reviews

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Addicted

Tony Adams, Ian Ridley

Collins Willow, £16.99,
pp 288
ISBN 0 00218794 9

Rating: ★★

Raymond Carver was one of the most elegant and lyrical writers about alcoholism and its corrosion of the human spirit. His solid evocation of ordinary life in recovery is inspirational. His gritty body of work, produced in the years before he died prematurely of cancer, is a gift to the world grabbed from the throes of self destruction. The same cannot be said of much of the torrent of self confessional autobiographies that have sprung from the recovery movement and flourished in this era of Oprah-like emotional transparency. However, some of these

stories, such as Julia Phillip's *You Will Never Eat Lunch In This Town Again*—a salacious account of her crawl through a drug infested Hollywood—will undoubtedly become part of modern social history.

And now Tony Adams, the outstanding captain of the Arsenal and England soccer teams, describes his experience of addiction and recovery. The book, cowritten with Ian Ridley, is thankfully not another grim tale of degradation with no details spared. Rather, it is an autobiography that focuses on the core of his career and his aspirations to be a soccer star. The narrow, driven world of young soccer players is described, where everything is football, football, and more football. Virtually no consideration seems to have been given to the notion that these youngsters might benefit from a broader education that would serve them beyond their playing career and potentially buffer them from alcohol being their single recreational activity. Adams describes his struggle and soccer performance in detail, with a post-match analysis of many of the critical games in his career.

Along the way, he manages to get sent to prison for drinking and driving, and his wife

develops a major drug problem, for which she seeks residential rehabilitation and then becomes involved in Narcotics Anonymous. Despite this, he continues drinking, with episodes of bingeing between training and matches. His Arsenal world will be familiar to fans of Nick Hornby, but this is no “high fidelity,” introspective text. He provides a dispassionate account of the grip alcohol had on his life and his lack of capacity to attend to the needs of his children and the rest of his family. And he also outlines his then rapidly fading and currently impressive soccer performance.

This book is courageous in its exposure of the more impaired side of his life and his capacity, through treatment and self help, to regain control. It's a message to many people in a culture where football and alcohol are synonymous that there is always the possibility of a different life. The devoted soccer fan will find much to read and think about in this work. As with much of this type of literature, it may just help some people to take the first step.

Michael Farrell, senior lecturer, National Addiction Centre, London

Evaluating Health Promotion

Ed David Scott, Ross Weston

Stanley Thornes, £18, pp 176
ISBN 07487 33132

Rating: ★★★

This is a collection of essays that provide a range of perspectives on evaluation. Readers hoping for practical advice on how to conduct an evaluation will be disappointed. The target audience for the book is not clearly defined, but it is certainly not those with a peripheral or early interest in evaluating health promotion programmes. The book instead takes the reader on a tour of different models, evaluation designs, and measures of success for the purpose of enriching debate.

The opening chapters are hard work, especially for readers unfamiliar with the jargon of postmodernism and educational

research. There are, however, rewards for those with the commitment to wade through these difficult passages. They provide a snapshot of the different perspectives to the research task (such as medical, educational, political radical, etc) and consider the relative merits of qualitative and quantitative research and the notion of an evaluator as a neutral observer of phenomena. The closing chapters are equally demanding of the reader in examining ethical issues in research and considering the conversion of theory into practice.

Sandwiched between these essays from the editors are the “meaty” contributions from several experienced and respected health promotion researchers and practitioners. Chapters by Keith Tones and Viv Speller set out, in a more readable form, many of the fundamental methodological and practical issues that make evaluating health promotion programmes a complex and dangerous task for researchers. Both authors make the point that there is often a trade off between what is desirable from the researcher's perspective (maximum definition and control over all intervention) and what is desirable from the

perspective of a health worker and the community (loose definition of programme content and sequence, but good procedures for quality control). Both identify the folly of evaluating programmes that are so narrowly defined or so highly refined as to be ineffective or impossible to reproduce. Bad interventions generate bad results, however good the evaluation design.

The chapters by the more established authors are almost entirely derived from previously published work. In this sense the book does not add a great deal to what has already been written on evaluating health promotion. However, its diversity is a strength, offering in one volume what would otherwise take time to gather through a literature search.

Overall, the strongest message that emerges is that the search for a “definitive study” in health promotion is illusory. Tones argues that methodological pluralism is not only acceptable but essential. Advances in knowledge in health promotion will continue to be developed in an incremental process, with the best available evidence derived from a range of different study designs and methodologies.

Don Nutbeam, professor of public health, Department of Public Health and Community Medicine, University of Sydney, Australia

Reviews are rated on a 4 star scale
(4=excellent)

The Spine and Medical Negligence

R W Porter

Bios Scientific, £19.95, pp 200
ISBN 1 85996 126 6

Rating: ★★★★★

Since 1991 the cost of medical negligence in the United Kingdom has risen fivefold—it costs the NHS over £300m a year. Fortunately, there is no evidence of any fall in clinical standards. The proportion of claims that are settled with payment of compensation to patients has in fact fallen from 34% in 1975 to 25% in 1997.

The medical profession cannot afford to be complacent, however, and even less so can orthopaedic surgeons, who regularly feature at the top of tables of claims. Clinical risk management is here to stay, and NHS trusts are adopting programmes of risk management to reduce the number of accidents to patients.

Professor Porter has done his colleagues great service in setting out the important issues surrounding consent, counselling, operative technique, and pitfalls where mismanagement can cause major neurological damage and costly disability.

The chapters on why patients sue, the legal process, informed consent, and risk management are worthy of any medicolegal textbook, but I was particularly taken with the many case reports emphasising the dangers behind clinical scenarios.

Four messages emerge: reliance on conservative surgery when anything more could not guarantee a better result; the importance of patient selection for difficult revisional surgery, coupled with the choice of an experienced centre; the great need for informed consent about difficult and highly technical procedures; and the obligation to educate patients about the reality of medical practice, as medicine cannot completely remedy every clinical problem.

Responding to a lawsuit may be one of the most stressful times of a doctor's life. Some allegations will be ill-founded because the undesirable outcome stemmed from the natural course of the disease or from a well known and unavoidable complication, but much morbidity and the consequent litigation is avoidable—how nice to be told how in such a measured and effective way.

Patrick Hoyte, deputy head of advisory services, Medical Defence Union, Manchester

Elsie Inglis

Leah Leneman

NMS Publishing, £5.99, pp 94
ISBN 1 901663 09 4

Rating: ★★

“My good lady, go home and sit still,” was the rebuff issued to Dr Elsie Inglis, licentiate of the Royal Colleges of Glasgow and Edinburgh, with 16 years of hospital experience behind her, when she offered her services to the Royal Army Medical Corps at the outbreak of the first world war. As this biography points out, “there was nothing personal in this, men considered war to be their business, not that of the ‘weaker’ sex.” In 1916, “when the shortage of male doctors was so acute that medical women had to be recruited, they were kept well away from the front line and were never granted officer status.” The Scottish Women's Hospitals for Foreign Service, however, led by Dr Inglis, was one example, running field hospitals and dressing stations in France, Serbia, Turkey, and Russia.

Elsie Inglis was born in India in 1864, trained in Edinburgh, and then worked in obstetrics and gynaecology. She was inspired by patriotism and the need to show that medical women did not have to be restricted to gynaecology and paediatrics. Her committee raised money, and the first hospital was set up in Paris in 1914. Their duties involved operating on and caring for the wounded, infection control, and arranging clean water and sewage control. The book describes the courage shown by Dr Inglis in the face of intimidation and accusations of spying. Her efforts were often not supported and sometimes obstructed by the British War Office, but the efforts of her team in maintaining high standards of asepsis and surgery in appalling conditions were recognised.

Compared with the body of literature concerning Florence Nightingale and other pioneering nurses, little has been written about the role of women doctors in the first world war. “To remember and to teach children about the achievements of Dr Elsie Inglis and the Scottish Women's Hospitals would have been to acknowledge that medical women were every bit as capable as men.”

Melinda Tenant-Flowers, consultant physician in HIV/GU medicine, King's College Hospital, London

On-the-Job Training for Physicians

David H Hargreaves, Geoff W Southworth, Paula Stanley, Simon J Ward

Royal Society of Medicine Press, £17.50, pp 151
ISBN 1 85315 325 7

Rating: ★★★

How can satisfactory training be provided in limited time when there are competing demands from clinical workload? This is the perennial question that this book sets out to address.

The authors argue that the answer is to “make learning of medicine more effective and more efficient.” Their concept is of training that is “combined with, and runs alongside, service delivery.” But this is not the traditional model of “apprenticeship by osmosis”; instead they advocate “apprenticeship by coaching,” in which training is “intentional, planned, monitored and followed up.”

The book is about developing partnerships between trainers and trainees; just as trainers have an obligation to provide teach-

ing, trainees have a responsibility to be committed to learning. The authors keep this balance in focus, and are careful to avoid being critical. Instead they offer constructive advice about how training opportunities can be derived from all aspects of daily clinical work.

Their examples come from a variety of clinical settings. The text is sprinkled with quotes from practising clinicians that range from the reactionary to the radical, including illuminating references ranging from Geoffrey Chaucer to Kenneth Calman.

Consultants are given techniques for asking questions and imparting information effectively, junior doctors are introduced to developing and implementing training plans, and there are tips about giving and receiving feedback, probably the most sensitive aspect of the relationship. Although some of the ideas have been discussed before, the clear and concise presentation produces a persuasive argument: with minimal effort and no extra money, postgraduate medical education really can be improved.

In the end, of course, there is no alternative. The duration of training may be further restricted by the European working time directive, and the service workload is not going to disappear to allow time for more teaching. The only option is to make sure that all the training that takes place is of the highest quality. Anything that helps clinicians to meet this challenge should be welcomed.

Richard Harling, editorial registrar, BMJ

George falls for Bill

After, at first, merely reporting the facts of the sacking of George Lundberg, editor of *JAMA* (the journal of the American Medical Association), the US media have come roaring back over the past two weeks, realising the link with the Clinton impeachment trial. Editorialists brandished scalpels as they castigated the association for its removal of one of the finest editors of *JAMA* in its 115 year history.

Lundberg was fired on 15 January by the association's executive vice president, E Rattcliffe Anderson Jr, after he rapidly pushed through a brief report that showed that 59% of US college students did not consider orogenital contact to be "sex." Leaders of the American Medical Association pulled together to defend the firing, which, they say, injected the journal into the impeachment trial. In providing an explanation worthy of Orwell, Anderson said that, despite his firing of Lundberg, the association was not censoring *JAMA*; it was protecting its integrity.

At least 53 metropolitan newspapers reported the firing on their front pages. It

seemed that the firing came on an otherwise non-newsworthy day, as the Senate was privately debating how to conduct the trial of the president, who is accused of perjury when he denied having "sex" with a White House aide. In the fast moving world of the broadcast media, Lundberg's sacking was the lead story for at least three hours.

Despite the widespread coverage, most journalists forgot to ask why Lundberg was fired—why the American Medical Association had "lost confidence in him." Rarely mentioned was that during his 17 year tenure Lundberg had taken a journal that was a second rate mouthpiece for the association and turned it into one of the "big five" medical journals worldwide. Lundberg turned *JAMA* into a relatively easy to read journal that reached out to clinicians in the United States and overseas, where it is published in 17 foreign languages.

The media generally chose to quote Anderson's statement that "I have lost confidence in him" and "it was the final straw." They failed to report how Lundberg had angered the association through his independence. Several years ago, for example, he published an unsigned essay called "It's over, Debbie," in which a physician recalled how he carried out euthanasia while he was a trainee. That article caused a furore within the association, with some leaders, and even some medical ethicists, calling for Lundberg's firing. Analysis of alternative medi-

cine, long labelled as "quackery" by the association, was given an entire edition of the journal in January 1998.

Medical editors around the world, however, did not remain quiet. Some of the sternest words came from the *Lancet's* editor, Richard Horton, who reviewed the years of tension between the association and its journal: "If Lundberg goes, the only honourable thing for the AMA to do is to get rid of the man who fired him."

Richard Smith, editor of the *BMJ*, pointed out that the American Medical Association's membership has steadily fallen to 38% of US doctors; the controversy may well speed up the trend, as doctors move away from the conservative association and toward more progressive specialty groups such as the American College of Physicians and American Society of Internal Medicine. As of last week, the *BMJ's* website had received 34 readers' responses on the subject: 33 criticised the American Medical Association, and one defended it. The association said that it received more than 500 emails the week after Lundberg was fired, but it said only that "a majority" opposed the association's position.

The *New England Journal of Medicine's* Marcia Angell was smug about the whole affair. "The truth is that the report was trivial and irrelevant," she wrote in the *Boston Globe*. But she criticised the association's overzealousness in dumping Lundberg. The correct response would have been to follow up the article with a critical commentary from the association's leadership, which, she said, could have criticised Lundberg's action even while affirming his editorial independence.

Finally, 10 days after the firing, US mass media editors began to speak up. Almost all, including right wing papers such as the *Wall Street Journal*, lined up to oppose the association's behaviour. The *New York Post* put it plainly: "I haven't heard recently of any editor being fired for being relevant about what's going on in the world." The whole affair was an exercise in hypocrisy, according to the *St Louis Post-Dispatch*. "In the past decade, the American Medical Association Political Action Committee has given more than US\$14 million to House and Senate candidates, with about two-thirds going to Republicans."

Robert Reno, writing in *Newsday*, echoed the hypocrisy theme by describing how the American Medical Association has injected itself into politics for decades by calling every health reform bill "socialised medicine." Now, as doctors are squeezed by private, for profit, managed care insurers, the organisation is seeking government's help. "And don't we all wish them well in their newly discovered social democratic enlightenment," he wrote. Finally, *Boston Globe* columnist Ellen Goodman observed that it was strange that the first person to lose his job in the impeachment trial was a doctor.

John Roberts, general internist, Washington, USA

WEBSITE OF THE WEEK

<http://www.maff.gov.uk/food/novel/acnfp.htm> This week's announcement of a new food regulatory body separate from the Ministry of Agriculture, Fisheries, and Food is recognition of the ministry's conflict of interest as it tries to represent consumers and producers alike. Its previous solution was to be "open," and, indeed, its advisory committee on novel and foods and processes (sic) posts its minutes on the web. The top story at the moment is that data from supermarket clubcards will be used for postmarketing surveillance on the so called "Frankenfoods," produce from genetically modified plants that include segments of bacterial, viral, or animal DNA (<http://www.newscientist.com/nsplus/insight/gmworld/gmfood/fruit.html>).

If civilisation advances by extending the number of operations we can perform without thinking, the necessity for debate on something as fundamental as food perhaps represents a decline in the quality of our lives. Still, partisans make the best websites, and neither Monsanto (<http://www.monsanto.co.uk/>), a commercial supplier of genetically modified organisms, nor Friends of the Earth (<http://www.foe.org.uk/>) can be faulted on either design or access to up to date content.

You can judge the success of their lobbying by reading Hansard on line at <http://www.parliament.the-stationery-office.co.uk/>, where the niceties of parliamentary procedure mean that the first 50 or so words of any transcript included in the automated headers is irritatingly content-free.

International perspectives can be found at the respected Centre for Food Safety and Applied Nutrition (<http://vm.cfsan.fda.gov/list.html>), which, unusually for a large organisation, has a useful set of high quality links near the top of its site. (Corporations please note: good links mean that users may leave, but they're also more likely to come back.)

Douglas Carnall
<http://www.carnall.demon.co.uk>

PERSONAL VIEW

Should we accept all comers?

In the 1980s, when general practice was popular, selecting applicants to vocational training schemes was a matter of picking the best from an excess of good candidates. If competition raises standards the converse must also be true. So now that fewer doctors want a career in general practice, the overall calibre of applicants is falling, and it is essential that standards be set for accepting doctors on to vocational training schemes.

Training schemes have a dilemma: faced with a palpable need to train more general practitioners, should they accept all comers or apply entry thresholds? If we set thresholds what minimum criteria should we apply? There are two major considerations: clinical competence and communication skills.

General practice accepts entry to training without membership of a professional college—specifically the Royal College of General Practitioners (RCGP). Anyone with full General Medical Council (GMC) registration can apply. The difference between the entry requirements to specialist training—the specialist registrar (SpR) grade—and to general practice vocational training schemes is striking. Membership of a professional college is mandatory for career progress in all specialties, whereas membership of the RCGP is a voluntary feather in the cap usually achieved at the end of training.

But what of entry criteria for general practice training? At the moment “satisfactory” (whatever that means) completion of the preregistration year is a good enough standard for acceptance on to a vocational training scheme. This is intolerable and merely reflects the fact that general practice training has been preserved in aspic since the early 1970s. Only one year is spent in a practice setting. The other two years are spent in a mix of senior house officer posts, designed for those destined for the secondary care sector. General practice is now the only area of medicine that has its formal training grade at the senior house officer level. The Joint Committee for Postgraduate Training in General Practice should grasp this nettle and work with the RCGP to introduce a first part to its membership examination—an assessment which should become an entry criterion to general practice.

Good communication skills are the core of medical practice. Nevertheless, communication skills teaching remains a poorly developed area in many undergraduate cur-

riculums, despite the call for a greater emphasis. Even at entry to training schemes many registrars have minimum development of communication ability. But good communication is secondary to language competency. The ability to clearly understand a patient and to impart information is a fundamental skill, which is valued highly by the GMC and would be a measure of a doctor's performance, if it were called into question. While it is accepted that training should develop communication skills, it cannot deliver basic language ability. It is logical therefore that competency in English is an essential minimum entry criterion for UK general practice.

General practice should no longer tolerate being perceived as the easy option

The National Advice Centre for Postgraduate Medical Education provides advice on postgraduate training to doctors who have qualified outside the UK. It states that: “European Economic Area (EEA) doctors are not obliged to take the Professional and Linguistic Assessment Board test for registration purposes but they may be required by their prospective employer, as a condition of employment in the UK, to produce evidence of a satisfactory standard of English.” The Department of Health has issued guidance stating that it is the responsibility of the employer to ensure appropriate registration, qualification, and ability in the language concerned.

To require EEA nationals to sit and pass a language examination could be viewed as unfair, unless every candidate were required to do so. This would apply equally to UK graduates with GCE or GCSE passes in English. The approach towards applicants to undergraduate medical courses merits consideration. All candidates for UK medical schools must achieve an acceptable level of competence in English. For UK nationals the usual standard is the GCSE and for those entering from overseas it is usually a satisfactory pass in the International English Language Testing System examination.

The arguments put forward lead to a clear conclusion: general practice should no longer tolerate being perceived as the easy option and needs to take a fresh look at its career structure. Basic language ability and communication skills should be assessed at selection by means of a first part royal college examination using written papers and video analysis of consultations with simulated patients, techniques which are now well validated. Surely the time has come to define the entry threshold for further training across the board and into general practice in particular.

Malcolm Lewis, vocational training scheme course organiser, Swansea, and **Glyn J Elwyn**, senior lecturer in general practice, Cardiff

SOUNDINGS

In which we served

I first set foot in one almost 30 years ago. The Royal Naval Hospital (RNH) Gibraltar, a colonial delight perched high on the rock, seemed a perfect place to work: old fashioned, easy going, and distinctly underutilised. I was just visiting, paying my respects as a lowly seaborne reservist to a surgeon captain who welcomed me kindly.

Later I served there as a locum physician. The other three doctors were an anaesthetist, a surgeon, and an obstetrics and gynaecology man, so my remit ran from neonatology through general medicine to things like psychiatry and dermatology. A little worrying, but fortunately very little happened.

RNH Malta was more serious, a vast colonnaded block high on the quiet side of the island. In summer in the mid-1970s naval hospital medicine at Mtarfa still ran at an agreeable colonial pace. Doctors drifted around in the mornings in white shirts and shorts, like ethereal boy scouts, and were little to be seen in the afternoons. I learnt quite a lot. It closed long ago.

There was even a naval hospital in Mauritius. I tried quite hard to check it out, suggesting to the appointer, as only a reservist could, that a couple of months there might help me make up my mind about signing on as a regular. He was fairly desperate—even his Irishmen were leaving—but we compromised instead on the Malta posting. But I still wonder sometimes what RNH Mauritius—also of course now closed—was really like.

In May 1982 RNH Devonport was eerily empty, cleared for the hundreds of Falklands casualties that never came. Each night we watched the war on the six o'clock news. On Sundays the hospital chapel was full and the naval hymn, “O hear us when we cry to thee for those in peril on the sea,” was sung with real feeling. The hospital has since closed.

Now the Royal Hospital Haslar, once the biggest and best, is to go too. In a few years the long RNH tradition of service and eccentricity will finally vanish and thousands of doctors who were part of it, even briefly and sometimes unwillingly, will sense the loss. The charm of the naval hospitals lay in their being just a little behind the times, generally never too busy, and always part of a greater service whose traditions they shared. Clabby, orderly, quaint, and decently resourced, they were everything that the current frontline NHS is not—clearly the reason they had to go, but a reason also to mourn their passing.

Colin Douglas, doctor and novelist, Edinburgh

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