**The story of cancer: Siddhartha Mukherjee's book reviewed, p 877**

# Junior doctors don't get enough teaching

PERSONAL VIEW **Anonymous**

I am a returning doctor. I qualified in the late 1980s and went through a general practice training programme of my own making, working all around the United Kingdom. Having been away for a few years because of ill health, I thought that the safest route back into medicine might be via a foundation year one (FY1) job, where the chance of doing anything catastrophic might be mitigated by the many layers of supervision.

What has happened to the profession in my absence? New drugs have evolved and practices have changed—and this is good and exciting (β blockers in heart failure was a bit of a shock though). But what has happened to education? In the past, you applied for a six month stint that looked interesting, and off you went. The consultants took pride in their work and saw teaching as a major part of their role. Consultant ward rounds were an opportunity to learn. Awkward questions were asked, to test and expand knowledge. Different treatment modalities were discussed and explained. The hard work and long hours were worth it, because we were learning. We worked in teams, and, as the junior house officer, you knew all your patients because you had personally clerked them in. You saw how patients with different treatment regimens progressed. Often, two consultants had different approaches, and you could compare the outcomes and reach your own judgment as to which was better.

Life as an FY1 is so different. Consultants are so pressured that they can't wait to get off the ward. They are in and out before the notes have even been found. There is no pride in teaching and no time between busy clinics. Nowadays, a poorly presented weekly lecture suffices, and the topics are chosen according to which poor registrar can be coerced into giving a talk.

Junior doctors no longer know the patients. They see them once or twice and then have a day off or do a different shift, so missing out on the ward round. Thus, the FY1 sees patients that they don't know and only briefly, and there is little continuity of care and little chance to follow a patient's progress.

The FY1 is becoming deskilled: now, health support nurses insert intravenous catheters and make up infusions. A phlebotomist takes blood samples. The ward round is constantly interrupted by the need to visit a computer, either to check results or to administer urgent discharge protocols. Computers demand more and more of doctors' time, to the detriment of time spent with the patient. Each programme demands its own username and password. Blood test results presented on computer screens have to be transcribed by hand into the notes. Who thought this was a good idea? The old system of results being stuck in the notes worked so much better, but somebody thought progress means that we computerise everything.

During the bad weather earlier this year the weekly lecture was packed with FY1s eager to work, learn, and progress in their chosen discipline. Despite terrible snow storms we were all there, working and learning. Immediately after the lecture, I visited the deanery. Acres of office space, hundreds of computer stations, and so many desks and chairs all lay empty. Only one administrator and a secretary had made it in because of the snow. Such is the commitment to training.

Is education being squeezed out of the junior doctor's role because of workload or because of indifference? Certainly the new system by which job applications are centralised through the deanery has not improved teaching or eased the path to employment.

What has happened to our profession? The consultant grade has not served us well. Consider the iniquitous hours that junior doctors used to work. The consultants ducked that issue and we got stuck with the EU Working Time Directive. Now they are ducking the issue of teaching, and we are stuck with an overly complex deanery system that works to no one's benefit. Consider: the junior cannot choose the job and the consultant cannot choose the junior. So who benefits? Consultants complain about a system that silts up the wards with patients awaiting their package of care, but they are unwilling to take the action necessary to resolve the situation.

Consultants need to take charge and protect the profession of which they are the senior leaders. Their job is not merely to heal patients and fulfil an administrator's target, but to leave behind them a profession better than the one they entered. You cannot help but feel that this is something to which many consultants have given little consideration; that they are content, instead, to become little more than technically advanced civil servants.

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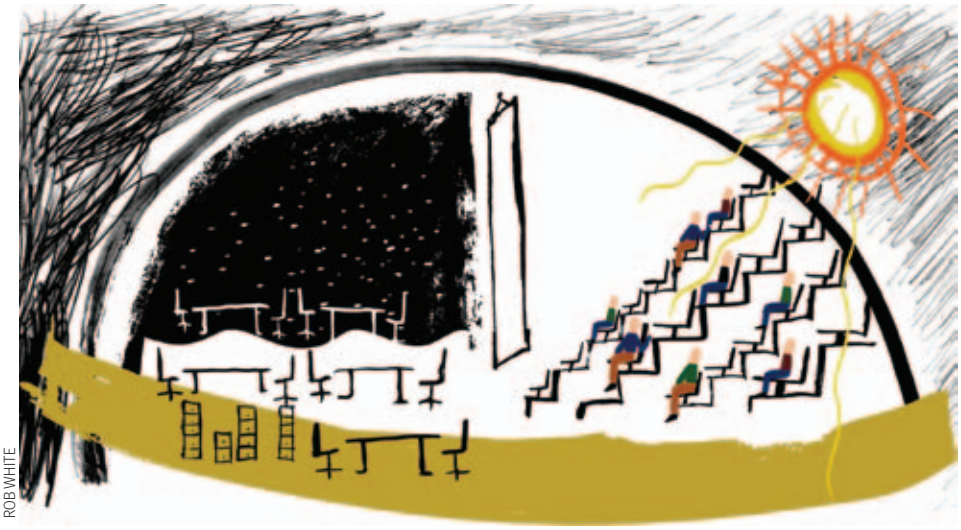
**Despite terrible snow storms we were all there, working and learning . . . Acres of office space lay empty. Such is the commitment to training**

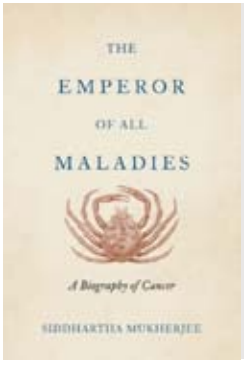


ROB WHITE

REVIEW OF THE WEEK

# A chronology of cancer

This comprehensive book describes a disease that kills seven million people globally a year. The stories of key doctors and patients, says **D Ross Camidge**, enrich this tale of cancer, from its first documentation to hypotheses about future treatment




The Emperor of All Maladies: A Biography of Cancer
A book by Siddhartha Mukherjee
Fourth Estate, 592 pp, £25
ISBN 978-0007250912
Rating: ★★★★

Quite possibly, all generations believe that they are *the* generation—the one that will make a difference. Such a belief can only be sustained when the past is ignored or overlooked. To read *The Emperor of All Maladies* is not just a way to open up the history of oncology, it is a way to relive it. The reader experiences simultaneously the thrill of feeling that we have entered the golden age of oncology, and the sobering realisation that so many generations before us have felt the same, and despite new and exciting victories, the war against cancer may never be truly won.

This so called biography of cancer tracks the disease's long interplay with humanity, from its first distinctive nibble marks on an ancient corpse through to its piecemeal tumble into the molecular biology grinder of the modern oncology clinic. Yet this is not just a biography of cancer: it is also in part a selected autobiography of the author. Mukherjee recognises that at its heart, medicine is about people and relationships. Time and again in this book, scientific revelations and tragic failures are given human context by flashbacks to the lives of individual patients, recalled from his recent experiences as a haematology-oncology fellow at Massachusetts General Hospital. And Mukherjee, undeniably, can write. Word play, witticisms, and literary references sparkle on every page, as if you had been kidnapped by a talkative and brilliant junior doctor who, desperate to impress, has strapped you down for company in his intimate homemade time machine.

The book is strongest and most gripping when it considers the science, art, and politics of cancer over the past 100 years. Fads for disfiguring surgery come and go. William Stewart Halsted challenges breast cancer "to duel with his knife," before the pairing of a lumpectomy with adjuvant radiation is proved to be equally effective in early stage disease. The now common sight of small, bald children fronting fundraising campaigns begins in 1948 with a boy called Jimmy, whose real name was Einar Gustafson; Jimmy seemed like a better name to speak to the American public. The involvement of the public in national cancer policies grows ever larger until the push for broad access to megadose chemotherapy in solid tumours—before clinical trials are complete—tips the public's enthusiasm for new developments in a lethal direction.

Written by a trained oncologist, this is a book that focuses on breakthroughs, in all their many forms. Quacks are given no noteworthy space on the page. Even the birth of biostatistics is celebrated and made interesting. Inevitably, as the focus moves to the more recent past, when most protagonists are still alive and working, the millwheels of history have had less time to loosen the wheat from the chaff. But even in this difficult territory Mukherjee makes excellent choices, spending over half the book on most of the revolutionary discoveries in molecular biology that have set the scene for today's multiple, hypothesis driven, targeted treatments.

Strangely, the only areas that seem forced are Mukherjee's descriptions of his own emotional reactions to his patients. Reports of his patients' interactions with him also seem oddly distant. Now this may just be an indication of a good writer who still has relatively limited clinical experience to date. But it may also be that, in a variant of Stockholm syndrome, the student of cancer cannot hide that he has fallen a little in love with the disease that so captivates him. This is not unknown. In Margaret Edson's play *Wit*, Dr Posner, the young researcher, is disarmingly self-aware, honest, and alienating at the same time when he tells his patient that he chose to study cancer because, "It's incredible, it's perfect."


IANS

**Mukherjee: oncological observations**

**The push for broad access to megadose chemotherapy in solid tumours—before clinical trials are complete—tips the public's enthusiasm for new developments in a lethal direction**

Perhaps it is simply that to function as any doctor, especially a cancer doctor, you have to ration your emotions. If you have to break the worst of news you can do it once, maybe twice, a day and still feel it. But if you have to tell someone they are dying more often than that—or, as a busy trainee, do so day after day without time for recovery—you may say the same words, and make the same gestures, but sometimes there is nothing left to feel, only the memory of what that feeling once was like. On such days, doctors may notice their own shell start to harden and wonder what the point of it all is.

*The Emperor of All Maladies*, with its compelling story of our checkered but unrelenting progress against the darkest of foes, could help us all to take a step back, see the bigger picture, and keep both our medical and human fires alive.

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**bmj.com archive**

- Read William Stewart Halsted's obituary (*BMJ* 1922;2:663-4)
- Read a review of the play Wit by Margaret Edson, about experimental chemotherapy in a patient with ovarian cancer (*BMJ* 2000;320:257)

BETWEEN THE LINES **Theodore Dalrymple**

# Himmler's doctor

Spy stories, with few exceptions, fail to excite me; I prefer a good murder any day. But one of the most gripping books I have ever read was by Joseph Kessel, *Les Mains du Miracle*, translated into English as *The Magic Touch* or, in the United States, as *The Miraculous Hands*. It is about Heinrich Himmler's personal doctor, Felix Kersten.

Kessel (1898–1979), like so many writers the son of a doctor, was born in Argentina and brought up for a few years in Russia before his family moved to France. He was an adventurer on a grand scale and wrote scores of books. Decorated in the first world war, he joined the French resistance in the second. After the war, he heard about Dr Kersten, then living in Sweden. He interviewed him for many days, and wrote a documentary fiction about him, which was published with a preface by Hugh Trevor-Roper in 1961, shortly after Kersten's death.

**Kessel: wrote about Dr Kersten**

Kersten was Finnish, though born in Estonia when it was still part of the Russian Empire; he fought against the Soviets in 1919 and afterwards became a masseur in the Finnish army. He studied medicine in Germany but became a disciple of Dr Ko, a Chinese masseur (who also qualified in Western medicine in London) who used ancient Tibetan techniques of massage.

Dr Kersten soon built up a large clientele in Germany—for example, healing a famous industrialist who was so grateful that he gave him a fee big enough to buy a large estate.

Himmler, who had intermittent but excruciating abdominal cramps that no doctor could relieve, heard about Dr Kersten and consulted him. Kersten's magic touch relieved Himmler's suffering as nothing else could, and Kersten became Himmler's trusted confidant. Kersten used his position to intervene with Himmler to save hundreds and ultimately thousands of lives.

**Kersten used his power to act as a spy . . . to get [Himmler] to abandon his plan to deport the whole population of the Netherlands to Poland**

According to Kessel's book, Kersten used his power over Himmler's abdominal cramps to act as a spy for the Swedish, Finnish, and Dutch governments in exile and to get him to abandon his plan to deport the whole population of the Netherlands to Poland. He told Himmler that his cramps would not yield even to his treatment while he, Himmler, was trying both to increase the size of the SS to more than one million members and work on the planned deportation; it was too much for his nervous system. Kersten told Himmler that he had to abandon one or the other if the massage to relieve his symptoms was to work; and he knew that increasing the size of the SS was more important. Himmler did abandon the plan to deport all the Dutch. However, no proof that such a plan existed has ever been found.

Certainly part of the Kessel-Kersten story is true; there is documentary evidence that Dr Kersten intervened to save many lives. However, some doubts creep in. Dr Kersten is portrayed in the book as playing on Himmler's weakness for charcuterie; but Himmler was a strict vegetarian.

What was Himmler's chronic condition, whose recurring acute exacerbations could be completely relieved time after time by Dr Kersten's "miraculous hands," and by nothing else? Even opiates had failed to relieve Himmler's pain. Kessel expresses no interest in the question; he accepts Kersten's story at face value and expresses no scepticism towards it.

But the book is so well written that it carries you along with it. I challenge you to put it down once taken up.

Theodore Dalrymple is a writer and retired doctor

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# MEDICAL CLASSICS

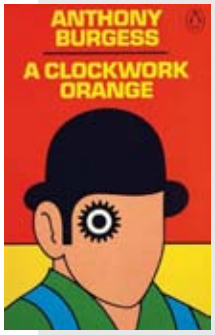
## A Clockwork Orange

A novel by Anthony Burgess, first published 1962

*A Clockwork Orange* is Anthony Burgess's exploration of violence and free will and their manipulation by the state through psychological treatment administered by the medical establishment. It arose from Burgess's abhorrence of the division of society by the establishment into the "well us" and the "sick them," and of his contempt for the dichotomous view that some people are criminals and others not, as opposed to a universal inheritance of badness as in the concept of original sin. The book is narrated by the teenager Alex, who displays conduct disorder and sexual sadism. He misuses drugs added to milk, the first of many perverse learning associations in which the state or the medical profession are culpable.

The reader learns to like Alex, despite graphic and remorseless acts of violence, including rape, because he is an eloquent and energetic intellectual. Alex is also cultured: he thrills to classical music and links Beethoven and violent thoughts together to stimulate himself more powerfully, the association demonstrating his propensity for both classical conditioning and self development.

After arrest for murder, Alex is beaten by the police and reminded that, "violence makes violence," introducing the concept of maladaptive learning by social modelling. Alex is treated with the Ludovico technique, an aversion therapy using classical conditioning. Injected drugs provide an unconditioned response of pain, sickness, and thirst, after which Alex is shown films of violence, including rape. Consequently, thoughts of violence and sex elicit conditioned unbearable suffering. The treatment cures Alex of his ability to contemplate or do evil, though his desire to do so remains. Dr Brodsky is triumphant, but the chaplain (like Burgess) is appalled: Alex ceases to be capable of moral choice; he is choosing to avoid pain rather than to be good.




During therapy, the violent films have classical music soundtracks, causing the accidental effect (by counterconditioning) of suffering whenever Alex hears his beloved music, demonstrating the imperfect understanding by the doctors of the consequences of their treatment.

After his so called cure, Alex is released from prison. The sickness induced by classical music leads to a suicide attempt. Alex survives and is again treated by the medical profession. Again Alex revels in Beethoven's ninth symphony, fantasising about carving the face of the whole world with his cut throat razor, sinisterly reflecting, "I was cured all right."

However, in the last chapter Alex loses interest in violence and wants to find a woman to father a child with, to become creative rather than destructive. His human instinct defeats the prediction of lifelong psychopathy. He embarks on modelling or social learning, from one of his gang who has settled into marriage; he realises he is growing up.

*A Clockwork Orange* questions the ability of doctors to treat antisocial people effectively and ethically. It illustrates the ubiquity of violence, which pointedly includes that of doctors. The book reminds us as doctors that professional privilege can extend to condescension and inhumanity.

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# Child of our time

FROM THE FRONTLINE

**Des Spence**

In general practice we study the so called consultation, and its various models. This causes much hilarity in other specialties: they say, "you can't teach consultation skills." This is true to an extent: if you are a plank of wood and you choose to smile, you are still a plank of wood. But the value is the opportunity to make us reflective.

Transactional analysis is one such model of the consultation: it suggests that during interactions with people we adopt three potential roles—that of the parent, adult, or child. Traditionally, doctors have been paternalistic, lecturing patients as we might our children (clearly I don't do this to my children, always explaining and reasoning to my blank faced five year old).

Modern medicine has rightly moved away from this parental approach, towards meeting patients as equals, adult to adult. We negotiate and come to joint decisions. Although I generally get lost in and quickly bored with psychology concepts, transactional analysis seems to make intuitive post-Freudian sense. There is, however, a problem.

Just as doctors began to move to an adult to adult relationship with their patients, something changed in society. The mantra of my generation was, "if you want to be treated like an adult, then start behaving like one." Childhood was merely preparation for adulthood. But society now sees childhood as a completely separate entity. Likewise, we have sought to protect other vulnerable people in society. We have evoked legislation and political correctness to stifle any discussion about the appropriateness of this value system. There is much good in it, but it has gone too far.

The results are persistent childlike attitudes and behaviour into adulthood. This is not the occasional irresponsible act, but severe and enduring behaviours. Adults nowadays are quick to blame others and unwilling to accept responsibility. With criticism, perceived or otherwise, many adults resort to anger, tears, stamping feet, complaining, and threatening behaviours. If this doesn't work, many resort to simple avoidant behaviour.

Medicine often rewards and reinforces these behaviours by offering medical explanations and by labelling them, allowing the social benefit of the so called sick role, and access to financial benefits too. Currently, we have the highest rate of reported disability, in a time with the lowest rate of physical illness.

Those in positions of responsibility, like doctors, teachers, and the police, find it almost impossible to challenge childlike behaviour, however destructive, manipulative, and disruptive. But the real victims of our misplaced overprotection are the coming generations, in whom childish passivity is replacing adult self reliance. And there aren't any parents left to tell.

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# Come back, Mr Chips

IN AND OUT OF HOSPITAL

**James Owen Drife**

Invited recently to give a talk on "the role of men," I felt I had plenty to say. Men make up only a quarter of the NHS workforce. Gender politics are deterring almost all male medical students from a career in obstetrics. Television commercials are filled with feckless male stereotypes. For a lecture, though, I needed some facts that were up to date.

Firstly, let's consider men's role in reproduction. Last September, the European Science Foundation reported that a fifth of men have abnormally low sperm counts. The Foundation linked the decline, and a quadrupling of testicular cancer in Scandinavia, to environmental factors. Furthermore, testosterone concentrations in US men have fallen substantially in the past 20 years, even taking obesity into account.

This was news to me. If such worrying changes were affecting women they would be all over the media. Scientists are recommending urgent research, but it is not clear if anyone is listening, perhaps because the experts calling for help are men. We need more female andrologists.

What about broader issues? Fortunately, *Social Trends*, that treasure trove of national statistics, is now on the web (www.statistics.gov.uk/statbase/Product.asp?vlnk=5748). I was pleased that the gap in pay between the sexes has disappeared among people under 30 but unhappy that, compared with 10 years ago, men older than 25 are more likely to be living alone—and if they are older than 75, much more likely.

But the trend that really upset me was in education. I knew, of course, that girls do better than boys at school, but the difference in percentage points between girls and boys who passed two or more A levels has increased from 2 in 1990-1 to 12 in 2005-6. The reason is not hard to find. Male teachers are leaving in droves. The number of male secondary school teachers in UK state schools fell from more than 150 000 in 1981 to fewer than 100 000 in 2006.

Does this matter? Doctors seem comfortable with medicine becoming, eventually, an all female profession. I think teaching is different, especially in a country where 2.8 million children are being raised by lone mothers. Surely boys need male role models outside the worlds of sport and computer games.

Putting this and more into my PowerPoint presentation, I braced myself for a hostile reaction. "Serves men right," has become a familiar response. But when I finished speaking, the faces in the small room were thoughtful, regardless of sex.

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