"We drink these horrible fermented fruit juices for one reason only"—Des Spence on alcohol, p 176

Foundation year doctors lack surgical experience

PERSONAL VIEW **James S Bowness, Ben Clift**

Junior doctors' training is always changing: from large scale changes, such as training and applications for specialties, to smaller ones, such as approval for study leave and taster opportunities. Developments such as the European Working Time Directive, restructuring of junior doctors' training, and the increasing strain on NHS budgets mean that pressures of time and money are increasingly taking their toll on all aspects of medical training. As these burdens filter down through the NHS it seems that the training element in foundation posts is also coming under increasing pressure, with service provision ever increasing as a proportion of foundation trainees' work.

An example is the reduction in time spent in theatre in doctors' first years of experience. Older doctors often say, "By your stage I could do . . ." For example, a decade ago most appendicectomies could be performed by senior house officers. However, many at the current equivalent grade—doctors in their second foundation year (FY2)—have never scrubbed for an appendicectomy, let alone completed one solo. This inexperience and lesser competency may in part be the result of the development of techniques that demand more advanced skills, such as laparoscopic surgery, but may be exacerbated by the reduced surgical component in foundation jobs.

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This has implications for training, service delivery, and good practice, from discussion with patients and families to gaining informed consent. But does it also make for less well rounded doctors? The trend for more diversity in teaching at medical school, with modules in French, law, or hypnotherapy, for example, is seen as a good thing. But a solid grounding in the fundamental principles of the medical profession should be essential before expanding horizons to other allied or non-medical disciplines.

Although most foundation trainees enter non-surgical specialties or become general practitioners, they need to understand why they are referring patients to surgical specialties. Junior doctors are keen to have this understanding, but the political will to ensure that this happens seems to be lacking.

Guidance on training doesn't say that theatre experience should be mandatory. The General Medical Council makes no mention of attending theatre in its *Foundation Programme Curriculum*. The closest it comes is specifically mentioning skin suturing and "observing at first hand" as a method of learning.

The Postgraduate Medical Education and Training Board's *Standards for Training* states that it is the responsibility of the postgraduate deans, in partnership with employers and education providers, such as the royal colleges, to develop and deliver curriculums that enable trainees to gain competence.

The Royal College of Surgeons of Edinburgh encourages all those interested in a surgical career to gain as much surgical experience as possible, without compromising the quality of service they are required to deliver as part of their foundation year job. However, on its website it states that the basic surgical skills course "is NOT suitable for FY1s and attendees should be FY2/ST1 [specialty training year 1] level."

There is no formal requirement from the postgraduate deanery for foundation year 1 doctors to attend theatre: "Educational supervisors or consultants in the surgical specialties are encouraged to allow FY1s into theatre but this is normally dictated by service pressures and as there is no formal requirement it is difficult to do anything other than encourage."

With ever more pressure on junior doctors and their employers, the opportunity for useful, beneficial, but ostensibly inessential surgical experience at a formative stage is steadily reducing. Junior doctors realise this, but even those with a declared interest in a surgical career find limited opportunity to pursue it. Supervising bodies seem reluctant to invest their diminishing resources to cover expanding "supplementary" activities.

Although service provision can continue with relatively little effect in the short to medium term, a long term effect is likely, and we are losing the benefits of a more rounded training. A diverse medical education is a key aim in reshaping many university curriculums, yet important practical postgraduate education is being eroded at the foundation level. Did this happen by indifference or by intent, and is it too late to redress the balance?

ROB WHITE

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REVIEW OF THE WEEK

At war with polio

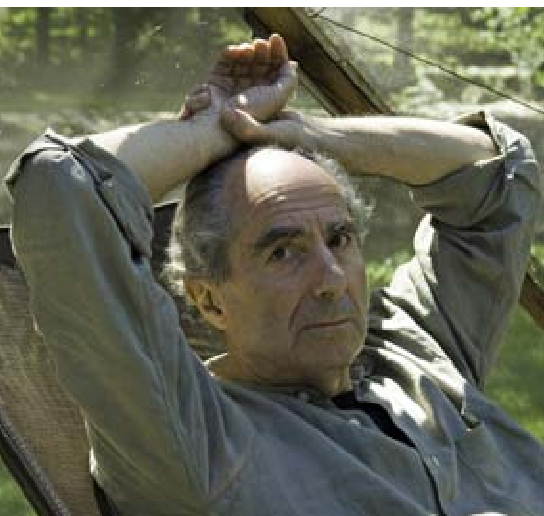
This novel, set during a polio epidemic in a US city in wartime, reminds **Julian Sheather** of medicine's progress

Nemesis
A novel by Philip Roth
Jonathan Cape, 2010, £16.99, pp 304
ISBN 978-0224089531
Rating: ★★★☆

Newark, New Jersey: a sweltering, "equatorial" summer. It is 1944 and the United States is at war, fighting in Europe and the Pacific. "Bucky" Cantor, playground director in the city's Weequahic district, is a short but fit Jew, a high diver and weightlifter.

In his charge during that long summer are the neighbourhood kids, girls and boys from tightly knit Jewish families, kids escaping small apartments and narrow yards, kids in search of a little air and elbow room. But summer in Newark is menaced by contagion. Bordered by once malarial swamps, the air putrid from upwind Secaucus—"the hog capital of Hudson County"—it swelters in a toxic, "all-blanketing" miasma.

The first case of polio is reported early in June in the Italian district. By 4 July the number has risen to 40, scattered throughout the city. Not until well into the summer though do the first cases appear in the Jewish district. Two of Cantor's kids are struck down. One dies almost immediately. The other lingers, paralysed.



Philip Roth: "rejoins his long argument with fate"

In 1944 knowledge of polio is scanty. Although it is known to be linked to poor hygiene and is helped along by the heat, its mode of transmission remains mysterious. A vaccine is six or more years away. As the unknown and invisible disease continues to kill and cripple the children of Newark, fear also spreads virally. Newark's racial faultlines begin to open: is it the Italian kids hanging around the playground or the black cleaning women?

With the worst of the epidemic centred on Weequahic, elsewhere in the city anti-Semitic rumours are heard. Anything in circulation is immediately suspect. Is it in the air—"Take a deep breath and you could die." Is it on the banknotes? "What about the mail?" Newark begins to come apart in the fear.

Newark's racial faultlines begin to open: is it the Italian kids hanging around the playground or the black cleaning women? With the worst of the epidemic centred on Weequahic, elsewhere in the city anti-Semitic rumours are heard

Cantor should have gone to war. He should have been parachuted into Normandy with his buddies: it was "what he would have wanted to do, exactly what he was *constructed* to do." Only his eyes are no good. Instead he holds the front in the playground. His war will be with polio. He criss-crosses the district, talking to the parents of stricken children, battling the rising fear. He plays ball with his kids. He keeps them active, keeps them focused. He encourages and cajoles.

And then he leaves them. Without warning and in the face of his ideals—"ideals of truthfulness and strength fostered in him by his grandfather, ideals of courage and sacrifice"—he makes a decision that will change him forever. He quits. He leaves his playground, leaves his grandmother and his menaced kids, and takes a job with his fiancée at a summer camp high in the Pocono mountains. "Marcia had told him that the lake was fed by natural springs.

"The name sounded like the name of an earthly wonder—yet another way of saying 'no polio.'" And the rest of his life will be lived in the shadow of a single question: "how could he have done what he'd just done?"

Because it has to do with a plague *Nemesis* has been likened to Albert Camus's *The Plague* and Thomas Mann's *Death in Venice*. Because it centres on a young man's single act of life defining cowardice it has drawn comparison with Joseph Conrad's *Lord Jim*. And yet the title ushers this brief novel firmly into the house of Greek tragedy. In the mechanistic brevity of its plot, in the speed and indifference of its catastrophes, in the almost toy-like helplessness of its character, Roth rejoins his long argument with fate.

Nemesis completes a quartet of late novellas, including *Everyman* and *The Dying Animal*, in which, enraged, Roth raises his voice against death and God, in which he takes arms against the appalling contingency of things.

Midway through the novel Cantor heads to the wealthy end of Weequahic to visit Dr Steinberg, the man he hopes will be his father in law. Steinberg, "one of those engaging family physicians who, when they step into the waiting room holding someone's file folder, make the faces of all their patients light up," brings him lemonade, and they sit on the dark porch eating peaches and talking about the epidemic. It is the only moment of reprieve in the Newark section of the novel.

And Dr Steinberg's calm, his quiet, almost scholarly commentary on the disease, brings out a forceful truth. Although not explicitly Roth's theme, the novel contains a powerful reminder of the terrifying potential of disease and also that one of our primary allies in our modern war against recalcitrant nature is medicine. Medicine will not, of course it cannot, win out against death and disease entirely. Tragedians will never be out of work. But this slender novel is nevertheless a sharp reminder, lest we forget, of just what medicine has achieved to date.

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BETWEEN THE LINES **Theodore Dalrymple**

A cut price *Frankenstein*

You do not normally associate the name of George Eliot (1819-80) with gothic horror, but she did try it once, in a novella called *The Lifted Veil*, written in 1859. It is a kind of cut price *Frankenstein*, exploring the desirability or otherwise of knowledge, especially but not only of foreknowledge.

The narrator is a man of indeterminate but not advanced age called Lattimer, who foresees his own death and wants to disburden himself of his story before he dies. He begins, "The time of my end approaches. I have lately been subject to attacks of *angina pectoris*, and in the ordinary course of things, my physician tells me, I may fairly hope that my life will not be protracted many months."

In fact, the narrator knows to the day, to the hour, the date of his final, fatal attack. As a result of illness early in life he, a sickly young man with the sensibility but not the talent of a poet, receives the faculty of knowledge of what other people are thinking, while retaining his own thoughts as his own. Quite which illness conferred this faculty on him is not stated; presumably it was one of those "brain fevers" in which Victorian fiction abounds. He discovers that the thoughts of others are generally petty and malicious.

The only person into whose thoughts he cannot penetrate is Bertha, a beautiful but cold young woman whom he determines to marry, though the other faculty conferred on him by his mysterious illness—precognition—informs him that she is an unfeeling and evil person.

To be perfectly frank the story is a bit of a dog's breakfast, though well written and with some striking observations about the nature of human existence. At its end, a servant to whom Lattimer's wife, Bertha, has been close, called Mrs Archer, lies dying of peritonitis (tuberculous, perhaps?), and by chance

If we were restored to life after death by resurrection we should be just as petty, rancorous, and embittered as the first time round

George Eliot: gothic horror

a childhood friend of Lattimer, a man called Meunier, who in the meantime has become a celebrated doctor, happens to be in the house.

Meunier wants to experiment on the body of Mrs Archer shortly after she dies by transfusing her with his own blood, a proceeding to which Lattimer consents and at which he helps. As a result of the transfusion Mrs Archer revives for a short while but only long enough to accuse Lattimer's wife of plotting to poison him and also to express her accumulated hatred of her.

George Eliot had been very religious in her early years but rejected religion entirely, indeed vehemently. Perhaps, then, she was making two points in this final scene: firstly, that the basis of life was purely physical (her common law husband, G H Lewes, was writing a book of physiology from this point of view at the time, which included reports of experimentation on blood transfusion); and, secondly, that if we were restored to life after death by resurrection we should be just as petty, rancorous, and embittered as the first time round.

Learning that his wife intended to poison him, Lattimer decides that discretion is the better part of resentment and leaves her. This irresistibly reminded me of one of my patients who tried to poison her husband and regarded his decision to leave her afterwards as unwarranted desertion. Personally, I think we humans are still some way from a full self understanding.

Theodore Dalrymple is a writer and retired doctor

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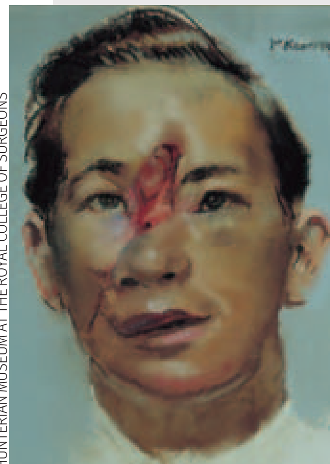
MEDICAL CLASSICS

Henry Tonks's war pictures

Paintings and drawings from the first world war

Henry Tonks (1862-1937) was a surgeon before becoming an established artist and teacher at the Slade School of Art. At the outbreak of the first world war he joined the Royal Army Medical Corps, was appointed an official war artist, and visited the western front several times. Tonks's pictures record the consequences of the great war, which left 15 million people dead and countless more wounded. His pastels and watercolours combine anatomical accuracy and attention to detail with emotional understanding. These qualities are evident in *Saline Infusion*, which depicts the pain of the patient and the compassion of the medical staff.

Tonks is most famous for his series of 75 pastel sketches of the torn faces of servicemen treated at the Queens Hospital Sidcup, a new unit set up by Harold Gillies to deal with facial injuries. Tonks was uniquely qualified to assist Gillies, having trained as a surgeon before abandoning medicine to follow a career as an artist. He produced before and after visual records and surgical diagrams for Gillies but also captured the character and despair of the injured men. Tonks called the series of pastels "the poor ruined faces of England" and thought that this "chamber of horrors" was too morbid to be looked on as works of art and should not be shown to the general public. After the war Tonks refused to allow the Imperial War Museum to show this work, and today the drawings are held in a storeroom at the Hunterian Museum, London. Even by today's standards the drawings are unsparing, dramatic, and shocking.



HUNTERIAN MUSEUM AT THE ROYAL COLLEGE OF SURGEONS

William Kearsey was wounded in France in October 1917 and transferred to the hospital in November

The Tonks collection is a powerful reminder of the devastating human toll of the great war and of the pioneering surgical innovations that it produced. Tonks was one of several artists, sculptors, and photographers called on by Gillies, who recognised the value of combining different media to provide a more rounded record of his patients. In this, as well as in the development of modern plastic surgery, Gillies was a pioneer. The first world war brought about important developments in medicine: technical innovations in operative technique and improvements in anaesthesia and in nursing care. It also led to a new recognition of the importance of psychological care for those undergoing physical and mental trauma.

After the war Tonks returned to the Slade. Although he continued to paint, he said that he could no longer record the conflict of the war and its aftermath as he "had lost his powers of expression." He died in 1937.

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Editor's note: Since conservation work was completed some of the works from Gillies's unit have been loaned to exhibitions at other venues, and the Hunterian Museum hopes to include at least some of them in a temporary exhibition to be held there in the near future.

Sour grapes

FROM THE FRONTLINE
Des Spence

We are not French—we are party people. A pervading British logic runs: "Why drink frequent, small amounts of alcohol when we can save our weekly rations for the weekend?" Sod the medical advice, because celebratory or (depending on your view) binge drinking is in our bloodstream and is a defining British social trait.

City centres on weekend nights are full of young people spewed across the pavements, decerebrated through alcohol. Hair awry, crumpled clothes: these are just friendly fire casualties of our "work hard, play harder" culture. Emergency services look on, too bemused to be amused. But there is no moral high ground in this deluge of drink, because we affluent, middle aged drinkers are merely more discreet, doing it behind closed doors. The truth is that we drink these horrible fermented fruit juices and cereal mulches for one reason only: the effect. To suggest otherwise is but denial.

Times are changing. Decades ago it was largely men who drank. But in the spirit of equality women are shouldering a more equal burden of the responsibility to drink. And the emancipation of children has freed them to drink at a younger age. The range of alcohol has changed. Beers were once 3-4% alcohol but are now often 5% or more. Traditional Old World wines were weak—vinegary French, sickly sweet German, and watery Italian. These wines were so disgusting that you would struggle to drink even a small glass, let alone a whole bottle. It once took effort to get drunk.

But vodka is now widely drunk by the young, and sales of wines have soared. Wine especially has become the drink of choice for women. Strong New World wines are 14.5% alcohol. A bottle can contain as much alcohol as 4-5 pints of beer. These wines have soft, floral names and are cheap, cheerful, and disarmingly palatable. The wineries, with French chateau facades that conceal million litre steel tanks, are owned and operated by petrochemical engineers from Melbourne. Today drinking a bottle of wine is common; even on a quiet night in on the sofa many people drink a bottle, from bucket glasses. This stronger drink means a higher rate of absorption, raising total alcohol consumption and causing more physical, psychological, and social harm. No social class is immune, but the middle class is most at risk from wine.

Wine has airs and graces of wealth and connotations of a chic continental cafe culture. Indeed, medicine is intent on promoting its medicinal effect. But in the hands of us celebratory drinkers the United Kingdom's 1.6 billion bottles of wine drunk a year are a chemical nuclear weapon. The more I see of wine the less I am convinced of its civility. Are the sauvignon suave our new lager louts?

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New year, new health?

PAST CARING
Wendy Moore

COLIN CRISFORD

More resolutions have probably been made—and broken—in pursuit of health than any other cause. When the Georgian rake James Boswell arrived in London in 1762 he firmly resolved to "have nothing to do with whores," to avoid a repeat of "the loathsome distemper" after first contracting gonorrhoea in his teens. But willpower was not his strong point. After a grand tour of casual sex throughout Europe he had 18 more visits from his old friend "Signor Gonorrhoea" before he died at 54 from the complications of venereal disease.

More successful was the 16th century Venetian nobleman Luigi Cornaro. After a misspent youth devoted to gourmandising and carousing, he was warned by physicians in his 30s that he would die within months unless he mended his ways. Vowing to adopt a "sober and regular" lifestyle, Cornaro found that he was "entirely freed from all my complaints" within a year. Cornaro stuck rigidly to his spartan regime for the next 50 years. And in an evangelising spirit he published his rules for a healthy lifestyle, the *Discourse on a Sober and Temperate Life*, in his 80s and 90s, before dying at the age of 98.

But the prize for the most impressive conversion from slothful overindulgence to prime health must be awarded to George Cheyne. Born in Scotland in 1671, Cheyne studied medicine and then set up practice in London and later Bath. But his devotion to physic did nothing to deter him from a life of binge drinking, gluttony, and addiction to snuff to the extent that he ballooned to a gargantuan 32 stone (200 kg) in his 40s. Not surprisingly he had shortness of breath, lethargy, and serious episodes of illness, probably heart disease. He sampled the usual poisonous potions and purges in his own medicine bag before finally fixing on a complete health overhaul.

Cheyne managed to halve his weight and radically improve his health. Keen to share the secrets of his success, the slimline Cheyne published his *Essay of Health and Long Life* in 1724, in which he recommended a "spare and simple diet," avoidance of "strong liquors," and working out at tennis, football, or "ringing the dumb-bell."

An enthusiastic fitness freak, Cheyne even advised his friend, the novelist Samuel Richardson, to emulate his example of a daily hour long session on the "chamber horse," the Georgian equivalent of an exercise bike. Although he did not quite match Cornaro's longevity, Cheyne stuck to his health regime until the grand old age of 73—and never consigned his chamber horse to the attic.

Sources: See bmj.com.

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