reviews

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Medics face the music

Why doctors and students are rushing to a new musical

A Canção de Lisboa (The Lisbon Song), a musical showing at the Politeama Theatre, Rua das Portas de Santo Antão, 109, Lisbon, Portugal, until 28 May 2006
Email: Teatro.politeama@netc.pt

Rating: ★★★★★

One of the first things I was told when I entered medical school was to see the 1933 film *A Canção de Lisboa* (The Lisbon Song). I didn't have to wait too long, for, just like *The Sound of Music*, it is regularly shown on national television in Portugal at Christmas. Now a stage musical adaptation of the film is running at Lisbon's Teatro Politeama and is pulling in crowds from all over the country. So what is its special appeal to doctors and medical students?

The Lisbon Song is a story about Vasco, a medical student in Lisbon, who is about to graduate but fails his final examination, a viva. Vasco is supported by a couple of rich aunts living in the remote countryside and is unable to tell them about his failure. He instead says that he graduated, whereupon his aunts assume that Vasco will have started his own successful practice and decide to visit him in Lisbon.

Traditional: a still from the film

And thus a single event unfolds into several parallel stories. Vasco tries all sorts of diversions, lies, and schemes to avoid having to show his practice to his aunts—for example, by taking them to the zoo. He is also a party animal, a lover of the good life and its pleasures rather than of his medical studies, and he vies with a classmate for the love of Alice, a tailor whose father cannot stand Vasco.

Brought to the stage by Filipe La Féria, a well known Portuguese producer, director, and writer, the current production is spectacular, with magnificent scenery, and delightful singing and dancing. In the viva scene, a panel of three intimidating professors towers some 10 metres above the ground in their huge chairs to question Vasco, their height symbolising their superior and almost untouchable status in an era when there was more formality and ceremony attached to this never easy student ritual than there is today, with relatives, friends, and colleagues often present to watch the exam.

Traditional Portuguese culture provides a constant backdrop, with scenes set in the old neighbourhoods of Lisbon, with their traditional stores, street parties, and Fado, the unique Portuguese melancholic music sung to a guitar accompaniment.

For medical students and doctors alike, the show's portrayal of Portuguese academic traditions—such as medical students wearing typical ornate black overcoats still used today in all sorts of university related events—is likely to create a feeling of déjà vu.

In the end, Vasco's lie is uncovered, despite all his efforts, and his aunts turn their backs on him. However, he overcomes that setback, by resitting his exam before the same panel that had previously failed him and passing it impressively (and so becoming a doctor). The final question of his exam, "What is the name of the neck's main muscle involved in lateral flexion?" has become the stuff of legend in

Bringing anatomy to the masses: a poster for the show

Portugal, and suprisingly most people in the country today know what the sternocleidomastoid is.

Vasco also regains his love (for Alice, meanwhile, had fallen into his classmate's arms). He also wins back his aunts' respect.

Perhaps the take-home message for the medic is that you can, with both commitment and luck playing their parts, have time for everything during medical school. Vasco might not, however, seem an appropriate role model today.

The glitter, cheerfulness, and genuine Portuguese soul and spirit reflected in this show (and which wins out over the melancholy of Fado) brings an acclaimed work back to life. Were it performed in English, *A Canção de Lisboa* might well deserve a slot on Broadway. As it is, anyone not familiar with the Lusophone pitch can follow the plot with the help of the small screen above the stage, which supplies a written summary of each act in English.

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Items reviewed are rated on a 4 star scale
(4=excellent)

PERSONAL VIEWS

When lecturers need patient consent

Medical ethics places much emphasis on patients' autonomy and the importance of informed consent, exemplified by detailed guidance on consent for clinical treatment or investigation and for research. Consent (or lack of it) is also relevant when students and doctors learn, and when medical journals publish educational case reports. The use of patients' information in medical presentations, however, seems to be largely ignored. For example, of nine royal colleges (of 13 contacted) replying to inquiries I made in preparing this article, only one issued specific guidance to lecturers about showing patients' photographs at its meetings—although one was considering it as a result. A further two colleges referred, on their websites, to the General Medical Council's guidance on audiovisual recordings of patients (www.gmc-uk.org/guidance/library/making_audiovisual.asp), and the website of one college referred to similar guidance issued by the BMA ([www.bma.org.uk/apnsf/AttachmentsByTitle/PDFAVrecordings/\\$FILE/AV.pdf](http://www.bma.org.uk/apnsf/AttachmentsByTitle/PDFAVrecordings/$FILE/AV.pdf)). None of the three US colleges that replied (of eight contacted) issued guidance to speakers, although all referred to US legislation governing patients' confidentiality (www.hhs.gov/ocr/hipaa).

The guidelines of both the GMC and the BMA cover audiovisual recordings in general, not just for educational purposes. Both stress the importance of preserving anonymity and conclude that if patients cannot be identified it is acceptable to use their images without consent for teaching. However, the GMC distinguishes anonymised information to which the public may have access. It says that consent would be needed for such information because patients' anonymity cannot be guaranteed (apart from images of tissue samples, radiological and similar examinations, and laparoscopic views), whereas consent would not be required if the same recordings were used just for teaching. Conversely, the *BMJ*'s policy (*BMJ* 2004;329:566-8) is that patients' consent should be obtained for "publication of any personal information about a patient" except for certain defined situations, and this reflects the stance taken in the guidelines of organisations such as the International Committee of Medical Journal Editors (www.icmje.org/index.html#privacy) and the UK Committee on Publication Ethics (www.publicationethics.org.uk/guidelines/code).

The ethical principles relating to the use of patients' information in lectures are similar to those relating to using it in other

contexts and can be considered in terms of benefits and harms. There are benefits to doctors and, through them, to society and future patients from presenting educational material, and the value of presentations is often enhanced by including patients' information, such as clinical details, photographs, blood test results, and pathological slides. Conversely, it is wrong to use patients (or indeed anyone) as means to an end and to disrespect their autonomy by, for example, using photographs of them without their permission. Breaching the confidentiality of the doctor-patient relationship is a further, related harm. (However, the two are not synonymous. For example, unconscious patients are non-autonomous, but the duty to respect their confidentiality still applies.)

The difficulty is that upholding these principles to extremes can pose practical problems. Strictly, using any information (even trivial, such as a blood gas test result)

Strictly, using any information without consent represents disrespect for autonomy

without consent represents disrespect for autonomy and is a breach of confidentiality—even if the information presented is totally anonymous (as it still arises from a confidential professional encounter). It is insufficient to use anonymity alone as a yardstick for deciding whether or not presenting data without

consent is acceptable, for although anonymity may reduce the magnitude of the harm it nevertheless remains a harm. A logical and practical approach demands consideration of the benefits and harms of each proposed use of information—as is implied by guidance on publication of case reports—rather than reliance on generalised rules.

Firstly, before using patients' information in a lecture—whether photographs, personal details, or the results of investigations—the lecturer must maximise the benefits by ensuring that its inclusion is really necessary to convey the desired message. Too often, for example, the easy availability of digital cameras and the seduction of PowerPoint slides may override the judicious inclusion of appropriate graphics (let alone create the potential for copying and dissemination of patients' information).

Secondly, the potential harms must be considered. These may be smaller in a lecture than when details are published in a journal, but they are harms nonetheless and should be minimised by seeking patients' consent (and most patients do consent when asked (*BMJ* 1998;316:1009-11), minimising the amount of detail revealed, and preserving anonymity wherever possible—and using effective methods of doing so. If it is impossible to seek consent, the benefits of including the information may still outweigh the

harms, but this should be concluded as a result of the above analysis and not merely assumed. Finally, although the final responsibility must rest with the lecturer, organisers of meetings might consider publishing guidance to their contributors to avoid confusion and potential embarrassment.

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I am grateful to Roger Worthington for helpful comments.

SMY is a committee member of the Obstetric Anaesthetists' Association, which has recently considered issuing guidance to its lecturers, and a member of the Association of Anaesthetists of Great Britain and Ireland's working group on consent for anaesthesia.

Hit parade

bmj.com

These articles scored the most hits on the *BMJ*'s website in their first week of publication

MARCH

- 1 News: Severe adverse reactions prompt call for trial design changes**
BMJ 2006;332:683
5099 hits
- 2 Editorial: Screening for breast cancer**
BMJ 2006;332:499-500
4795 hits
- 3 Editor's choice: A big mistake**
BMJ 2006;332 (4 March)
4160 hits
- 4 Clinical review: Osteoarthritis**
BMJ 2006;332:639-42
3767 hits
- 5 Clinical review: Disorders of sodium balance**
BMJ 2006;332:702-5
3647 hits
- 6 Clinical review: Diagnosis and treatment of multiple sclerosis**
BMJ 2006;332:525-7
3487 hits
- 7 News: CMA draws criticism for sacking editors**
BMJ 2006;332:503
3400 hits
- 8 Editorial: Preventing coronary heart disease**
BMJ 2006;332:617-8
3092 hits
- 9 Research: Pattern of declining blood pressure across replicate population surveys of the WHO MONICA project, mid-1980s to mid-1990s, and the role of medication**
BMJ 2006;332:629-35
2970 hits
- 10 Editorial: Learning from the TGN1412 trial**
BMJ 2006;332:677-8
2886 hits

All articles cited are full text versions.

The French connection: how I found orthopaedic surgery on the internet

One Saturday last December I found myself unpacking my suitcase in a room in a French clinic, awaiting a hip resurfacing operation. How had I got to this stage? How was I going to communicate with the staff, whose command of English seemed to be about as good as my command of French—not wholly adequate? All the notices were in French, and I had little idea what was going to happen next.

I had been having increasing difficulty with my left leg for about three years. As a keen walker I had assumed my problem was soft tissue damage. In 2003 I was referred to an orthopaedic surgeon who thought, after reviewing the x ray pictures, that nothing needed to be done about my mild to moderate osteoarthritis.

Throughout 2004 and the first six months of 2005 the pain in my leg came and went and my mobility slowly decreased. At first it was gradual, but after a walking holiday in July 2005 the deterioration accelerated. It became impossible to walk any distance without pain. Standing and sitting were very uncomfortable, and the pain would keep me awake at night. Occasionally searing pain would suddenly drive up my leg to the pelvis, causing me to fear that my leg was about to give way, as it did on several occasions unexpectedly.

I could no longer tolerate the pain and immobility. I am 54 years old and work in a job where I sometimes need to be on my feet all day. My hip problems were seriously affecting the quality of my life.

I returned to my general practitioner in August 2005 and asked to be referred to a physiotherapist and for further radiography, together with a referral to a different consultant. These x rays showed significant deterioration.

At about this time delay started to become an issue. The waiting time to see an orthopaedic surgeon is four months, followed by a wait of about six months for surgery. Because of my age I was reluctant to undertake hip replacement and preferred hip resurfacing, so to hasten the process I asked to see a consultant privately. I was concerned I might be running out of time, as excessive deterioration of the femur would preclude the option of resurfacing. The consultant said he would study the x rays and write to me in a week. Four weeks later I eventually received his confirmation that the x rays showed the need to be urgent and that he would put me back into the NHS system.

I can't wait to see the orthopaedic surgeon's face when I tell him it has all been done

Exasperated at the continuing delays, I turned to the internet to research the possibility of having the operation abroad. There were four clear criteria in my choice: hip resurfacing experience, speed, price, and reinfection rates. My research showed that France and Belgium were the most realistic options.

I eventually selected a French doctor because of his extensive experience of total hip replacement and hip resurfacing, the possibility of surgery within 10 days, the price at just over 50% of the UK private fee, and the zero reinfection rate. All I needed was a copy of my x rays and a referral letter from my GP, who was surprised and a little sceptical until she realised I was determined.

So that is how I ended up in a French clinic. I ended up staying for two weeks—the standard time in France—having had a hip resurfacing operation, which has been entirely successful. The surgeon, a jolly man and clearly an expert, visited every day. Although I had daily doses of heparin I also had a phlebitis scan. The physiotherapist visited daily to check progress and set new challenges. The nurses regularly massaged potential bed sore locations. Dressings were changed every two days; half the stitches were removed on day 11 and the other half on my departure.

It has been a remarkable experience. I used the services of a UK company that specialises in joint replacement abroad to handle the travel, clinic bookings, and all my needs. They picked me up at my house and drove me to the clinic and back. Nothing was too much trouble, and the price was genuinely all inclusive. The only money I needed was €5 a day for access to the television in my room.

I am entirely satisfied with the quality and standard of the nursing care. Yes, you do need a basic knowledge of French to build rapport with the staff and to cope with the postoperative emotions, which can leave you feeling frustrated, anxious, and isolated. However, I met all my objectives: an urgent, high quality resurfacing procedure without reinfection at a reasonable price.

At the time of writing, 12 weeks after the initial private consultation with the UK orthopaedic surgeon, I have still not received the NHS appointment date. I can't wait to see his face when I tell him that it has all been done.

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SOUNDINGS

Bring back post-nominals

Dear Editor,

Catching up with my back numbers (I have a pile of unopened *BMJs* in the dining room) I was shocked to find in your issue of 4 April 1992 that letters like MB, MD, or FRCP will no longer appear after authors' names. You said: "The eagle-eyed will notice various small changes in this week's journal." Indeed we have, and may I be the first to protest.

Alert readers realised something was afoot on 4 October 1975, when you removed all full stops and commas from authors' qualifications. We stayed silent, feeling in those straitened times that the saving on ink was worth inadequate punctuation. That was our mistake. Emboldened, you lost no time in removing the letters themselves. This is a different matter entirely.

Using abbreviations to list one's achievements is a British tradition, still practised by Masters of Fox Hounds (MFH) and Commanders of the Order of the British Empire (CBE). Many years ago military decorations embellished your pages, and no editor would have dared to delete DSOs, MCs, or DFCs. My generation was just as proud of our hard-won academic credentials, but in today's *BMJ* the only place we can be MD FRCS FRCGP and TD (Territorial Decoration) is on the obituaries page.

Some will argue that you have struck a blow for egalitarianism by cocking a snook at the medical elite. What you have really done, I fear, is sideline universities, whose PhDs and MDs betoken academic excellence, and undermine the medical royal colleges, which have a hard enough job maintaining standards in today's jungle of incompetent quangos.

So please, stop hammering nails into the coffin of academic medicine. Bring back post-nominals to inspire the younger generation. If you don't like the old ones, you can invent new ones to represent today's medical hierarchy.

Young high-fliers could have a BOT (Been On Telly) while their seniors will trump this with FBOT (Finished Being On Telly). Doctors on local committees will be KTBW (Knows The Buzz Words) and those on national committees, KATBW (Knows All The Buzz Words). And for doctors who actually see patients, MB will be replaced by FA. (Fully Appraised. What did you think?)

Your humble and obedient servant,

James Owen Drife professor of obstetrics and gynaecology, Leeds