MEDIA WATCH Ben Goldacre

Beware of mentioning psychosocial factors

How doctors describe the many interactions between a person, their illness, and society has little purchase in the crudely dualistic world of popular culture

Although we are constantly told to “engage with the public,” many doctors and academics avoid the media like the plague. This month, like many doctors before me, I walked into a broadcast studio a man and came out an ass.

The story was acupuncture. A major study had been published showing that acupuncture is more effective for back pain than conventional medical treatment, and as I sometimes write about complementary medicine and research methodology I was invited to discuss the study on BBC Radio 4, where nobody can tell that I look about 14.

The very interesting paper (*Archives of Internal Medicine* 2007;167:1892-8) had three arms. Results from the “sham” and “real” acupuncture arms were indistinguishable—make of that what you will—but both outperformed conventional medical treatment. The patients in the study, I should mention, were people who had already been failed by conventional medical treatment for an average of eight years.

If you're a doctor, you can probably imagine what I said. The important background information missing from the news reports didn't concern the study's methodological details or anything to do with acupuncture: what was missing was a wider understanding of back pain. Back pain isn't like tuberculosis or a fracture; it's one of the leading causes of sick leave and misery, but the simple fact that no clear cause is found itself exacerbates distress and causes conflict.

And just as many of the big risk factors for a niggle turning into chronic, longstanding back pain are personal, psychological, and social—things such as working conditions, depression, job dissatisfaction, unavailability of light duty on return to work, and so on—so are many of the interventions.

Anti-inflammatory drugs are undeniably better than placebo, at the cost of possible side effects, but if you were going to look at the evidence

beyond pills, then resting in bed is actively harmful (specific exercises can be too), and trial data show that simple educational interventions such as giving advice to “stay active” can speed recovery, reduce chronic disability, and reduce time off work. In fact, in Australia they even put money into that notion, and a simple public information campaign (“Back pain: don't take it lying down”) was shown to reduce back pain significantly in the whole target population (*Medical Journal of Australia* 2001;175:456-7).

I talked about this kind of stuff, although I suspect that the Radio 4 people may have been hoping for some old duffer to say that acupuncture is “poppycock.” The acupuncture study raised important issues, I agreed. It's very important to think about whether and when doctors should go beyond merely prescribing pills, and we often do. But if we accept, in the case of back pain, that acupuncture may in part be a surrogate psychosocial intervention or theatrical placebo, then it's a pretty expensive one. Maybe we could consider pushing for other options, less expensive and less fashionable, such as brief education interventions, public health information programmes, perhaps cognitive behavioural therapy, and so on.

This all felt pretty sensible. Much of it was lifted from a bog standard review on back pain in the *BMJ* (2006;332:1430-4). Working doctors are accustomed to thinking beyond the prescription pad, after all, and it's a peculiar side effect of the branding of alternative therapists that medicine is portrayed in mainstream media as crudely biomechanical.

So I was a bit surprised three days later to hear this read out, in a very angry voice, in the letters slot of BBC Radio 4's afternoon news programme *PM*, to a million people: “I would take issue with your speaker Ben Goldacre, who, if I recall correctly, said that 90% of back

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problems are psychosomatic disorders. What planet is he on? Whilst I would agree that there are a lot of schmucks out there that want to sit around and skive off work every day (and thereby make the problem even worse) . . . never tell me my backache of 20 years is imaginary. OKAY?”

Now I'm quite prepared to accept that I may not have expressed myself very clearly—obviously I don't think back pain is “psychosomatic,” and I accuse nobody of malingering—but something more interesting is happening here. The finer distinctions between concepts that doctors use to describe the multiple interactions between a person, their illness, and society have little purchase in the crudely dualistic world of popular culture, and sometimes it can seem that there is a hypersensitivity to anyone even mentioning psychosocial risk factors or interventions.

Perhaps it is a matter of who is permitted to discuss them: patients shop for advice, after all, and you don't go to a crystal therapist for steroids, any more than you go to a urologist for marital guidance. Perhaps even a biomedical doctor merely raising the question is seen as questioning the legitimacy of symptoms and suffering. Perhaps the problem is magnified because we live in a country with millions of people receiving sickness benefit, where many people perceive at least some claimants simply as rebranded “unemployed” people.

But this is a dark corner, framed only by the crude marketing claims of quacks and their notions of “holism.” In a culture where “psychosocial risk factors” can be heard as “psychosomatic illnesses,” and with a popular media where “psychosomatic” simply means “imaginary” and “malingering” (*Psychosomatics* 2004;45:287-90), these negotiations will never be easy.

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RESPONSE **Fiona Patterson replies to Parashkev Nachev**

Although there is over a century's literature on selection methodologies, rarely has any process provoked such fierce debate as MTAS. Many facts surrounding specialty selection, and our role within it, are not well understood. This is illustrated by Dr Nachev's personal view (*BMJ* 2007;335:615), which contains two fundamental factual inaccuracies. The problems surrounding selection methodology are multi-faceted and multi-dimensional, well beyond disregarding CVs, relying on "white space" questions and poor IT delivery.

For the distress caused, I share the anger of the profession. The inquiry led by Sir John Tooke details the facts about our role in the process (www.mmcinquiry.org.uk). Here, I highlight critical issues to encourage close scrutiny of facts surrounding principles, methodology, and context underlying MTAS, so that there is learning for the future.

Clearly, in the past, selection practices in medicine have been effective. Although few would deny there is scope for improvement, the CV and interview process has generally worked well. So why change? MTAS was devised alongside the MMC (Modernising Medical Careers) programme introduced by the Department of Health, where the fundamental principles underpinning gateways to progression were changed overnight. Consequently this changed the rules governing selection. Traditionally, medicine has relied on robust indicators of attainment on the CV, such as work experience and Royal College examinations for selection decisions. The MMC pathway relied on the belief that doctors could be selected to specialties without previous experience in that specialty. The selection methodology in MTAS was designed for ST1 (the first level of specialty training), not for thousands of doctors already working in specialties. Under MMC principles and in compliance with Postgraduate Medical Education and Training Board (PMETB) (www.pmetb.org.uk/index.php?id=456), we were advised that work experience and exams could not be scored or used to rank applicants. The introduction of run-through ST1 posts was new.

I have worked on selection methodology in medicine for over 12 years. This work informed the development of selection centres and the introduction of new shortlisting tests in general practice. In 2007, all deaneries worked together through a GP national office, where thousands of doctors are successfully appointed using this process. Since 2002, in partnership with doctors

we have developed selection methodology for many secondary care specialties and for graduate entry into medical school. Although commonality exists across all specialties and levels, selection criteria for each are distinct, with evidence supporting different priorities between specialties.

Having completed this work, in 2004, I was invited to meet the MMC team to advise on selection methodology into specialty training. I recommended developing a national test for shortlisting (supported by early evidence from general practice) and validated selection centres with full involvement of the royal colleges and with large scale consultation. Following this meeting, I received no further correspondence from the MMC team and no pilots were put in place. In May 2006 we won an open competition tender organised by the Department of Health. Our work included advising on selection methodology for foundation programmes and the general practice selection process. For specialty selection, the scope of work states; "The number of applicants expected to apply for entry into Specialty Training is approximately 6000 and that applications will be via a single electronic national portal entry system (separate project) the working assumption for the closing date will be 5th January 2007." At the outset we were asked to advise on selection methodology for ST1. We were not asked to deliver selection methodology for doctors in "transition" via ST2, ST3, ST4, and FTSTA (fixed term specialist training appointment) posts, nor academic posts. We believed these arrangements would be delivered via local processes.

The rules and conditions governing MTAS were defined by MMC, based on PMETB principles, and, via the Conference of Postgraduate Medical Deans steering group, they represented all stakeholders. Given the time scale (less than 16 weeks) there was no option but to use materials from existing application forms used (over several years) for entry into specialist training. By contrast, in collaboration with the general practice national office, my team designed the shortlisting test with general practitioners, which has shown to work well. For the future, the general practice model has been identified as best practice.

However, this model cannot be transferred into all specialties. Medicine is a broad discipline and secondary care is significantly different from general practice, requiring bespoke selection methodologies. Different selection ratios for

specialties and for locations add complexity; one size cannot fit all. Some believe selection practices in other professions can be readily transferred, but medicine in the UK is unique. Few of those deciding policy understand what a clinician does on a daily basis. An important challenge is to translate the needs of the profession to policy makers.

In the past 12 years, advising on selection methodology in all sectors, I have learnt more from collaborating with the medical profession than from any other. Unlike selection approaches used by some organisations, I applaud the focus on psychometric scrutiny, the need for validity evidence, and the demand to treat human beings with respect and dignity in the process. The fact is, MTAS was not designed by psychologists. Without a full understanding of the issues, we cannot hope to navigate the future, which looks yet more challenging.

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EDITOR'S NOTE

Having investigated the points raised by Professor Patterson, we have concluded that two statements in "MTAS or a tale of evidence heedless medicine" (*BMJ* 2007;335:615) were factually inaccurate.

The first was that "The criteria and procedure for selection in MTAS were principally designed by a handful of organisational psychologists engaged through their consulting firm, Work Psychology Partnership." In fact, the criteria and procedure for selection in MTAS were principally designed by the MMC team, Department of Health personnel, the UK strategy group, and the COPMed steering group for recruitment and selection (as set out in the Tooke report, *Aspiring to Excellence*). The second was that "The selection methods they have developed have never been used to select specialist trainees." In fact, Professor Patterson and her team have researched and implemented selection methods for trainees entering general practice, paediatrics, obstetrics and gynaecology, and surgery. A substantial portion of this work has been published in the *BMJ*.

We're happy to set the record straight.