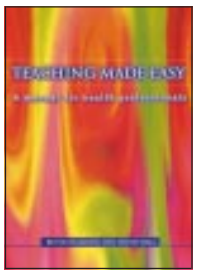
reviews

BOOKS • CD ROMS • ART • WEBSITES • MEDIA • PERSONAL VIEWS • SOUNDINGS • MINERVA

Teaching Made Easy: A Manual for Health Professionals

Ruth Chambers, David Wall



Radcliffe Medical Press, £18.95, pp 216
ISBN 1 85775 373 9

Rating: ★★★

As a busy clinician with a healthy commitment to medical education, I found the title of this manual instantly appealing. For here is a book that promises to coach me in the delivery of good teaching practice within the constraints of the new NHS.

A concise, readable guide to modern teaching practice, it makes an ideal companion for healthcare professionals already involved in teaching. The language of medical education is made understandable, yet the concepts of educational theory are no less forceful and are sufficient for the proposed wide readership. I found the pertinent and up to date references at the end of each chapter particularly useful.

The text sometimes verges on the didactic, but then you have to consider both the intended audience and the size. The cartoons illustrate key points and add to the book's readability. One of my concerns on first perusing the manual was that, in trying to be germane to all health professionals, it would lose some of its immediate relevance. However, it tackles this concern by focusing on the principles of the teaching process, exploring aspects of implementation and evaluation that are applicable to most of those concerned with delivering teaching. So, even if you feel some of the chapter headings seem a little uninspiring, the content is pertinent to teaching practice in most clinical settings. I did become somewhat confused between teaching methods and tools used in delivering teaching in chapter 4, but this could easily have been addressed by creating a separate chapter.

Teaching Made Easy provides some much needed support to teachers, who are increasingly being asked to participate in multiprofessional initiatives as well as teaching across a wide range of subjects. The book obviously reflects the authors' expertise, with examples and appendices focusing on medicine, but it is a brave book, which mentions clinical governance and alludes to the need to develop a parallel approach in teaching.

What I most enjoy about a book is its feel. *Teaching Made Easy* feels like a well timed introduction for us all, whoever we are.

Jean Ker *lecturer in medical education, Ninewells Hospital and Medical School, Dundee*

ART

The Origin of Captured Images

Specimens and Marvels:
The Work of W H F Talbot

National Museum of Photography, Bradford, until 9 July

William Henry Fox Talbot is widely regarded as the founder of modern photography. He is credited with the discovery of the use of "negatives" and "positives" in photographic processing and produced the first camera negative in 1835, a picture of a lattice window at Lacock Abbey. This exhibition at the National Museum of Photography in Bradford displays some of the earliest photographs in the national collection and celebrates the bicentenary of the birth of the genius who made photography possible.

Talbot was a true Victorian polymath, who became a fellow of the Royal Society aged 32 for his contribution to mathematics. He was an accomplished classical scholar with a wide range of interests, from Hebrew and Greek to Assyrian cuneiform inscriptions and astronomy. He even contributed ideas for the development of internal combustion engines in the 1840s and found time to enter politics, becoming a Whig MP in 1832.

The idea of photography came to him while on honeymoon at Lake Como in Italy in 1833. In his book *Pencil of Nature* he writes how charming it would be if it were possible to cause these natural images to imprint themselves durably on paper.

He gradually lost interest in politics and immersed himself in photographic research, producing the first camera negative in 1835 with his camera obscura. His early "photogenic drawings," as he called them, were of leaves and copies of sketches and engravings. Josiah Wedgwood, the potter, and Sir Humphry Davy were also working on photography, but it was Talbot who eventually invented the photographic process, weeks after the Frenchman Daguerre announced his version in 1839. Talbot used light on sensitised paper for his image and fixed this with common salt. Over the years, refinements in techniques continued. A photographic society was founded in 1853, and Talbot twice declined the offer of its presidency.

Towards the end of his life he became a recluse. Little would he have imagined that, 18 years after his death, Roentgen in 1895 would make another momentous leap in imaging research with his discovery of *x* rays, which enabled internal pictures of the human body to be captured. However, the medical application of photography might not have been possible without Talbot's pioneering work.

The lattice window in the south gallery, Lacock Abbey, August 1835

Arpan K Banerjee *consultant radiologist, Birmingham Heartlands and Solihull Hospitals*

Ratings are on a 4 star scale, 4=excellent

Tarring consultants with the Ledward brush

Pity the poor consultants. No sooner do they recover from the battering given to them by the media over their inability to diagnose cancer of the tongue in a 41 year old man (20 May, p 1414) than they receive a new thrashing over the inquiry into disgraced surgeon Rodney Ledward, who botched operations on scores of women. "The gods who fell and betrayed our trust in medicine" was how the *Mail on Sunday* described the consultant body after the report was published. "Ledward is an Establishment figure … whose disgraceful behaviour was allowed to continue … in the full knowledge of powerful figures in the profession. The case destroys the image of doctors as a totally respected elite whose judgement is beyond question," Peter Dobbie wrote in that paper.

Never slow to take advantage of a passing bandwagon, the politicians soon weighed in against the profession. They saw it as a chance to attack the "toffs" in medicine and stoke up the class war that had been ignited by Gordon Brown's attack on the elitism of Oxford dons the previous week (10 June, p 1612). Alan Milburn went on to the *Frost Programme* on the Sunday after publication to call for an end to the elitist culture of the NHS in which the "consultant is king." His attack on senior doctors led to a spate of aggressive headlines the next day proclaiming that "Consultants must answer to patients" (*Daily Telegraph*) and " 'Consultant is king' culture must end" (*Guardian*).

Knowing that such attacks were bound to follow the Ledward debacle, the BMA had geared itself up for a counterattack. It took off its gloves and entered the fray. In the four days after the publication of the report, BMA leaders gave 17 radio interviews and five television interviews, submitted at least two articles to the national press (BMA secretary Mac Armstrong's was published in the *Guardian*), and fired off numerous letters to national and regional newspapers. The association's press office held a press conference on the day of the Ledward inquiry's publication (1 June) and issued two press statements the next Monday.

The counteroffensive paid off. The headlines on Tuesday 6 June were far more sympathetic to the profession. "Doctors refuse to accept blame for NHS failings" declared the *Daily Telegraph*, while the *Daily Mail* proclaimed: "Labour 'insults and assaults' outrage doctors."

Swiftly the government's attitude changed. From playing "nasty cop," a role that seems to come naturally to him, Milburn switched to "nice cop." He told the BBC *World at One* interviewer Nick Clarke that "the overwhelming majority of consultants do a quite brilliant job for the NHS" and that doctors did a "very, very good job indeed for the health service." The government tone did not change even after Ledward came onto Radio 4's *Today* programme to claim that in striking him off the medical register, "the profession has got rid of a first class consultant."

Such words do not come easily to someone of Milburn's ilk. He was described by Simon Hoggart in the *Guardian* as a man who used every oath in the language, except the Hippocratic oath, and as having "metaphorical tattoos all over his political credentials." When Milburn starts taking an emollient line it must be significant. So are the doctors now in the government's good books, and is it all going to be plain sailing?

Unlikely. A new case is already hitting the headlines (consultant gynaecologist Richard Neale is appearing before the General Medical Council charged with substandard treatment and falsification of documents), and that case will undoubtedly be followed by others. The public will be indignant, and politicians will feel obliged to recognise the public anger and promise to do something. The BMA will have to go on firefighting.

So what is the solution? Strangely enough, the solution that is staring consultants in the face is one that they have just rejected. The GMC's plans for revalidation, whereby doctors will be assessed on their suitability to practise every five years, is designed to reduce the number of Ledwards who hit the headlines. Yet the consultants rejected the GMC's proposals at their annual conference earlier this month (10 June, p 1557). If they do not want to be constantly attacked for the poor performance of some of their colleagues, they had better work out an alternative solution pretty quickly.

Annabel Ferriman *news editor, BMJ*

Another dose of doctor battering

WEBSITE OF THE WEEK

Transplant organs This week a news story highlights a BMA campaign to increase the number of donor organs available for transplantation. In Britain the situation is worsening: 1000 patients each year die on waiting lists, which are increasing by 3% each year while the number of donor organs remains constant. At its annual representative meeting last year, the BMA advocated that donation of cadaveric organ transplantation should be on the basis of opting out (a register of non-donors) rather than of opting in (carrying a donor card), and its medical ethics committee has been carrying the new policy through. Its report is available on the BMA's website (www.bma.org.uk/).

Other countries that have adopted the opt out approach, such as Belgium and Spain, have managed to increase the number of organs donated, although they also revamped other related systems too. Civil libertarians demur, but opt out systems are driven by the basic fact that, although 70% of UK people claim to wish to be organ donors if eligible, only 20% fill out donor cards.

This might be regarded as an informational problem. Making and storing an advance directive about one's wishes for organ transplantation on an internet server that could be checked by intensivists is technically straightforward; the difficult issues are social: quality, security, and confidentiality. Naturally, the United States is making some progress towards this goal on the web: at www.unos.org/Newsroom/critdata_main.htm you can read a weekly updated list of the number of Americans on transplant waiting lists, as well as drilling down for more detailed information about waiting lists in transplantation centres in a given locality.

Promoting the idea of organ transplantation is more straightforward. The Coalition on Organ Donation is using "viral marketing" to get people talking about their wishes for organ donation. Viral marketing exploits the willingness of email users to forward each other files and links to things they have themselves enjoyed. Whether the *BMJ*'s readers would enjoy downloading the excessively schmaltzy 600 kb presentation at www.shareyourlife.org/ is open to question, but internet marketeers are certainly abuzz about the technique.

Douglas Carnall
BMJ
dcarnall@bmj.com

PERSONAL VIEW

Priority setting in health care: should we ask the tax payer?

It is popular and politically correct to involve the public in healthcare priority setting. But it may not necessarily be a good thing to involve it in rationing decisions.

It is almost an article of faith among many United Kingdom health economists that a publicly funded and provided healthcare service is more efficient than if left to the free market. Several reasons sustain this view. An important one is the low level of knowledge by the potential healthcare consumer of the relative utility of a healthcare service with respect to its price—or in economists' jargon—informational asymmetry. Consumers tend to choose the most expensive procedure they can afford on the basis that the most costly will be the best. Hence, in the context of hip replacements consumers may choose the most expensive prosthesis in the belief that this must be better.

This phenomenon partly explains the reason that the United States spends a much greater proportion of its gross national product on health care compared with other, less market oriented, healthcare systems. For example, public pressure has made 10 US states pass legal requirements that autologous stem cell support for patients with breast cancer should be available if requested. This is despite it being more expensive than conventional treatment and no more effective.

By taking the healthcare purchasing decisions away from the consumer the NHS improves efficiency by allowing only those people with sufficient knowledge of health care to purchase effective (and occasionally cost effective) medicine on behalf of patients. Thus, doctors act for patients by assessing the therapeutic options available and advising the patient which is best.

While the NHS may remedy some of the market's inefficiencies it is not without its problems. One weakness, which ascertaining the public's view seeks to address, is that provision of healthcare type is divorced from what people actually want. Thus, for example, doctors may not wish to provide a service so women can have home births because it is easier for them to let women have their babies in a maternity hospital. Similarly, the public may wish local general practitioners to provide unproven complementary medicine rather than spend their budgets on the cost effective vaccination of older people against influenza. While the NHS is accountable to the public through the electoral system this accountability is very muted as people rarely cast their votes solely on the basis of one issue.

The belief that ascertaining the public's view on resource allocation is efficient within a publicly funded service must rest on the following assumptions. Firstly, the public is incapable at an individual level to make efficient choices. Secondly, it possesses sufficient knowledge to ration health care on a population basis. The first assumption must hold otherwise the best way to make the health service responsive to the consumer is to abandon public healthcare provision and meet the equity objectives of the NHS by giving transfer payments (either in the form of cash payments or vouchers) to the poor and let people decide which health care to buy. Only if both these assumptions hold will it be possible by eliciting public perceptions to produce a more efficient healthcare service.

> Rationing is painful, complicated, and difficult

On the other hand, if you assume that if people who cannot make an efficient choice about their own health care are also unlikely to be able to ration healthcare delivery to the population efficiently then we may end up with the worst of both worlds. Assuming the views of the public are actually used rather than seen to be used then the healthcare system could end up being as inefficient as one in the private market but without the relative freedom of choice a market offers. Thus, resources could be diverted into popular medical procedures that at best might be effective, but horrendously expensive, and at worst expensive and harmful.

Rationing is painful, complicated, and difficult. Involving the public may result in inefficient use of resources. From the published surveys of public opinion on priority setting the results tend to be fairly predictable. Questionnaire surveys show that smokers, drug users, heavy drinkers, and the elderly should receive lower priority than other people. Clearly, if "local voices" give the wrong answer healthcare managers can ignore them. If this is the case the only inefficiency will be the money that is wasted soliciting public opinion.

David J Torgerson *senior research fellow, University of York*
Toby Gosden *research fellow, University of Manchester*

Competing interests: None declared.
Funding: The National Primary Care Research and Development Centre at the University of Manchester (TG) is funded by the Department of Health, but this articles does not express the views of the Department of Health. DJT is partially self funded from research grants and by the University of York.

SOUNDINGS

Why seeing a patient after the counsellor is so difficult

"I know now that I haven't resolved my inner conflicts. I have to come to terms with the emotional violence I've suffered and learn to do what *I* want to do." The "*I*" is always italicised in the inflection. "My counsellor says that I am far too generous and must learn to live life on *my* terms."

Why is it that we feel such profound fatigue when faced with the regurgitated views of the counsellor? It is not because the statements are necessarily wrong or invalid, merely that, repeated so frequently to hordes of moderately dissatisfied people, they seem to become almost totally devoid of meaning. It is as though the counsellor has dipped his or her hand into the cookie jar of aphorisms labelled "dissatisfied housewife" and come out with a series of brightly coloured platitudes.

The difficulty is that once we have subscribed to a particular, usually simplified version of reality, it is often impossible to experience the world without those blinkered preconceptions. I am reminded of something that John Mortimer wrote in his autobiographical *Clinging to the wreckage*. As the curtain fell on the opening night of his play about his father, he realised that he had lost something. In the process of creating lines for the stage character he found that he could no longer remember what his father had actually said, and what he had created for him. Something is always lost in the process of articulation. In talking about ourselves, we risk creating fiction.

It seems to me that talking about yourself, in any way, with anyone, is actually rather hazardous, and that perhaps we do too much of it now. My parents came from a generation to whom discussion of their feelings was something for which they had almost no vocabulary. But perhaps because they couldn't articulate their feelings they also did not degrade them. They did not pulverise their emotions in order to fit them into the same shaped boxes as some celebrity in *Hello* magazine.

The trouble is that the words we use to describe the world ultimately constrain the way we feel about it and the way we see it. Before embarking on a voyage of self discovery, or helping another on the same path, I would be mindful of Einstein's aphorism: "You should strive to make things as simple as possible, but no simpler."

Kevin Barraclough *general practitioner, Painswick, Gloucestershire*