How not to make a drama out of a crisis
Simon Wessely

BMJ 2008;336:1251-
doi:10.1136/bmj.39587.679086.3A

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The case for resurrecting the long case

PERSONAL VIEW Narci C Teoh, Francis J Bowden

Reports of the death of the long case as a tool for assessing medical students' clinical skills may be greatly exaggerated. Unfortunately, the unintended consequence of highlighting its poor inter-case reliability is that even the judicious use of the long case may be seen as being out of touch with modern educational practice. In the ongoing struggle to improve the reliability of our assessment of students, we may forget that knowing that a student will be examined in a particular way determines that student's learning behaviour.

Firstly, a definition: at our school a long case is where a student sees a real patient in a clinical setting, takes a history, examines the patient, makes a diagnosis, formulates a management plan, and then presents this information and discusses the issues arising from the case with a clinical tutor. Each long case is marked against a set of criteria and graded. Students must complete 14 long cases over two semesters in the third year; but because of historical concerns about validity we do not currently have a barrier long case examination in the final year.

It would be hard to argue against the proposition that the clinical method rehearsed in the course of a long case is the way that a good doctor should practise. The long case assesses a student’s overall ability to carry out a medical interview, appraise and synthesise findings, and plan and decide on a management plan, and then presents this information and discusses the issues arising from the case with a clinical tutor. Each long case is marked against a set of criteria and graded. Students must complete 14 long cases over two semesters in the third year; but because of historical concerns about validity we do not currently have a barrier long case examination in the final year.

The long case can never be the only assessment of a graduating doctor, but to omit it in the spectrum of assessment procedures is another way of playing down the centrality of the patient encounter in medical practice. Problem solving skills and communication skills are intimately linked to the content of any problem and should never therefore be assessed separately. An OSCE based assessment system encourages them to sit a written and a clinical examination comprising a combination of long and short cases. The candidates know that they will undergo a senior colleague for scrutiny and calibration. The candidates know that they will undergo a senior colleague for scrutiny and calibration. The candidates know that they will undergo a senior colleague for scrutiny and calibration. The candidates know that they will undergo a senior colleague for scrutiny and calibration. The candidates know that they will undergo a senior colleague for scrutiny and calibration. The candidates know that they will undergo a senior colleague for scrutiny and calibration.

There is a spin-off here: the knowledge that candidates will sit a formal long case drives them to do their “real” job properly.

The long case can never be the only assessment of a graduating doctor, but to omit it in the spectrum of assessment procedures is another way of playing down the centrality of the patient encounter in medical practice. Problem solving skills and communication skills are intimately linked to the content of any problem and should never therefore be assessed separately. An OSCE based assessment system encourages them to sit a formal long case drives them to do their “real” job properly.

We urge medical schools to resurrect the final barrier long case as a means of assessing professional competence but with the introduction of strategies to improve its reliability and validity, such as:

• Observing candidates’ interaction with the patient, in addition to their presenting the case to the examiners
• Using a structured checklist to assess several measures of clinical competence, such as Gleeson’s objective structured long case examination record (OSLER)
• Training examiners of long cases and setting standards, and
• Formative assessment of several long cases over an extended time period.

We would like to suggest a corollary of the educational axiom “assessment drives learning”: assessment drives practice. If we expect students to become doctors who take a “whole person” view of their patients, seeing them as more than the sum of their diseased organ systems, then we must push them to learn medicine in an integrated manner.

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References are on bmj.com
A new book that describes the changing responses of medical professionals to people who have been in a disaster represents a welcoming maturing of the field, finds Simon Wessely

This is the first textbook “specifically on disaster psychiatry,” its preface claims, and there is no doubt that the editors, distinguished scholars themselves, have assembled an impressive line-up of contributors to consider a range of issues, from epidemiology, assessment, and diagnosis to pandemics, terrorism, bereavement, service planning, and interventions.

But why is this the first such volume? One contributor, David Benedek, notes that “social scientists, historians and psychiatrists concerned themselves with the consequences of traumatic experiences on individual and populations for decades before the diagnosis of acute stress disorder (ASD) and post-traumatic stress disorder (PTSD) were specifically identified.” True enough; nevertheless fewer than 30 of the book’s 1300 or so references date from before 1980, the year when post-traumatic stress disorder entered the diagnostic canon.

The arrival of the disorder in the third edition of the Diagnostic and Statistical Manual of Mental Disorders was a turning point—not in our acknowledgment of the psychiatric consequences of disaster and trauma but more in the way we conceptualise the nature of those consequences. Before 1980 it was assumed that as long as people were essentially sound before a disaster and did not show evidence of a predisposition to vulnerability then reactions would at best be short lived. After 1980 it was argued that long term disorders could arise even in the most robust individuals. The result was an explosion of interest and research, amply reflected in the various chapters in this impressive text.

Nevertheless, the rejection or ignorance of the past, together with a Whiggish view of the march of progress, led to many hubristic mistakes. One such was a naive belief in a “universal trauma reaction” that was stable across time and cultures, amply refuted in an excellent chapter by Joop de Jong on non-govern mental organisations and mental health interventions. Another mistaken belief was that normal people who experienced a disaster would still need help in the form of immediate psychological interventions such as psychological debriefing, now shown to be at best ineffective and at worst harmful.

The chapters in this volume now reflect this new thinking. Patricia Watson emphasises the psychological importance in the immediate response period of “helping survivors meet their basic needs (eg safety, shelter, food, and rest) as well as providing soothing human contact and information.” There is no need in those first few days to go around asking, “How do you feel?” as the answer is likely to be, “Dreadful—how do you think I am going to feel?” Other contributors describe how professionals may be required to ensure that the flood of well meaning but untrained volunteers wanting to do just that is checked and instead to focus resources on providing longer term, evidence based treatments to the minority, to be delivered by appropriately trained professionals once the dust has either literally or metaphorically settled and the media circus has moved on.

The volume also contains well argued contributions on possible mechanisms for psychological responses from various fields, including from psychology and neurobiology and even some (albeit not enough) from sociology. Those who have to plan disaster services may, however, skip these sections and focus instead on more practical issues, such as public health planning and services and handling bodies, where they will find much common sense advice—even if it is not always new. For example, it is acknowledged by historians, even those of the revisionist tendency, that civilian morale did not collapse in either Britain or Germany during the second world war, despite both populations being subject to a deliberate policy of strategic bombing intended to destroy resilience and create panic.

Neither goal was achieved—the much anticipated epidemic of mental disorders never materialised. And what they learnt then about disaster psychiatry (not that they called it that) remains true today: “The morale of the bombed largely depends on the care they get in the first 36 hours… rest centres, facilities for children, information, health care and the provision of food” (Public Record Office, “Report on Liverpool and Manchester 10th Jan 1941” (Social History of Medicine 2004;17:463-79)).

The past is not always a foreign country, and it still has a lot to teach us. Simon Wessely is director, King’s Centre for Military Health Research, Institute of Psychiatry. King’s College London Simon.Wessely@iop.kcl.ac.uk
The rubber ear

The male lead singers of US rock bands of the 1980s—with their frizzy, long blond hair and pink makeup—were the prettiest girls on television. Their screaming guitar solos and the wailing backing vocals were a rock abomination, although the greatest danger lay in listening to their lyrics. Listening, however, is the doctor’s mantra. I have spent the past decade teaching undergraduates how to listen. I have suffered the tantrums of medical school actors who clearly resented the bit part of “a middle-aged man presenting with chest pain,” and I have gritted my teeth during the feedback sessions. The final insult has always been the ridicule of colleagues who exclaim: “You TEACH communication skills?”

As a postgraduate trainer I pretend to have read all the worthy but tedious books on conducting a consultation. I struggle to stay awake during a thousand video feedback sessions. I am bilingual in the pseudoscientific babble of communication. Whatever the setting, I emphasise the importance of listening to patients. But should I?

My medical Alan Sugar (worshipped by patients and colleagues alike) once told me, “Dear boy, don’t actually listen to the patients—just look like you are listening.” And of course he was right. I spend most of my time actively not responding to patients’ cues or listening. I engage in the art of distraction and misdirection, getting them off the medical topic by making mental notes of hobbies, football teams, and family.

For most of GPs’ time is now spent on an increasing number of patients with primary care season tickets, standing in the terraces of waiting rooms, week in, week out, rain or shine. Since we cleared the slums and fed and vaccinated the children, real illness has plummeted. The medical model is now largely defunct and has been replaced by aberrant health seeking behaviour, encouraged by ill conceived disease awareness campaigns and disproportionate media coverage of celebrity illness. The victims—the worried well—duly attend with health care beliefs clipped directly from the medical pages of gossip magazines. If we doctors responded to all the cues, most people would be in hospital for investigation most of the time.

I always try to deal with patients’ concerns by listening to the soft rock music of their lives. But much of the time, for the sake of their health, I ignore the lyrics. I am not sure that the communication authorities, however, are ready to hear this.

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Campaign for real lectures

I recently decided that I had been on the receiving end of death by PowerPoint one too many times. I have probably also dished out my share of worthy, overly structured lists of bullet points to glazed, uninterested audiences. So I’m starting the campaign for real lectures.

Last month someone bet that I couldn’t talk for 45 minutes on the state of primary health care in the world using only slides of pictorial images. I gave my lecture last week, and we’re still arguing about who won the bet (which rests on whether I was allowed to use text in my summary slide). That apart, I think I pulled it off. I read from a typed script (written in full paragraphs) and linked each theme to an image (or three). In total I showed 94 photographs, five diagrams, three pieces of abstract art, two maps, and a graph. Afterwards, someone said “that must have taken you ages,” and I admitted that it had. But nobody (even someone’s accompanying 6 year old) seemed to be bored.

People rarely go to lectures to learn facts. They go to be inspired, to discover what’s new in the field, and to be challenged to think differently. The success of a lecture should therefore surely be measured not by how much more people’s knowledge has grown but by how much their framing of the topic (and the extent to which they care about it) has shifted. Images generally achieve this better than words. Yet although I have been on several PowerPoint courses that covered font size, arrangement of text, and so on I have never had—or been offered—training in the use of visual images.

I’m still a novice at real lectures, but here’s a tip that saved my hide last week: make use of royalty free images (use Google). There are hundreds of thousands of them in internet image banks. Each image has usually been uploaded by a private seller, who has already made sure that the file is large enough to project crisply, has optimised the colour and tone, and has gained informed consent from the subject. The seller collects a small sum (typically less than £5) whenever anyone downloads that image. You can search the image banks with keyword terms (“domestic violence,” “children in Mongolia”) and store a shortlist for later browsing. You can also reuse the images as often as you like.

I had planned to keep this idea to myself, so that the applause for my lectures was louder than that for yours—but since I listen to more lectures than I give, it’s in my interest to share it. Join the campaign!

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Trisha Greenhalgh

FROM THE FRONTLINE
Des Spence

OUTSIDE THE BOX
Trisha Greenhalgh
Tobacco meets its match

One day a comprehensive history of opposition to tobacco will be written. In it, James I’s famous Counterblaste will be given an honourable mention.

Less prominent in the history, no doubt, will be Thomas Reynolds’ Anti-Tobaccoism: Three Hundred and Sixty-Five interviews with Smokers, Chewers and Snuff-takers, in a Series of Letters to John Lee, One of the Vice-Presidents of the British Anti-Tobacco Society, published some time in the 1850s, with “prefatory remarks” by Thomas Hodgkin, of Hodgkin’s disease, who opined that reading these letters would be more profitable to most persons than reading a fashionable novel.

Thomas Reynolds, who died in 1875, had once been an enthusiastic smoker, but underwent a conversion experience. The titles of his letters have a charm of their own: for example, Letter XIX is headed “Interview with a tobacconist, who had been a chewer of tobacco—A snuff-taking young surgeon—With three other snuff-taking surgeons.” (The young surgeon did not live long, which Reynolds attributed to his habit.) Letter XXXIX is headed “A smoker’s experience and report of misdoings by smoking Ministers [of religion]—A London warehouseman fearing to trust himself on Southwark Bridge—A snuff-taker shaking off his doctor—A sniffer deploring smoking—A smoking foraker of the means of grace.”

In what he called his “walks of usefulness,” he would wander the streets expostulating with smokers, not all of whom appreciated his efforts. And one of the students asked the mayor whether he would like a cigar. Then there was a fight. Reynolds quotes the report the following day in the Cambridge Independent Press: “So soon as the lecturer commenced to dilate against the practice of smoking, the University men began to smoke and shout, offering every obstacle to the lecturer, who, losing his presence of mind, expressed himself somewhat warmly, and a general disturbance ensued.”

This suggests that Dickens’ depiction of the meeting of the Brick Lane branch of the United Grand Junction Ebenezer Temperance Association, in which the drunken Reverend Mr Stiggins accuses the meeting in general, and Brother Tadger in particular, of being drunk, was mere reportage, not caricature.

However, we must all approve of the sixth principle of the British Anti-Tobacco Society: “It is the imperative of every lover of mankind, to unite in suitable efforts to remove this rapidly increasing evil, by exhibiting its injurious effects on the health, its degrading consequences on the morals, and its enslaving power on the habits, of its deluded victims, and also, by seeking to deter others, especially the young, from acquiring this unnecessary, offensive and injurious practice.” Amen.

Theodore Dalrymple is a writer and retired doctor

In what he called his “walks of usefulness,” he would wander the streets expostulating with smokers, not all of whom appreciated his efforts.