thought to a mnemonic formula is unhelpful ( $E = MC^3$ , where  $E$  = 'empathic understanding',  $M$  = 'moral tradition',  $C$  = 'consciousness',  $^1$  = 'yours',  $^2$  = 'mine' and  $^3$  = 'mine of yours'); I'm not sure I understand it, even after reading this section several times. Apart from the Hippocratic writings he draws copiously on many philosophers – Aristotle, Wittgenstein, Hume and Kant, as well as Foucault and other postmodernists. Much of their philosophy has little direct relevance to clinical medicine, and their inclusion sometimes seems incongruous. Professor Gillett expounds his own interpretations, through which he comes across as a caring and

dedicated doctor, who thinks deeply about medical matters and applies a profound knowledge and understanding of historical and modern philosophy to refine his concerns about them, but the book ends up stronger on philosophy than on clinical medicine. At the end of each section one is left asking, 'What is the message?' Too often it is right but trite: different cultures have different values; medical decision-making should be shared with patients and their families; attention must be paid to what the patient says – or doesn't say; decisions at the ends or beginnings of life have to be carefully considered and based on respect for the individual; one must distinguish medical misadventures (which happen to all of us) from more serious transgressions and act accordingly; the sexual needs of disabled people should be considered but they must be protected from abuse; and so on.

I suspect the book was not written with a medical readership in mind, but the reflections do make one think more closely about what one does as a doctor – and why.

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### The epidemic of coronary heart disease in South Asian populations: causes and consequences

By Kiran CR Patel and Raj S Bhopal. South Asian Health Foundation, Birmingham 2004. 161pp. £15.

This is a timely book, which summarises the epidemiological evidence demonstrating the impact of western living on an immigrant population from South Asia. Coronary heart disease (CHD) is the major cause of premature death in western society and the epidemiological data show that UK citizens of South Asian origin appear not just to have an exaggerated coronary risk but also to have a worse prognosis once the disease is manifest. Apart from summarising the issue the authors have attempted to explain the mechanism underlying these results. The section conceptualising the causes for excess coronary heart disease in South Asian immigrants provides interesting reading, with the subsequent chapters exploring systematically the role of both conventional and unconventional risk factors in the development of the disease. The different chapters describe what is known but each contributor calls for more research – clearly indicating that no one knows the answer!

It's always more complicated than you think at first sight. For example, there is huge genetic, cultural and environmental heterogeneity in the South Asian population, which comprises Pakistanis, Indians and Bangladeshis. As a consequence the risk factor profiles of the groups differ quite markedly – yet the impact of CHD is much the same. This suggests that the epidemic of CHD cannot be accounted for by the traditional risk factors.

The essential point is that South Asians in the Indian subcontinent have a low incidence of CHD but when they migrate to a western society like the UK there is a dramatic rise in the incidence of, and deaths from, CHD, which is far higher than that of native westerners. This racial difference is best explained by a gene-environment interaction. The first of the two most attractive explanations for the observation is the 'thrifty gene hypothesis', according to which

protective genes have evolved which have a survival advantage at times when calories and salt are less abundant, but are disadvantageous when there are unlimited or increased supplies. This goes some way to explaining the marked weight gain and trunkal obesity, insulin resistance and diabetes seen in South Asian immigrants to the UK. Alternatively, building on the Barker hypothesis of intra-uterine growth and its impact on adult health comes the second explanation, the 'adaptation-dysadaptation hypothesis', which investigates the mismatch between 'foetal thrift' and 'postnatal plenty'.

The book also aims to identify areas for treatment and strategies to reduce the epidemic and improve cardiovascular health in this population. The reasons for a higher prevalence of tobacco smoking and a lower quit rate in some ethnic subgroups have been examined well with innovative and culturally-appropriate public health strategies suggested.

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### The good doctor

By Damon Galgut. Atlantic Books, London 2004. 240pp. £7.99.

This novel is an enthralling, all-consuming and intense read right up to the last page. The two main characters are doctors and many of

the sub-plots have a medical slant, but one certainly does not have to be a medic to appreciate and be profoundly moved by the book.

The scene is post-apartheid South Africa and the focus is on the lives of two totally contrasting doctors who find themselves working closely together, indeed sharing a room in a hopeless, run-down hospital. The hospital is 'managed', so to speak, by an incompetent female surgeon and is in one of the old Bantu homelands not far, I suspect, from the Angolan border. One of the two is young, new, energetic, full of ideas and thoroughly enthused about and committed to the 'new' South Africa and what can be achieved. The other is older, has been there a long time, lacks ambition, is not very successful in the eyes of his traditional upper middle-class family, and his marriage has failed. This tale relates the tensions that develop between them and the catastrophic consequences.

The main plot and the various sub-plots deal with violence, corruption and desperation, and are weaved in and out of each other with great skill. There are many unexpected twists and turns; every page is compelling, and many are disturbing and shocking, but the writing is always horribly plausible. The story is brilliantly narrated in its discomfiting way, and it was no surprise to learn after I had read it that it had been shortlisted for last year's Booker Prize.

It is a short book, just 200 pages. It is now in paperback and is to be thoroughly recommended.

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# letters

## TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by email to: [Clinicalmedicine@rcplondon.ac.uk](mailto:Clinicalmedicine@rcplondon.ac.uk).

### The 2001 guidelines on cardiopulmonary resuscitation

Editor – The 2001 guidelines on cardiopulmonary resuscitation (CPR) emphasise patient participation in the CPR decision-making process.<sup>1</sup> However, two recent articles in your Journal highlight the difficulties in doing so (*Clin Med* July/August 2004 pp 424–6; *Clin Med* July/August 2004 pp 471–2). Over the past five years several studies have shown similar trends, thus exposing the huge gulf between the guidelines and common medical practice. On one hand, the medical profession has been vocal in their disapproval of these guidelines<sup>2</sup> and on the other, patients have shown no enthusiasm for discussing these issues.<sup>3</sup> Even the national press has admitted their ignorance on the subject by linking euthanasia to the 'do not resuscitate' order.<sup>4</sup>

The time has come for policy-makers to listen to the profession and revisit guide-

lines on cardiopulmonary resuscitation. Emphasis should not only be on political correctness, but also on practicality and improving patient care. Ambiguity surrounding existing guidelines should be rectified by clearly stating that patient engagement in discussing CPR should be at the discretion of the medical team. Models of engaging patients, where appropriate, in end-of-life issues must be an integral part of any revised guidelines.

Policy-makers have the responsibility to present a clear and balanced view, which increases the patient's confidence in the system and is acceptable to doctors and nurses who provide front line care. Failure to do so will harm the very heart of patient care, which these guidelines are intended for.

### References

- 1 British Medical Association, Resuscitation Council (UK), Royal