



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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VIEWS & REVIEWS

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 course of action. Resistance to the use of the long case as an examination tool is predicated on its poor inter-case reliability—unless a large number of cases are offered. However, some evidence exists that the long case is actually a little more reliable than objective structured clinical examinations (OSCEs) if similar amounts of time are allocated to each type of assessment.

We have also taught at another university where final year students are not required to do a long case. After completing their summative long case assessment in the third year, many students stopped seeing patients and spent most of their time



Could we conceive of a professional music student who is told that her final acceptability as a musician will depend on a series of assessments of scales and short pieces but never on a recital of a complete piece of music?

studying for the written assessments. It was not surprising that their clinical skills in the final year deteriorated. We also shepherd young doctors from internship to specialty examinations for the Royal Australasian College of Physicians. Currently candidates for fellowship are required to sit a written and a clinical examination comprising a combination of long and short cases. The transition from hesitant, unpractised trainees to fluent, insightful, and decisive clinicians is achieved through the constant practice of seeing patients and being required to present their findings and management plan to a senior colleague for scrutiny and calibration. The candidates know that they will undergo a long case examination at the end of the process, so there is a direct match between the actual world of care of patients and the contrived world of the examination room. 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 a “reductionist” approach. Splitting the tasks of clinical medicine into their individual parts and testing them separately may be efficient,

but it has a consequence for more than just learning. Could we conceive of a professional music student who is told that her final acceptability as a musician will depend on a series of assessments of scales and short pieces but never on a recital of a complete piece of music?

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 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.

Narci C Teoh is senior lecturer in medicine and Francis J Bowden (frank.bowden@act.gov.au) is professor of medicine, Australian National University Medical School at The Canberra Hospital, Canberra

References are on bmj.com

The best novelistic
description of a 19th
century European woman
with “hysteria”?
P 1253



REVIEW OF THE WEEK

How not to make a drama out of a crisis

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-governmental 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 psychologi-

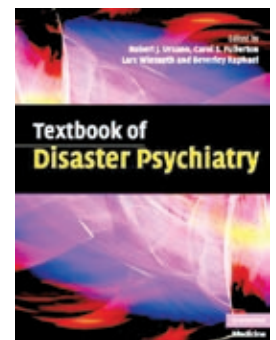
cal importance in the immediate response period of “helping survivors meet their basic needs (eg safety, shelter, food, and rest) as well as providing soothing human contact and information.” There is no need in those first few days to go around asking, “How do you feel?” as the answer is likely to be, “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 commonsense 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



Textbook of Disaster Psychiatry

Eds R J Ursano, C S Fullerton, L Weisaeth, B Raphael

Cambridge University Press, £55, pp 354
ISBN 978 0521852357

Rating: ★★☆☆

Few now advocate mental health interventions across the board for everyone affected by disaster

The rubber ear

FROM THE
FRONTLINE
Des Spence



The male lead singers of US rock bands of the 1980s—with their frizzy, long blond hair and pink make-up—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.

Des Spence is a general practitioner, Glasgow destwo@yahoo.co.uk

Campaign for real lectures

OUTSIDE THE BOX
Trisha Greenhalgh



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!

Trisha Greenhalgh is professor of primary health care, University College London p.greenhalgh@pcps.ucl.ac.uk

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.

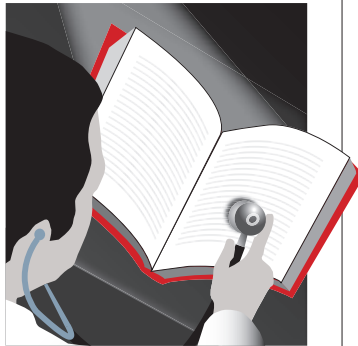
Less prominent in the history, no doubt, will be Thomas Reynolds' *Anti-Tobaccoism: Three Hundred and Sixty-Five interviews with Smokers, Chewers and Snufflakers in a Series of Letters to John Lee, One of the Vice-Presidents of the British Anti-Tobacco Society*, published some time in the 1850s, with "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 snuffer deploring smoking—A smoking forsaker of the means of grace."

In what he called his "walks of usefulness," he would wander the streets of London and other cities expostulating with smokers, not all of whom by any means appreciated his efforts. His arguments were half religious, half medical. In Cambridge, where he attempted to hold a public meeting against smoking, there was a disturbance.

"I thought it probable that among the University gentlemen I might meet with opposition, and that indeed I desired to

BETWEEN
THE LINES
Theodore Dalrymple



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

induce, but when I arose to commence my lecture, I was greeted with crowing in imitation of cocks, which the gentlemen performed with considerable ability. They crowed well, but their taste was bad. Things went from bad to worse: Some arose on the forms smoking cigars, and with caps in hand, bowed gracefully to a company of ladies in the gallery, amongst whom they threw lighted fireworks, which caused them to shriek with terror."

The mayor arrived with 25 policemen, 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

MEDICAL CLASSICS

La Regenta By Leopoldo Alas Clarín

First published in 1884

Ana Ozores, "La Regenta," is a character who has often been compared to Tolstoy's Anna Karenina and Flaubert's Emma Bovary. Like them she is a young woman who becomes involved in tempestuous relationships in an oppressive society where she struggles to find her place. Clarín, who was well informed about trends in psychiatry at the time, created a magnificent case study in his character. By coincidence, her first name and initial are almost the same as those chosen by Freud to write about Bertha Pappenheim ("Anna O") 11 years later in his *Studies on Hysteria* (1895). Clarín masterly describes the contemporary notion of the "hysteric," starting with the causative factors in Ana's presentation: early loss of her mother, followed by a harsh loveless childhood with aunts and a governess, and finally an arranged marriage with an older man who treats her like a daughter.

The novel begins when Ana is 28. The local playboy is pursuing her to consolidate his Don Juan reputation. At the same time her old confessor, "overwhelmed by her psychological complexity," transfers her to the younger and ambitious new priest, "the Magistral." The womaniser and the new confessor both wish to dominate her, sexually or spiritually, and their open competition played out before the eyes of the parochial community has terrible consequences for Ana, who has a mental breakdown. Today's psychiatry would diagnose Ana's condition as a dissociative disorder characterised

by sudden onset and loss of integration of her memories, of awareness of identity and immediate sensations, and of control of body movements and tending to remit after weeks or months.

Ana recovers with the help of Dr Benitez, a young physician who represents the opposite of the fear, superstition, and dogma personified by the "doctor of the soul," her confessor. Dr Benitez, the scientist, uses reason and logic to treat



Ana's disorder, recommending among other measures that she move from the suffocating provincial town to the countryside. Through Ana's letters to Dr Benitez, Clarín reveals two of his basic sources of investigation into mental illness: he describes her reading "Maudsley and Luys, with all their pictures on brains . . . without disgust or fear." Maudsley believed in the physical basis of mental illness and was influenced by evolutionary theory and neurophysiology. Luys worked in La Salpêtrière in Paris with Jean-Martin Charcot, famous for his work on hysteria, and was interested in the anatomy of the brain and hypnosis. Quoting these two psychiatrists, Clarín takes the side of science against religion.

La Regenta is the best novelistic description of a 19th century European woman whose illness was, as the historian of psychiatry Ellenberger said of Anna O, "the desperate struggle of an unsatisfied young woman who found no outlets for her physical and mental energies, nor for her idealistic strivings." Anna O overcame her symptoms to become a leader of the women's movement in Germany. I am sure you won't regret reading this novel to find out how Ana Ozores resolves her plight.

Carmen Pinto, consultant child and adolescent psychiatrist, London Carmen.Pinto@iop.kcl.ac.uk