

In Britain a recent letter from the chief medical officer has advised against breast feeding for HIV positive women.⁸ It gave no specific advice (beyond suggesting follow up counselling and testing) for women who were HIV negative but at risk. Yet these may be the group most likely to transmit HIV through breast feeding.

Where wet nurses are used there is another problem. HIV has been passed not only from a wet nurse to a child but also in the opposite direction.⁶ In the Soviet Union seven breast feeding mothers seroconverted after their babies had been infected through reuse of injection equipment. All seven babies had stomatitis and bleeding gums (V V Pokrovsky, E U Eramova, fifth international conference on AIDS, Montreal, 1989). As more mothers die and more babies receive infected transfusions, transmission to and from wet nurses may become important in the spread of HIV, especially in developing countries.

Given that the risk of transmission through breast milk seems highest for babies whose mothers seroconvert after delivery, the small additional risk for the baby born to a mother with established HIV infection may be outweighed by the benefits of breast feeding. This is especially true in

developing countries, where maternal antibodies are important in preventing neonatal infections.

It must be the mother's decision whether or not to breast feed. The doctor's responsibility is to explain as fully as possible the current medical evidence and to discuss it in relation to each woman's social and medical circumstances.

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Self assessment and medical audit: an educational approach

Lessons from the Wessex course for trainers

The concept of medical audit has acquired two quite different interpretations. In one it is seen as the collection of numerical clinical data for evaluation through peer review against a background of predetermined criteria.^{1,3} The other—supported by the General Medical Council—takes a more educational approach and emphasises the assessment by individual doctors of their own clinical practice.^{4,5} I want to support this second view. At its heart audit should be concerned with taking note of what we do, learning from it, and changing if necessary. Fundamentally, it is educational. Self assessment is crucial to effective audit, but I suggest that it will not occur automatically through peer review alone.

People learn best when they are helped to define their own problems, acknowledge and accept their strengths and weaknesses, decide on a course of action, and evaluate the consequences of their decisions.⁶ Such self evaluation is at the heart of education.⁷ It does not, however, mean using self administered tests to determine knowledge and skills; what it does mean is helping people to judge their own performance. In reality much medical education is still off target⁸; many doctors report that their assessment as students was highly threatening and often humiliating. The danger with peer review is that either it will become collusive or it will be avoided altogether. A recent conference was told that at audits junior doctors often remain silent and some request audit sessions separate from their consultant colleagues (Association for the Study of Medical Education conference on medical audit, May 1989).

Thus for audit to become educational both insight and self esteem must be developed. This will require open relationships to be fostered among the participants.⁹ The process has been developed in the Wessex region's course for general practice "training the trainers," which has evolved an approach to audit by emphasising self assessment through peer review.

It is based on the educational principles that should (but often do not) lie at the heart of medical audit:

- Firstly, a clinician presents to a group of about half a dozen colleagues a video of a recent consultation with a patient; thus some "practice" is presented for critical reflection
- Immediately, people declare their feelings (positive and negative) about the consultation, and they must be permitted to express and "own" their emotions
- The good points concerning the consultation are listed, as are those that did not go so well, and the rules of constructive feedback are obeyed
- The presenter gives his views and opinions before those of his colleagues and records these for all to see for further discussion: the approach is learner centred yet public
- The group facilitates this process in a supportive, collaborative, and cooperative yet critical atmosphere
- Next the presenter identifies his "wants," including what he now sees himself as wanting to know, to know about, or to do differently regarding the consultation, thus stating his own learning objectives
- Group members declare what they see as the presenter's "needs," that is, anything the presenter did not identify as his "wants," thus additional learning objectives are set by peers
- The presenter is encouraged to discuss any differences between these wants and needs and to negotiate priorities and deal with them in some appropriate way, not necessarily there and then—a process that might include gathering further numerical data in a wider survey
- Finally, the presenter and then the group declare what has (and what should have) been learnt in this exercise, what still

requires attention, and what will now happen as a result of it, thus crystallising and confirming the outcomes.

Our experience is that participants find that this approach leads to their developing a learner centred rather than a teacher centred approach to their training.⁷ As a result they see how important it is for trainees to define their own learning objectives and that the trainer's task is to facilitate learning rather than directly to teach people what he or she thinks they ought to know. Although the scheme is unusual and quite unlike their previous experience of medical education, participants find it surprisingly unthreatening and learn a great deal about different ways of teaching. They also report new insights into their own consulting skills and often suggest that patients should play a greater part in diagnosis and management. They find, too, that their knowledge has increased despite not a single lecture having been given. Most speak of seeing the value of being open and constructively critical with their colleagues and of being helped by their peers to recognise the strengths and acknowledge the weaknesses in their professional practice.

In this approach the criteria for evaluating practice, the learning objectives, and the means for achieving change all emerge during the process—they are not defined beforehand or imposed on the participants in the course. And as they have a sense of ownership for these end points they feel more positive about their implementation. Next—and this is very important—the self assessment process provides a sound foundation for more conventional audits. By going through it participants report being more able to declare misgivings about their own consultations and to discuss with their peers general issues of clinical practice.

The essence of this approach is a reflection on actual practice^{10 11}—unlike much medical audit, which often reviews only abstractions of practice. Moreover, it can be generalised and adopted for other parts of medicine. It is clear too that each step in the process depends on the successful resolution of the previous one. Audit should proceed from the particular to the general and from concrete personal experience to abstract collective responsibility, but people need some means for doing so.

Those who advocate audit through peer review may claim that self assessment is implicit in their approach, but this is often not so. Introducing people to a simple procedure for self assessment such as the one described above, however, can make audit truly educative.

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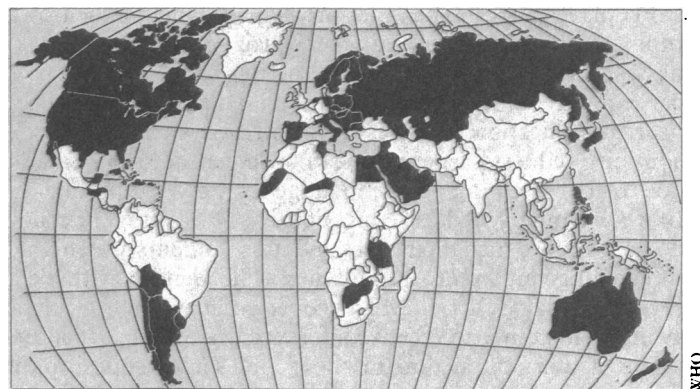
Regular Review

Immunisation: causes of failure and strategies and tactics for success

Strong professional commitment is the key

Immunisation of children is one of the most cost effective activities in health care. Impressive benefit to cost ratios have been shown in the United States for measles (12:1), rubella (8:1), and whooping cough (11:1).^{1 2} Measles vaccine is also cost effective in Britain,³ and there is no reason to believe that similar benefits would not also apply for whooping cough. In Britain protection against polio, diphtheria, and tetanus has made all three rare, though a few cases still occur among the unprotected.^{4 5} Cost-benefit ratios for these rare diseases are harder to calculate, but it would be unacceptable to stop immunisation as epidemics would inevitably return after importation of infection from abroad, and the costs can be carried by the more economic parts of the programme.

The World Health Organisation has set a target for the year 2000 for the protection of all children by immunisation; it argues that a decision to withhold immunisation should be taken only after serious consideration of the potential consequences for the individual child and the community.⁶ For countries in Europe a target uptake has been set of 90% by 1990 for the primary immunisation series.⁷ Britain's performance is worse than most industrialised nations and even some developing countries (figure): only a handful of



Countries with better measles completion percentages than Britain, 1987

health districts have achieved the 90% target for measles, and no district has reached 90% coverage for diphtheria, pertussis, and tetanus immunisation.

And yet there is good evidence that effective and enthusiastic services will achieve a good uptake even in the face of socioeconomic deprivation and parental uncertainty.⁸ The