PostScript

LETTER

Prehospital and retrieval medicine

I would like to clarify some points in the useful review of retrieval medicine provided by Shirley and Hearn.¹ Their opening sentence cites an article regarding the provision of prehospital critical care and retrieval services.² In that article, Dr Bevan and I argued that "immediate care" (previously defined as the provision of skilled medical help at the scene of an accident or medical emergency and during transportation to hospital) should be regulated in the same way as any other specialist undertaking within the National Health Service. We expressed concern that there was no system, training stream or workforce in place across the UK to ensure that the prehospital and in-transit critical care needs of patients are met in a consistent or organised manner. We did not propose that "those currently involved in immediate care" should be considered as "the core providers of these services" for the future. Rather, we made the point that provision of specialist on-scene and in-transit medical support is likely to be "beyond the scope of the occasional or fringe immediate care doctor". This is an important distinction.

The review also argues that the competences required for transporting a patient from the scene of an accident to an emergency department (primary retrieval) or between two healthcare facilities (secondary retrieval) are "by no means interchangeable". However, one of the more remarkable features of the established Australian retrieval services referred to in the review is that they do just that: combine primary and secondary retrieval functions. Rather than maintain a divide, we should recognise the overlap and develop a competence and curriculum framework that encompasses all retrieval demands.³

It is also important to highlight that "retrieval medicine" is not actually a formally recognised specialty or subspecialty in Australia. Rather, as with the UK, individual practitioners have developed a personal interest in this area. The lack of a single specialist body or professional group to develop clinical practice and drive service standards has resulted in a disparate range of retrieval services and models both within and between states.⁴⁻⁶ The authors make particular reference to the systems in place within the state of New South Wales and the Sydney area. Although elements of this model are highly effective and relevant, the model is currently undergoing a major reconfiguration. Primary, secondary and specialist retrieval services have historically been provided by a number of contracted independent operators using different combinations of transport platforms, clinical teams, and operating procedures. Development of these services has, as in the UK, been driven by local communities, individuals and non-governmental organisations, with little strategic direction or planning. The recent adoption of a "whole-system" approach in New South Wales, which properly integrates retrieval services within the wider ambulance service (which also includes a state-wide fixed-wing flight nurse-led retrieval service as well as the land ambulance resource network), will lead to a far better service model in the near future. This is

perhaps one of the most important lessons we can learn from the Australian experience.⁷

In the final paragraph of our article, Dr Bevan and I wrote: "The development of a rigorous, accredited career stream in prehospital and retrieval medicine would fill one of the few remaining gaps in the provision of emergency care in the UK. There is a real opportunity for both individual practitioners and the organisations responsible for regulating and applying standards to now collaborate and reach agreement on the scope of practice, competency framework and licensing arrangements for the subspecialty of pre-hospital and retrieval medicine."² Dr Shirley and Dr Hearn, who have vast personal experience across the spectrum of retrieval services, are exactly the sort of people who should be driving this process. Their review is very welcome.

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BOOK REVIEW

Making Sense of Medical Ethics

Edited by Alan G Johnson, Paul R V Johnson. London: Published by Hodder Arnold, 2007, \$29.95, pp 222.

Don't know your "Deontology" from your "Consequentialism"? Well, don't panic. *Making sense of medical ethics* by the late Alan Johnson and his son Paul will clear that up for you. And much else besides.

This pocket-sized book, described as "a hands-on guide", is written by two clinicians: surgeons, as it happens. It seems to be aimed, fairly, at the beginner.

The book is divided into three parts. The first six, introductory, chapters are especially rewarding as they provide a clear summary of general principles and a pithy dispelling of some ethical myths and

misunderstandings. It is also here that you will find an excellent explanation of deontology, consequentialism (teleology), virtue ethics and subjective individual ethics. You will also be guided through the various religious and non-religious value systems, which form the moral basis of medical ethics. The chapter on "Ethics in conflict" alludes to such contemporary issues as whistle blowing, government targets, Jehovah's Witnesses and the case of Charlotte Wyatt. Although the authors, very reasonably, make no attempt to examine the history or development of medical ethics, to write that, "This document (The Hippocratic Oath) stood in splendid isolation for hundreds of years until the atrocities of Nazi Germany in the 1940s... led to the modern spate of declarations and codes," is stretching things. Thomas Percival's *Medical ethics* published in 1803, and which had an impact in both Britain and North America, may not merit a mention, but at least makes the statement untenable. Apart from that, these chapters alone make the book worth reading.

The middle part covers the core areas: autonomy and consent, beneficence, confidentiality, justice and fairness, truth and integrity, which can be found in most books on ethics. The chapter on autonomy and consent is perhaps the weakest of these. Although capacity is an essential prerequisite for informed consent, no attempt is made to define capacity or how it might be assessed. Having said that, it contains several gems, including a clear exposition of why we should not refer to patients as "clients".

The word patient comes from a Latin word meaning "to suffer" whereas client comes from a word meaning "a person who is dependent on others' patronage".

The authors remind us that even in an age of increasing patient autonomy, many patients put their trust in us as professionals to guide them to the right decision. After all, we fly to our holiday destinations without being told about all the risks involved: we trust the pilot and the crew to get us there safely. And that is a perfectly reasonable way to behave.

The final chapters tackle the practical difficulties in applying these principles. Here, the authors present the fact that, in a given situation, ethical principles may be in conflict. By forming "ethical pathways", the authors suggest, an ethical solution appropriate to the patient may be found. The book concludes with an "Ethics survival guide for medical students", and a chapter on "What makes an ethical doctor?".

The layout of the book makes it very accessible. The text is broken down by the use of multiple subheadings, summary boxes, clinical scenarios and occasional quotations. Each chapter ends with a summary box of bullet points. The wonders of modern publishing mean that the authors have managed to include some of the important events from 2006, if only sketchily. Unfortunately, this excellent little book is let down by a large number of irritating typographical errors. A second edition deserves thorough proof-reading.

If you have never considered reading a book about medical ethics, this would be a good one to start with. Even if you have read others, there is plenty in this one for it to make a useful addition to your collection.

Bernard A Foëx