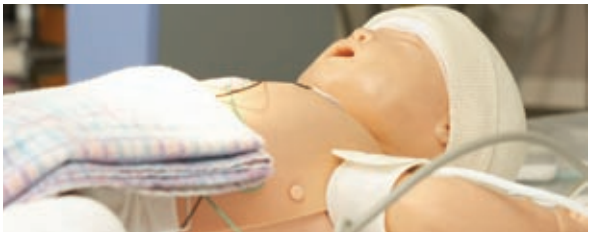
Is it time to jump off the training bandwagon?

PERSONAL VIEW **Rob Walker**

I recently spent three days and £600 of my study leave allowance, not including expenses, to attend an APLS (advanced paediatric life support) course. This followed an email instructing all consultants at the children's hospital where I work as a consultant anaesthetist that this was now mandatory training. After 13 years as a consultant, I thought it was time to bite the bullet and go for a refresher. I was also interested to see if the reliance placed on APLS courses as a mark of the competent practitioner was well placed. So, after completing the online, compulsory, multiple choice questionnaire (MCQ), I joined the course with 31 other fresh faced but apprehensive young colleagues all eager to pass the course and enter it on to their CVs and thus on to job applications. I was told by many that this course and other such courses were now mandatory for successful career progression. They told me that the course fee almost emptied their annual study leave budget (£600-800 (€880-1170; $1160-1550) a year) and therefore it was possible to do only one per year, and little else.

So, what do you get for the handsome sum of £600 kindly donated to the ALSG (advanced life support group) charity. Well, in true APLS style, let's look at the positives first. You get a course that is generally well organised, a large ring binder folder containing a 380 page manual (thrilling reading, although not with new guidelines), a large faculty of APLS enthusiasts, lots of didactic lectures and workshops reinforcing the message, and the opportunity to be examined (and embarrassed). Some sessions were enjoyable, such as the basic life support training and some of the trauma management teaching—things I don't do on a regular basis.

What about the negatives? The workshops were mixed. Some were well led, but others involved simplistic activities to identify symptoms and signs from a plastic envelope and others involved role play. The days were long, and I had the feeling at times that I was in a strange religious cult, all of us trapped until we finally submitted to the will of the APLS movement and embraced the teaching. Many "advanced skills" were taught on plastic manikins—so proper intubation technique was not possible. Many other techniques, such as cricothyrotomy, needle thoracentesis, and femoral line insertion, were demonstrated using adult equipment. The scenarios were set by the faculty, and individuals were put on the spot. The course ends with testing of all the participants in scenarios and multiple choice questions. Failure to pass either of these results in the need to resit either immediately or at a later date. This is extremely stressful for participants who desperately need this qualification on their résumé. I had to wonder if all the testing was really necessary. It took away any enjoyment and gave many the impression that failure to adhere strictly to the protocols would have dire effects, which is, of course, rubbish (after all, the protocols change every few years). Passing implied competence and failing, incompetence.



Hospitals offer the real thing

PHOTOS.COM

Nothing is taught on APLS that could not be taught at base hospitals

So did I benefit from the experience? It was nice to feel like a trainee again and experience the camaraderie of the exam sitting fraternity and . . . I passed! I am, therefore, an APLS provider (for four years, anyway; then I must renew the qualification). Or am I? In the same folder with my little provider card is a disclaimer issued by the ALSG. This states that although I have successfully passed the course, the certificate "does not constitute a certificate of competence." What?! It also states: "Employers are themselves directly responsible for establishing that their staff have the capabilities requisite to their clinical setting . . . Accordingly, they must not rely to any extent on the holding by an individual of a certificate of qualification." This I agree with. It is the employer's responsibility to ensure that all staff are properly trained in resuscitation, and not just the few sent on these courses.

These courses are expensive and must make a healthy surplus. Also, we mustn't forget about the participant's expenses and any locum payments that trusts may have to cover during this leave.

So, is the reliance on these courses well placed? Nothing is taught on APLS that could not be taught at base hospitals. Basic life support and cardiac arrest training can be, and should be, part of all doctors' annual mandatory training and should be provided by resuscitation departments at no cost to either the individual or the study leave budget. Experienced staff in the operating theatre, the intensive care unit, and elsewhere in hospitals are all capable of teaching resuscitation. They may not be APLS trained, but does that really matter? We can teach the same protocols, and offer real experience of airways and intubation—an excellent confidence builder. Problems, such as status asthmaticus, that require advanced management could be provided by a well designed tutorial system for trainees in different specialties.

Let's stop emptying the study leave coffers and jump off this bandwagon. Leave the trainees with money to spend on courses that stimulate them and interest them in their base specialty. And, hey, the NHS might save a bit of dosh along the way.

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What would the GMC have made of this doctor? p 699

REVIEW OF THE WEEK

Addiction in America: in search of a fix

Can a series of quality documentaries undo the sensationalised image given by Hollywood to the issue of alcohol and drug addiction in the US, asks **Chloe Veltman**

Drug addiction is a problem that affects 23 million Americans, yet less than 10% are getting treatment. According to the Centers for Disease Control and Prevention, drug overdoses are the cause of the second highest number of accidental deaths in the United States after car crashes, doubling between 1999 and 2004, from just over 11 000 to close to 20 000. With most people's views on drug addiction being shaped by over-sensationalised Hollywood films like *Requiem for a Dream* and *Traffic*, never has there been a greater need for a straightforward, high profile documentary series on the theme of drug addiction.

HBO's new documentary film series, *Addiction*, ought to fill this much needed gap. Produced in partnership with the Robert Wood Johnson Foundation, the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the series sets out to explore the current state of drug and alcohol addiction in America through real life stories and views on treatment and recovery by drug and alcohol addiction experts. But despite the no nonsense approach aimed at educating viewers about drug addiction rather than shocking or entertaining them, *Addiction* leaves the viewer feeling as battered as a heroin user going cold turkey.

The core message is that addictions are chronic diseases of the brain that can be managed through a combination of medical and behavioural treatments

The series, which was premiered on 15 March, is undoubtedly ambitious. It involves the collaboration of numerous filmmakers and medical experts across a broad range of themes and media. The centrepiece of the series is the *Project*, a 90 minute documentary that explores the drug and alcohol addiction landscape over nine short segments. Filmmaker Jon Alpert's opening sequence, "Saturday Night in a Dallas ER," is an unflinching depiction of hospital staff dealing with several drug related injuries, from a deep arm wound sustained by a patient high on cocaine to an alcoholic's snapped ankle. Eugene Jarecki and Susan Froemke's "The Science of Relapse," meanwhile, examines why addicts can't just "stop" taking drugs. By looking at the triggers in the brain that set off the craving state, the segment examines the potential use of medications like baclofen in recalibrating the brain's dopamine pathways. Elsewhere, "The Adolescent Addict," a short segment about teenage addicts, uses the real life stories of teens Dylan and Ted as a prism through which to discuss the causes of addiction in young people and the programmes available for treating this group.

The educational aspects of *Addiction* are comprehensive in scope. Supplementary short films and extended interviews with medical experts including Nora Volkow, director of NIDA, and Mark Willenbring, director of the treatment and recovery research division of NIAAA, provide an in-depth investigation of drug addiction related issues. The extensive online resources devoted to the *Project* on HBO's main website further *Addiction*'s outreach endeavours. Features include podcasts and information concerning such matters as "how to select a good treatment provider" and "five things you can do to enhance your recovery odds."

Yet despite—or perhaps because of—the targeted, highly practical nature of *Addiction*, the series makes for perhaps the least addictive programming put out by HBO in years. The *Project* suffers most acutely from a bludgeoning case of didacticism. Repetition has long been viewed as a key component of the learning process. But the series' core message—that addictions are chronic diseases of the brain that can be managed through a combination of medical and behavioural treatments—is repeated so often, that it is rendered practically meaningless. Furthermore, the producers make little attempt to address opposing beliefs about the causes of—and treatments for—addiction. Coupled with its ham fisted public service announcement tone, this single minded view of the subject makes *Addiction*, at times, border on propaganda.

HBO has hired some of the most acclaimed documentary makers working in the industry today. But traces of the filmmakers' particular styles are mostly absent from the finished product. In the main documentary, only Barbara Kopple's touching segment about the efforts of members of a New York Steamfitters Union to ameliorate the pandemic alcohol problem among hard drinking workers reaches beyond the merely moralistic.

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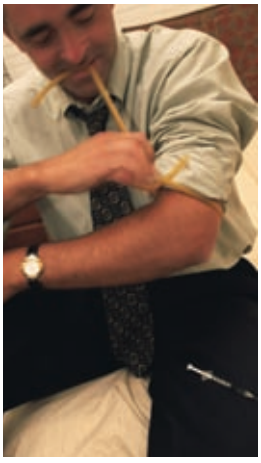

The Addiction Project
A series of films produced by HBO
All available on HBO on demand in the US from 15 March to 16 April
www.hbo.com/addiction/
Rating: ★★☆☆

Our chemical romance

FROM THE FRONTLINE
Des Spence

I love music. At 9 am, hunched over my computer, I try to buy tickets on Ticketmaster before the touts. At 9 02 I whoop inappropriately loudly, as I receive my email confirming the My Chemical Romance tickets. At 9 05 I call in my first patient, apologise for being late, and say, "No, I have no idea what that animal noise was."

It is the pain, the energy, but most of all the passion of music that appeals. Music is a form of escapism that lifts your mood and quells anxiety. I can't prescribe music, but I can prescribe benzodiazepines.

I hate benzodiazepines. Whole neighbourhoods seem to be dependent on benzodiazepines, a drug that transcends the generations—abused by one and all. I know that many of my prescriptions are diverted into the black market of prescription drugs: thriving small businesses, not unlike touting—a 10 mg diazepam tablet ("a blue") is worth £1. The streets are awash with our prescription drugs and also a multitude of imports and fake drugs. I do not know how to stop this and, trust me, I have tried.

Psychological pain is not abstract—it burns like no other kind. The temptation to self medicate is strong. I am guilty of having tried alcohol to ease the pain, but alcohol merely snuffs out the last few remaining stars in the darkness. Benzodiazepines are no different. A recent reclassification of drugs placed benzodiazepines up with ketamine and amphetamines (*Lancet* 2007;369:1047-53)—it is where they belong.

Benzodiazepines are a blunt instrument and just another example of medicine's staggering oversimplification of life. Psychological pain has purpose—it is something that we need to work through. Friendship, family, loyalty, and time heal—the scars serve to remind and educate.

I have worked with benzodiazepines for 20 years and I believe we should consider withdrawing them from clinical practice. They offer no answers. A slow strangulation of dependence and tolerance is their only certainty. They help collude in the deceit that medicine or medications have anything to offer towards true happiness. I am grateful that I find solace in music.

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Keeping mum

PAST CARING
Wendy Moore

Commercial confidentiality has always had an uneasy relation with the Hippocratic oath. In a world of fierce competition, a doctor's duty to share new treatments that have been proved to benefit patients can conflict with financial considerations—and this was so even before the NHS internal market.

None has wrestled with the dilemma for so long—or to such devastating effect—as the Chamberlen family. Over a period spanning roughly 150 years, the Chamberlens handed down the secret of the forceps through four or five generations while protecting their lucrative midwifery business.

Huguenots who fled persecution in France, the Chamberlens arrived in Britain in 1569 when William Chamberlen, who was probably a surgeon, landed his young family at Southampton. With a tenacity that would serve the family well, William named two of his four sons Peter. Pursuing mirror image careers, the two Peters became maverick surgeons who specialised both in midwifery and in irritating the powerful Company of Physicians, which controlled midwives in London.

It was probably big brother Peter who invented the forceps, although his nephew (also Peter, of course, but known as Dr Peter since he became a physician) did most to promote them. Almost identical to the Chamberlen forceps still used today, the instruments enabled the operator for the first time to deliver a live baby in an obstructed birth. Previously the only instruments that offered hope to a woman in a difficult labour were brutal hooks or crushers, which saved her life but killed her child.

Paradoxically, the successive Chamberlens thereby saved countless lives of mothers and babies when called by female midwives to problematic births, yet condemned many more to excruciating deaths by refusing to share their invention. Meanwhile, the forceps provided the family—and male doctors in general—with the key to the previously all-female delivery room.

The Chamberlens were clever businessmen; they advertised their services and shielded their invention from rival eyes by transporting the forceps in a covered carriage and carrying them into the delivery room in a huge box. A whisper of the secret emerged in 1634 when midwives criticised the "instruments of iron," but it was another 99 years before the forceps were fully described. The original instruments, used by Dr Peter Chamberlen, surfaced in an attic in 1813.

Interestingly, if medics had paid more attention to literary rather than scientific studies the secret might have emerged much earlier. An anonymous 17th century poem has always been taken as referring to one of the family, Hugh Chamberlen the Elder. "He's a little old man very pale of complexion / Into many deep things makes a narrow inspection / His head's very long and his hand's very small" begins the verse. Read carefully, this could equally be describing the family's treasured secret.

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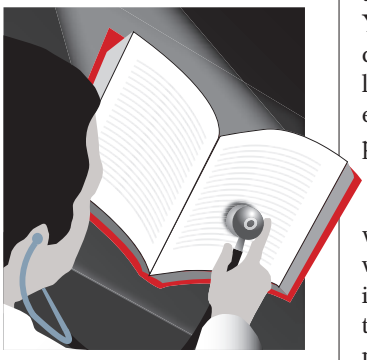
Crimes and misdescriptions

BETWEEN THE LINES
Theodore Dalrymple



"The head of the criminal is oxy-cephalic, trigono-cephalic, scapho-cephalic, plagio-cephalic, hydro-cephalic and sub-micro-cephalic"

When I was about 12 years old, my father took me to see a production of *Measure for Measure* at Stratford. Angelo, the fanatical puritan and anti-sensualist who is left in charge when the Duke leaves Vienna for a time, and who then falls prey to an illicit passion for Isabella, which he tries by means of corruption to consummate, was played by Marius Goring.

Goring was a very distinguished actor and an accomplished linguist who played cabaret in German in Berlin and Hamlet in French in Paris. During the second world war, he was head of the BBC's broadcasts in German to Germany; he also was a founder of the actors' union, Equity.

When Goring died, aged 85, more than a third of a century after I saw him in Stratford, I imagined him still clad in the burgundy velvet tunic he wore as Angelo, and still a middle aged man: such is the egotism of the imagination. When he played Angelo, in fact, he was exactly the age (49) I was when he died; not much of a coincidence, perhaps, but so persistent is the tendency to superstition that it had a patina of significance for me.

Another coincidence, perhaps, was that Goring's father, Charles Goring, who died in 1919 (aged 49), was a prison doctor, as I was myself to become. He wrote an enormous tome, published by HMSO, called *The English Convict*, which consists of a statistical study of 3000 prisoners taken at random. This immense work, truly a labour of Hercules, with vast numbers of tabulations correlating everything with everything else, was undertaken to refute the theories of Cesare Lombroso, the Italian doctor, anthropologist, and criminologist who believed in the existence of natural born criminals who displayed atavistic physical signs of their criminality. You could tell a criminal, more or less, by his eyes, or ears, or some other physical characteristic. I think Goring had fun with the whole idea: "We will now describe in detail some of the salient 'criminal characteristics,' according to the teaching of Lombroso's school. The hair of the criminal . . . is dark and thick, they tell us; another common type is woolly in texture; whereas red and grey hair, and baldness, are relatively rare among criminals.

"The head is alleged to be anomalous in shape, and in its dimensions. Dimensionally, there are two types of criminal heads: the one larger, the other smaller than the normal type. In shape, five types are described . . . the head of the criminal is oxy-cephalic, trigono-cephalic, scapho-cephalic, plagio-cephalic, hydro-cephalic and sub-micro-cephalic . . . The expression is cringing, timid, humble, suppliant; [or it is] brazen, shameless, ferocious, brutal." And so on and so forth.

My copy of this vast work is annotated by a follower of Lombroso, to judge by the irritated pencilled comments in the margins. For example, Dr Goring writes "Atavistic, insane, savage, degenerate, all or any of these things, whatever they may mean, the criminal may be; one thing the criminologists will not let him be: he is not, he never is, say the Lombrosians, a perfectly normal human being." To this, the furious annotator (whose annotations, I note, nevertheless cease at page 27 of 440) has written "Who is?"

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

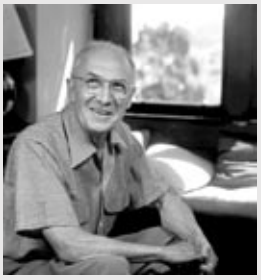
The Doctor Stories
By William Carlos Williams

Compiled by Robert Coles; first issued 1984

William Carlos Williams (1883-1963) made his living as a doctor and his reputation as a writer. After initial training in New York he worked as a family practitioner in his home town of Rutherford, New Jersey, for 40 years, seeing—in his own estimation—a million and a half patients. His formative working life was spent during the Depression, his patients being mainly blue collar workers and the unemployed underclass. Many were immigrants who spoke little or no English, and a chronic feature of his consultations was their struggle to pay him even a meagre fee. He worked hard, seeing patients every day and regularly attending calls through the night.

In view of this punishing workload, it seems astounding that Williams produced a canon of writing that leaves him regarded as one of America's foremost poets. In addition, he was a prolific prose writer, and *The Doctor Stories*, a compilation of short stories and autobiographical essays written between 1932 and 1962, is a compelling testament to his originality and skill, both as writer and doctor.

His subject is his patients and, to a lesser extent, his colleagues and domestic life. So, there are stories about mothers who lose their babies, about a girl with suspected diphtheria who won't let him look down her throat, and about a badly burned workman who needs a sick note to placate his unforgiving boss. The key feature of Williams's prose is its absolute, sometimes brutal, honesty. If he finds his patients (even children) physically attractive, he tells us; if he doesn't like his patients, he explains why. Williams holds nothing back about them, nor little about himself, in his desire, as he puts it, to "penetrate to some moving detail of a life." These days, the GMC might take issue with a doctor reporting his clinical experience so freely, but a key issue for Williams seems to be deciding which is the overriding responsibility: of the doctor to his patient, or the artist to his subject? As he states, in an autobiographical chapter: "My business, aside from the mere physical diagnosis, is to make a different sort of diagnosis concerning them as individuals."



Brutal honesty: William Carlos Williams

PAUL BISHOP

In his prose style, Williams is a modernist, and at first reading his stories seem almost draft in form. On reflection, however, the style is a crucial part of the honesty and testifies to the pressured reality of his life as a doctor-writer. He worked fast. Thus, he writes like an impressionist paints, quickly capturing the essence of a clinical moment. As a result, *The Doctor Stories* leave images of patients that last forever.

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