book reviews

The philosophy of palliative care – critique and reconstruction

Fiona Randall and RS Downie. Oxford University Press, Oxford 2006. 256 pp. £29.95.

This book was written by a consultant in palliative care and an emeritus professor of moral philosophy. I am no philosopher and found the text hard work which is a pity, since the book is thought provoking and deserves a wider audience within palliative care than I suspect it will achieve.

The book is divided into three sections. The first likens Dame Cicely Saunders' vision of palliative care to the ancient Greek Asklepian tradition (where emphasis was placed on the attention paid by the physician to the individual patient, with change coming from within the patient) and contrasts it with the Hippocratic tradition (which focused on discovering patterns of symptoms and diagnoses, leading to treatments which were applicable to all patients). The authors regret the increasing dominance of Hippocratic evidence-based medicine and the exclusion of the Asklepian tradition with its focus on the 'attention which should be given to each patient with their story, and their own values'.

The authors discuss quality of life (and how ridiculous it is to make a quantitative assessment of what is, by its very nature, a qualitative experience), patient autonomy and dignity. When the philosopher Immanuel Kant first described autonomy, it meant the ability to exercise self-restraint in choices that affect others. Consumerism, the rise of human rights and the patient-centred approach of today's NHS have profoundly affected our view of autonomy, truth telling, consent and dignity. As one who feels we have wrongly given 'autonomy' precedence over 'beneficence', 'non-maleficence' and 'equity' in ethical matters, I found myself agreeing with many of the authors' views.

The place of relatives within a palliative care philosophy is also discussed. The authors feel that too often professionals give relatives equal rights to patients with regards to information-sharing, preferred place of care and measures which may prolong or shorten the dying phase. This is contrary to my own experience – I would be interested to know how the authors would deal with a desperate patient who demands that their physically and emotionally exhausted relatives continue to care for them at home.

The second section covers some common ethical issues in palliative care, such as withholding or withdrawing life-prolonging treatments; introducing treatments which may hasten death; distinguishing between killing, euthanasia and 'letting the patient die'; and considering patients' and professionals' responsibilities in making these decisions. The ethics of cardio-pulmonary resuscitation in patients with terminal illness are discussed, as is the difficulty that advance statements may cause for physicians when the new Mental Capacity Act comes into force in 2007.

Many palliative care professionals will find the next chapter gives them hypertension. Fundamentally the authors feel that palliative care has no responsibility to attempt to modify psychosocial and spiritual problems of patients, let alone those of their families. The authors state that formal assessment of such problems is often intrusive and may be harmful to the mental well-being of patients, families and staff themselves. Neither the close personal relationship advocated by some researchers, nor the detached 'counselling relationship' is favoured by the authors. Instead the professional should give the patient Asklepian attention and forget the 'tricks' learned on communication skills courses. This is termed 'friendly professional interest' – an attitude of close listening from a warm, interested and encouraging professional which may help the patient understand the meaning of his illness. Interestingly, the references cited to support this approach seem to be as poorly evidenced as some of the approaches already dismissed by the authors.

The final chapter of this section shows that 'needs assessments' do not always reflect what aspects of care deserve top priority and that demonstrating the cost-effectiveness so loved by the NHS is almost impossible in palliative care. Finally, the authors recommend that all patients with a terminal illness should have access to palliative care provided by generalists, leaving more complex problems to specialist palliative care.

The authors then present their vision for how palliative care should develop – a much quicker task than demolishing what has gone before. The authors suggest increasing Asklepian attention to the patient while still providing good quality symptom control. They make suggestions as to how staff can help the patient maintain 'honest hope'. Finally, the authors also look at how we can train the staff to provide such care.

This book makes a number of excellent points but they are hidden among a lot of philosophical argument. If you are interested in philosophy or ethics as applied to palliative care, then this is a book you will enjoy. If you work in palliative care, prepare to be incensed and challenged.

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Binge Britain: alcohol and the national response

Moira Plant and Martin Plant. Oxford University Press, Oxford 2006. 208pp. £19.95.

This book by two of our national experts on alcohol misuse provides a thoroughly good read that can be tackled cover to cover or dipped into for its wealth of data and references. It is certainly timely, as binge drinking is rarely out of the media spotlight. The authors admit at the start that 'binge' is an ambiguous and sometimes unhelpful term but one we are stuck with so we just have to get used to it – to some it conveys a behaviour, often with destructive intent, to others it means exceeding an arbitrary limit within a set time period. For most people it means simply becoming intoxicated, and it is but one mirror of the UK's increasing alcohol problem.

While shocking in respect of the facts reported, *Binge Britain* never goes beyond the evidence and maintains a commendable balance. The first chapter is an excellent review of the history of alcohol consumption in the UK. This is traced back to before the Roman invasion of 43 AD and followed through to the present time. Legislation is not a new approach to curb public drunkenness and

disorder – attempts go back at least to the 15th century, and during Elizabethan times there were no fewer than seven alcohol-related acts of Parliament passed in less than 25 years. I was surprised to learn that restriction of the licensing hours had been introduced long before the First World War (when it was brought in hastily to protect the safety of workers in the munition factories). Restricted hours had been introduced in 1854, but the act was repealed the following year because of its unpopularity! The weapon of taxation had already been used, of course, in a series of 'Gin Acts' in the 18th century. Their abject failure to curb the problem had more to do with the lack of enforcement, in the view of the authors, than a flawed principle, but as ever the full and amusing historical review shows that there is little new in the current discussions on how best to tackle 'binge drinking'.

The authors have been responsible for some of the best work in recent times on patterns of drinking in young people across Europe and these data make uncomfortable reading, although come as no surprise to those who man our accident and emergency departments. There follows a full and frank review of the factors leading up to the Government's alcohol harm reduction strategy finally published in 2004,[1] and the Plants leave us in little doubt that the strength of the producers and retailers' lobby has been a major factor in the perceived weakness of the outcome.

Given the long and intractable nature of the darker side of our favourite drug, it is not surprising that the book leaves us with little optimism about the way forward. Perhaps we should accept that the way we use alcohol mirrors the issues that are current in society. It is not just the recipients of merchant bank bonuses (and their teenage offspring) that are drinking more to celebrate, it is those trapped at the bottom of the socioeconomic ladder drinking more to soften that reality. It is in the deprived urban areas of our northern cities that the worst ravages of alcohol misuse are most evident, and it is through tackling the roots of health inequalities that we can make the most sustained difference. This book frames the context of our current plight and I hope was included in the Christmas stockings of our political masters.

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Reference

1 Prime Minister's Strategy Unit. *Alcohol harm reduction strategy for England*. London: Cabinet Office, 2004. www.cabinetoffice.gov.uk/strategy/work_areas/alcohol_misuse/

Napoleon's doctors

Martin Howard. Tempus Publishing Ltd, Stroud 2006. 304 pp. £25.00

The Napoleonic Wars, an extension of the French Revolution, revolutionised the European military systems on an unprecedented scale through mass conscription. Napoleon aimed to sustain the democratic and republican ideals of the French Revolution, but in 1804 imperial ambitions overtook him. Over little more than a decade his armies fought almost every European power and conquered most of mainland Europe until his disastrous invasion of Russia in 1812, followed by defeat at the Battle of Leipzig in 1813, his abdication and exile to the island of Elba. After a brief return – the Hundred Days – Napoleon was defeated by Nelson at the Battle of Waterloo on 18 June 1815. Exiled to Saint Helena, he died there in 1821.

The inevitable medical consequences of Napoleon's warfare were of huge proportions. The French army peaked in size in the 1790s. In total, about 2.8 million Frenchmen fought in the conflict on land, and about 150,000 at sea. The monumental task of Napoleon's doctors is evident. It is estimated that 400,000 French were killed in action and 600,000 died of other causes. The major hazards to life were infectious disease, wounds and blood loss, starvation, and exposure.

In this well-researched, well-written and thorough history, derived in part from their memoirs, Howard introduces us to the health services and to the professional life of army doctors. Many eyewitness accounts from serving soldiers and doctors enliven his narrative. He relates and appraises the work of a small group of doctors, Pierre François Percy, Dominique Jean Larrey, René Nicolas Desgenettes and Jean François Coste, who tried to shape the medical services of the Grande Armée. We are given vivid sketches of each, portraying their varied vanities, medical prowess, and their political adroitness in manipulating a myriad of difficult or impossible situations.

Howard describes the battlefields of 1792–1802 and of 1803–1809 with clear accounts of the weaponry and the risks of injuries from shells, shrapnel, case shot, and musket balls. The French muskets were far less accurate than the rifles of specialist units of the British, Austrian and Prussian armies; muskets hit 60% of targets at 75 metres, but only 20% at 300 metres. Here too we learn of the plight of injured soldiers, and of their inadequate transport, culminating in Larrey's pioneering adaptation of wagons backed up by a legion of 340 men, each designated a specific role. The supply of these flying ambulances, however, was inadequate to provide for most of Napoleon's injured soldiers, often left where they fell, on the bloodied mud of the battlefield. The skills of the most senior surgeons were often confined to the guards and others of high rank or privilege.

The repeated failings of the *service de santé* were highlighted by Percy who proposed a plan for a *chirurgie de bataille* to Napoleon, who gave them little attention and rejected the plans. The consequent lack of hospitals, food, clean water, dressings, equipment and surgeons had predictable and disastrous consequences for the wounded, graphically related by Johann Christian Reil after the conflict at Leipzig. Napoleon opposed his doctors' recommendations for prompt evacuation of the wounded, and issued orders that the casualties at the front should not be collected for treatment until the battle was over. Non-combatants were not to impede the fighting.

Howard describes the state of the military hospitals, which amounted to charitable institutions adapted for warfare. Patients' existence was hellish, and they were named *Les sépulcres de la grande armée*. Two out of nine patients died in the Hôtel-Dieu of Paris. Many thousands were abandoned in the field or dumped untended in nearby emptied houses or gardens.

The impossible tasks facing Napoleon's surgeons are graphically related. When they did receive attention, soldiers were often operated on in the filth of the field, without suitable instruments, and often by surgeons so inexperienced that senior colleagues had to mark the skin to indicate where they should operate. Surgical improvisation was needed. There was no anaesthesia and they operated very rapidly to minimise the agonies of the knife.