

Preference is given to letters commenting on contributions published recently in the *JRSM*. They should not exceed 300 words and should be typed double spaced

Is learning driven by teaching or research?

Professor Leinster (January 2004 *JRSM*¹) states that there has yet been no proof that high-quality teaching in universities is correlated to high-quality research:—a point often expressed by the senior politicians and civil servants responsible for higher education. However, during the last decade it was often remarked that, to cursory examination, there was a remarkable coincidence between those university departments that scored highly in the research assessment exercises (RAEs) and those that scored highly in the teaching quality assessments. All of this information is in the public domain: has nobody yet analysed it?

More to the point is the suggestion, in his excellent article, that to look for a correlation between research and teaching is to obscure the irrefragable relationship between research and learning. Learning, and acquiring the skill of how to learn, can only take place in an environment of discovery provided through research.

However, I must challenge some of Professor Leinster's facts in his analysis of the RAE and its outcomes. The RAE was actually a 7 (not 5) point scale. A curiously English invention, it ran from 1 to 5, but with grades 3a and 3b and 5 and 5* there are actually 7 points. More importantly, it is not true that only the highest (5 and 5*) grades were funded. 4s were funded, but at a lower level than previously. 3s were funded for the first year; 3as in unit of assessment 11 (professions allied to medicine) continue to receive 'developmental' funding.

But it is the philosophical basis of his contention that is a double-edged sword. Yes, it may well be deplorable to remove research funding from departments engaged in medical education, because the subsequent demise of research activity will inevitably damage the inquisitive learning that is necessary if we are to maintain the highest quality supply of educated doctors capable of advancing their profession. However, if the research of some departments has been judged not to be of the highest grade (i.e. 5/5*), does this not, by his own argument, suggest that the learning will also be second rate? Or is 'good enough' research sufficient to produce 'good enough' doctors?

I will be the first to admit that there is no comfortable answer to these issues. I do believe that research which has been judged to be of (at least) 'national levels of achievable excellence' is not only worth encouraging, but is also a valuable and positive beneficial stimulus to students' learning, and therefore should be supported. The essential problem is that, in the UK, we are world beaters at

producing excellence in both research and teaching for the minimum financial input, and that the indisputable increases in both the quality and quantity of our teaching and research over the past years has outstripped the nation's political desire to provide adequate funding. This not only affects medical education but also has a major negative impact on strategic research undertaken by our universities that might otherwise support innovation and growth in the domestic economy.

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- 1 Leinster S. Medical schools: are we paying for education or for technical training? *J R Soc Med* 2004;97:3–5

John Snow and anaesthesia

As an admirer of all that Dr Stanwell-Smith has done for the John Snow Society, I comment reluctantly on her review (December 2003 *JRSM*¹) of the recently published biography.² Why does she describe Snow as curmudgeonly? Sir Charles Locock, in his 1859 presidential address to the Royal Medical and Chirurgical Society, eulogized Snow as follows: 'Dr. Snow was recognized everywhere as a remarkably modest and unassuming man, strictly honorable, of a thoroughly amiable disposition, and few have been more regretted by all who had the pleasure of knowing him.' Hardly the description of a curmudgeon.

How did his decision to specialize in 'the new and controversial technique of anaesthesia' militate against the recognition of his contribution to medicine? The controversy, if it had any existence at all, was against obstetric analgesia, and did not last long. Snow could list the Queen and members of the nobility among his patients. His contribution to the science of anaesthesia was well recognized in his lifetime, and has been ever since. He is one of the supporters of the Royal College of Anaesthetists' coat of arms, and the Association presents a John Snow Silver Medical.

There would be no point in the Michigan-based authors belonging to the John Snow Society, because it does not publish proceedings. However, I, who was the authors' gofer on this side of the Atlantic for some four years, and whose name appears on the title page, have been a member for more than ten, and I can testify that three of the authors, during visits to London, bought memorabilia from the John Snow Society and visited the eponymous pub.

I was present at the late Dick Ellis's memorable Blessed Chloroform Lecture. That there has been only one does not indicate a lack of interest in Snow; the *Proceedings of the*

History of Anaesthesia Society and the anaesthetics journals provide evidence to the contrary. Has anyone been invited to deliver a second Blessed Chloroform Lecture? Anaesthetists being a self-effacing lot it goes with the specialty are not going to nominate themselves.

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- 1 Stanwell-Smith R. Book of the month. *J R Soc Med* 2003;96:612-13
- 2 Vinten-Johansen P, Brody H, Paneth N, Rachman S, Rip M. *Cholera, Chloroform, and the Science of Medicine: a Life of John Snow*. Oxford: Oxford University Press, 2003

John Snow and St George's

In her review of *Cholera, Chloroform and the Science of Medicine: A Life of John Snow* (December 2003 *JRSM*¹) Rosalind Stanwell-Smith is right to point out that John Snow's achievements have met with little recognition in Britain, while his true worth has been properly celebrated in the USA, because of 'the traditional British manner of delayed acknowledgement of non-military heroes (particularly in science)'. In 1847, John Snow was invited to give ether anaesthetics to dental outpatients at St George's Hospital and in *A Short History of St George's Hospital* (Athlone 1997) Terry Gould, an anaesthetist himself, wrote 'St George's may proudly boast of its connection with this great medical pioneer'. However, in 1997, when Dr Alex Thurlow and some of his anaesthetic colleagues at St George's Hospital made a formal proposal to call his department 'The John Snow Department of Anaesthesia' it was rejected by the majority of anaesthetists there. They obviously thought that a ward and a pub named after John Snow were sufficient honour.

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Evidence-based and complementary medicine

The two articles on evidence-based medicine versus complementary medicine, published in the January 2004 *JRSM*^{1,2}, would perhaps be more convincing if they did not ignore the numerous drugs which we are happy to peddle and the benefits of which, while 'evidence-based', are all too obviously either doubtful or negative. As I survive into retirement I have to listen more and more to the experiences of friends and relations who are on various

tablets. Many are on six or more different compounds, often given to counteract the side-effects of the others. Some are more or less disabled by their pills. As a purely social acquaintance one cannot be too inquisitive about the exact identities of the substances involved, but ordinary conversation often raises doubts about what has been prescribed and what for.

An example might be provided by a close relation, aged 74, who was found at a routine examination to have a marginally raised blood pressure. He was given medication for this, and as a consequence suffered from dizziness, which prevented him from driving a car. He went back to the surgery, where he saw another doctor, who put him on another medicine for the dizziness. This gave him a dry mouth and indigestion, so he went back to the surgery again, where yet another doctor diagnosed depression and put him on an SSRI. Following this he became confused and inarticulate and even more depressed. His wife and daughters began to think about funeral arrangements. Fortunately he went back to the surgery again, where he saw the practice principal, a woman on the verge of retirement and still applying a measure of commonsense, who decided that there never had been any hypertension and took him off all medication. He is now symptom-free and alert and drives his car all over the county where he lives.

This is an anecdote. Does that mean we must ignore it? How many such anecdotes constitute evidence? How can there be a controlled trial of old folk who are on too many pills? Which drug company will subsidize such a trial?

My first experience as a house physician was in 1955 with Donald Hunter, then senior physician to the London Hospital. He used to say that we were leaving the period of dangerous surgery and entering that of dangerous medicine. He seems to have been right.

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- 1 Koutouvidis N. CAM and EBM: arguments for convergence. *J R Soc Med* 2004;97:39-40
- 2 Ernst E. Patient choice and complementary medicine. *J R Soc Med* 2004;97:41

Diagnosis of abdominal tuberculosis

From their retrospective survey (December 2003 *JRSM*¹) Mr Rai and Mr Thomas conclude that, in suspected abdominal tuberculosis, diagnostic laparoscopy is the investigation of choice. They do not refer to a similar report by myself and colleagues on 14 patients, in which we recommended diagnostic laparoscopy when the Mantoux