

news story.

What causes silence in such situations? Health care “insiders” are frightened they might make the situation worse. They worry that disclosure of problems will be seen as unjustified criticism, not just of the current state of affairs in the health care system, but also of health care professionals — in some cases colleagues — who are already stretched to their limits, demoralized and working miracles in very difficult situations. There is a risk of being labelled as not being team players, as troublemakers, as self-serving in some way, or as “the enemy” — whistleblowers often are — and of suffering the consequences of such stigmatization. Those consequences can include loss of professional opportunities, promotion, prestige, a congenial work situation and even friendships.

Addressing these problems is complex, and it would be a grave mistake to think otherwise. But I would like to make a few suggestions as to where we might start. First, we must recognize that it can be seriously unethical to not speak out and to not change a culture that does not recognize the necessity of open disclosure. Furthermore, it is not only people who can be unethical; systems can also be unethical. Therefore, we must try to design ethical hospital systems. At the least that requires protecting those who try to prevent or correct breaches of ethics — for instance, whistleblowers — and ensuring that the organizational structure does not create or condone what Nuala Kenny calls “ethical distress.”² A person experiences ethical distress when he or she knows that another is acting unethically but, because of lines of authority, is powerless to do anything about it or would suffer serious repercussions by doing so. In short, we need a comprehensive system of identified corrective mechanisms and remedies for such situations.

Finally, many ethical mistakes are made because an ethical problem is not recognized as such, but rather is wrongly identified as a public relations or communications problem. Instead of asking what ethics requires in the situa-

tion, those involved ask, “Will it make the minister, the hospital, etc., look bad, and if so, how can we avoid that?” The problem is spin-doctored, a process that often augments the ethical wrongs, as for example in deciding for public relations reasons not to tell the public about risks or tell patients about mistakes.

I once heard a PR person give the following advice: “Never say you don’t know. Never say you were wrong. And never apologize.” How not to do ethics, in a nutshell.

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The doubts and fears of emergency physicians

My colleague Dr. Ursus describes the emotional turmoil of working in an emergency department.¹ As an emergency physician myself, I have faced some of the same questions and concerns, but I have also gained a few pearls of wisdom from my patients, their families and the emergency health care team.

First, nobody expects the physician to be infallible, although patients do expect honesty, caring and loyalty. Over the years, many have forgiven my mistakes, as long as my efforts to help were perceived as genuine. Families have found solace in the fact that I could show my emotions, but virtually none of my patients were offended when I could not tell them exactly what was wrong with them. They were quite ready to accept that I could only reassure them about what was *not* wrong and provide some relief for

their suffering.

Similarly, members of the emergency health care team can accept the fact that, at times, our hands tremble and we have doubts. In fact, these caregivers are themselves plagued by fears and worries. The essence of emergency medicine is dealing with the unknown and working with frightened patients. We have to make rapid yet appropriate decisions, often with virtually no information or proper resources. The burden is enormous, and one person cannot do everything alone; the load must be shared.

Being an emergency physician is far from being “small,” and the only expectation one need live up to is one’s own. Similarly, the only guarantee we must give is that we will endeavour always to be the patient’s advocate and to provide our best effort.

I ask Dr. Ursus not to succumb to fear, not to fake omniscience and never to hide his or her humanity. The best emergency physicians I know are the ones who care about their patients and are emotionally honest with themselves.

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Clostridium difficile colitis: A marker for ischemic colitis?

In an electronic letter published in *Gut* earlier this year,¹ I wrote, “Nine years ago I alerted the CDC [US Centers for Disease Control and Prevention] in Atlanta to the possibility that *C. difficile* colitis might be a marker of a far more common and potentially serious disorder [than *C. difficile* colitis], ischemic colitis.”¹ The same possibility should be considered in the current

outbreak of *C. difficile*.²

That proton pump inhibitors should be a risk factor³ is of interest in this regard.⁴ These drugs stimulate cation-dependent short-circuit currents in the colonic mucosa, possibly by converting the vanadate-sensitive H⁺/K⁺-ATPase into an electrogenic cation transporter.⁵ Should the demand for energy from ATP (adenosine triphosphate) hydrolysis so induced exceed the capacity for ATP resynthesis, the action might precipitate an aerobic energy deficit or unreversed ATP hydrolysis similar to that developing for different reasons in ischemic colitis that occurs as a complication of abdominal aortic surgery. As in *C. difficile* colitis, the passage of liquid, blood-stained stools is an established feature of this condition.

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[Dr. Dial responds:]

Richard Fiddian-Green raises interesting questions about the possible direct effects of proton pump inhibitors on the colon. Although we hypothesized that the use of proton pump inhibitors increases patients' risk by making them more susceptible once exposed or perhaps through effects on the intestinal flora,¹ we questioned the possibility of other mechanisms, especially given that proton pumps in the colon have been described. Diarrhea is in fact one of the more common side effects of proton pump inhibitors.² The reports of lansoprazole-induced microscopic colitis³ and the possible effects of elevated gastrin levels from use of proton pump inhibitors in the colon,⁴ as well as the hypothesis raised by Fiddian-Green regarding increased ischemic risk for the intestinal mucosa, suggest that research in this area is warranted.

In some of the more severe cases we have observed, we questioned

whether progression to a more fulminant course occurred because of a combination of an infectious with an ischemic insult, with the following possible scenario: severe diarrhea from *C. difficile* causes dehydration and relative hypotension, which leads to either global or localized bowel ischemia, which then acts as a motor for a systemic inflammatory response syndrome and a more fulminant presentation. The possibility that the reverse occurs — prior relative intestinal ischemia leading to increased susceptibility to the toxin and a more severe presentation — is intriguing, especially in light of a report by Dallal and associates.⁵ These authors found that cardiothoracic procedures and vascular surgery were the most common operations that preceded fulminant *C. difficile* colitis, although this observation may simply reflect the high rate of these procedures.

I believe that the current outbreak is primarily infectious, since the observation of bloody diarrhea has been the exception rather than the rule; nonetheless, the contribution of an ischemic insult should be considered in the more severe forms. At this point, many unanswered questions remain, but hopefully continued research in this area will help clinicians to decrease the incidence of infection and improve patient outcomes.

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