Summary points

Traditional medical training produces doctors with a sound knowledge base that allows them to practise across a broad spectrum of medicine

Reformers aim to cut the student's factual knowledge base, while replacing traditional teaching methods with student led and problem based approaches

There is no evidence that the "new" strategies will produce better doctors, and a risk that students with inadequate knowledge will become poor clinicians

A rigorous comparison of "traditional" versus "new" curriculums is urgently needed to determine the best strategy for training doctors

have effectively thrown out the bath water, baby, and much of the plumbing.

Reformers always have a duty to prove that their proposals are necessary, sound, and practicable and that they will genuinely improve on whatever went before. We believe that the current reforms are a creaking bandwagon whose wheels will eventually drop off—with dire consequences for the future of the profession and our patients. This view can be convincingly rejected only by rigorous comparison of the doctors produced by new and traditional curriculums. The stage is ideally set to test whether the current reforms are the right answer to the shortcomings of

traditional medical training. Any damage caused by a patchy knowledge base might not become apparent until doctors acquire relative seniority⁸; it follows that the comparison should begin without delay and should follow doctors as they progress through their career.

The training of doctors is too important an activity for bold experiments to be conducted without discovering what really happens. The GMC should now seize the initiative in driving forward a comprehensive review of "old" versus "new."

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Seeing is believing

The popular history of medicine largely consists of stories of brutal procedures carried out at great risk to the patients in the hope of curing disease or preventing death. Some would say that such brutality continues in the 21st century.

I was recently told the shocking story of what had happened to a friend of mine during the birth of her first child. She had hoped to have the baby at home, but after prolonged labour it became clear that an emergency caesarean section was indicated. My friend was rushed to hospital in considerable pain, along with her worried husband, and was taken directly to theatre. It was clear that the baby needed to be delivered immediately, and at this point the anaesthetist apparently did something quite extraordinary.

He suggested to the husband that he left the room for a moment, because he "probably wouldn't want to see this," and then throttled my friend until she lost consciousness, so that the obstetrician could begin the operation. The husband witnessed this happening as he was leaving the room, and the memory of it has caused him considerable distress.

I was amazed by this story and tried to find out whether this could really have happened. After speaking to a surgical colleague, a more plausible explanation emerged. Apparently, when somebody undergoes an emergency general anaesthetic and has not fasted beforehand, it is good practice to apply manual pressure on the cricoid cartilage during induction to prevent aspiration of stomach contents. Presumably the husband had witnessed this being done, shortly after his wife had been anaesthetised in the normal way. It is quite understandable that a

layperson, especially in a highly anxious state, might think it feasible that the quickest way to render someone unconscious would be to strangle her. After all, in an emergency, drastic action is often necessary.

There must be lessons to be learnt from this story, but I am not sure what. Should the anaesthetist have explained to the husband the purpose of everything that he was doing? Could the obstetric team have asked the husband afterwards if he had seen anything upsetting? In an ideal world, perhaps these things could have been done, but the anaesthetist had done nothing unusual (let alone wrong) and was acting in an emergency. Moreover, how could anybody be expected to know that the husband had seen and misinterpreted something in such a dramatic way unless he said so?

Perhaps the real lessons are these. Firstly, remember that doctors still perform gruesome procedures on their patients in the name of medicine (just ask any orthopaedic surgeon). The fact that they may be accepted practice and done for all the right reasons does not mean that they are not brutal and potentially dangerous. Secondly, such procedures must seem horrifying to anybody who is not used to seeing them, especially when they are carried out on loved ones. Finally, beware the subjective nature of reality and remember that what our patients witness is not always the same as what they see.

Ashley Rule *specialist registrar in adult psychiatry, Royal London Hospital, London*