ACP news

Trainees, banding and the future
Black and white magic in Turin
Death in the South Atlantic
Top tips for tutorials
## Calendar of Forthcoming Meetings

### DIARY DATES FOR 2011

<table>
<thead>
<tr>
<th>Date 2011 &amp; Organisation</th>
<th>Title</th>
<th>Venue</th>
<th>Contact Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 – 30 September</td>
<td>25th ACP Management Course</td>
<td>Hardwick Hall Hotel, Sedgefield</td>
<td>01273 775700 <a href="mailto:info@pathologists.org.uk">info@pathologists.org.uk</a> <a href="http://www.pathologists.org.uk">www.pathologists.org.uk</a></td>
</tr>
<tr>
<td>Association of Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathologists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>President-elect</td>
<td>Professor T J Stephenson</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vice-Presidents</td>
<td>Dr A Galloway Dr E Watts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chairman of Council</td>
<td>Dr W J Fuggle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td>Dr D Bareford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treasurer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Editor/Publications</td>
<td>Dr Julian Burton</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Editors</td>
<td>Dr E Carling Dr Su Enn Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postgraduate Education</td>
<td>Dr M K Heatley</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management Course Organisers</td>
<td>Drs A and M Galloway</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Secretariat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Association of</td>
<td>The Association of Clinical Pathologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Pathologists</td>
<td>189 Dyke Road Hove, East Sussex, BN3 1TL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tel: 01273 775700 Fax: 01273 773303 email: <a href="mailto:info@pathologists.org.uk">info@pathologists.org.uk</a></td>
<td><a href="http://www.pathologists.org.uk">http://www.pathologists.org.uk</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Administrator Ms A A Martin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrator – Finance Mrs R Eustace</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Editorial Assistant Miss J Rush</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Correspondence should be addressed to: The Editor, Association of Clinical Pathologists, 189 Dyke Road, Hove, East Sussex, BN3 1TL Email: JulianBurton@doctors.org.uk)

© acpnews 2011 all rights reserved. No part of this publication may be reproduced in any way whatsoever without the permission of the Association of Clinical Pathologists. Charity registration number: 209455

The ACP accepts no liability for errors or omissions in this calendar of meetings. Readers are reminded that advertised meetings may be cancelled. Those intending to attend are obliged to check the details on booking with the organiser in every instance. There will be a £25 administration fee per issue for entries in this table.

---

**Dr Ed Carling** is Assistant Editor of ACP news and Consultant Histopathologist at James Cook University Hospital

**Dr Su Enn Low** is Assistant Editor of ACP news and Consultant Histopathologist at Pennine Acute Trust
Contents

P4 Invitation to contributors
P5 Editorial

LEAD ARTICLE
P7 Trainees, banding and the future – Dr Mark Ong

ARTICLES
P10 More than just a case – Mr Mike Tonkins
P12 Black and white magic in Turin: anatomy, criminal anthropology and fruit – Dr Carl Gray
P15 Death in the South Atlantic: a tale of two pathologists– Dr Stuart J Hamilton and Dr Sarah L Saunders
P19 How to approach Extended Matching Questions – Dr Julian Burton
P22 Ten top tips for floorless undergraduate tutorial teaching – Dr Alison Finall

BURSARY AND AWARD REPORTS
P24 ACP Travel Grant: Uropathology with Dr J Epstein– Dr Preeti Chaudhri
P26 The “USCAP” meeting in San Antonio, Texas – Dr Mark Heatley
P27 ACP Travel Grant 6th joint meeting of the BDIAP and the Pathological Society of Great Britain and Ireland, Ghent, Belgium, 10-13th May 2011 – Dr Orla O’Mahony
P30 Career development award: MSc Medical Education – Dr Esther Youd

TRADECRFT AND MEETINGS
P33 Liaison Officers Annual Meeting report – Drs Mike and Angela Galloway
P36 Report of the ACP Alumni Meeting in Morecambe: May 2011 – Professor B Corrin
P38 30th Annual meeting of the British Association for Ophthalmic Pathology – Dr Caroline Graham

TRAINEES’ ZONE
P39 Making the transition from trainee to consultant – Dr Ed Carling

BOOK REVIEWS
P41 Another collection of book reviews collected by Dr Ian Chandler

THE COLUMNISTS
P45 Mat cat woman disease! – Dr Su Enn Low
P46 Support your local R&D department – The Unmasked Pathologist
P48 Adventures in 21st Century Medicine (part 2) – Professor Kevin Kerr
P49 The King’s Fund Top Manager Programme 2011. Part 1: conscious incompetence – Dr Simon Knowles

CURETTINGS
P51 More of the weird and wonderful spotted by readers
Cover Story

This delightful autumnal scene allows the editor to play a visual pun on the American term for Autumn. It is Corra Linn – the largest waterfall in Britain by volume of water. Wordsworth wrote about it. Turner painted it. And now Dr Jonathan Watt, ST5 in Cardiology has photographed it with his Nikon D5000, f/14, 1 second at 35mm.

Invitation to Contributors

In addition to the constant flow of material from ACP Council, ACP committees and ACP branches, ACP news needs new material from you, the members of the ACP.

Pathology news items (1200-1500 words): Any items related to the ACP or the College, pathologists in general, or medical and management matters that may have an impact on pathologists.

Articles (1500-2000 words): These can be papers, reviews, essays, commentaries, critiques or polemics. Submitted articles are always very welcome, as well as suggestions for articles and/or details of people whom the editor may approach.

Reports (1000 words): These may be personal views and reports on interesting meetings, travel or anything else of interest to the readership. Travel reports are specifically for holders of ACP travel fellowships; however, other reports from abroad are welcomed.

Columns (600 words): Regular and irregular columnists exercise their thoughts. Please feel free to rant.

Pathological creative writing: All literary forms, including short stories, serials, surrealism and even poetry.

Appreciations (1000-1500 words): We prefer appreciations on retirement, rather than obituaries. Please discuss these with the editor before submission.

Photo-journalism: Favoured subjects include pathologists doing something interesting, or College and ACP officers doing anything at all. Interesting or artistic photographs are welcomed.

Columns: Suggestions are welcomed.

Trainees: Trainees are especially encouraged to submit material in any and all of the above categories. These will normally be placed in the trainees’ section. Appointments committees in particular value publications in ACP news.

Editorial Policy: The editor would particularly encourage overseas contributors, material from trainees, material from nonhistopathologists, commentary on current affairs in pathology, occasional columnists, innovations in pathology, humorous writing on pathology-related topics, and anything downright cantankerous.

Format: The ACP news style guide is now available on line via the ACP website in PDF format at: http://www.pathologists.org.uk/allpagestuff/publications_frameset2.htm. The publication is a magazine, not an academic journal, and long lists of references are generally considered unnecessary. Where given, references should be in the Vancouver style and should be kept to a maximum of around six per article, unless absolutely necessary. Alternatively, authors may prefer to give a recommended reading list, or a list of relevant internet links. The editor prefers these as they take up less space.

All suggestions are welcome; however, the editor’s decision is final.

ACP news is published quarterly. Regular publication dates are:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Publication month</th>
<th>Copy date</th>
</tr>
</thead>
<tbody>
<tr>
<td>SPRING</td>
<td>February</td>
<td>5th December</td>
</tr>
<tr>
<td>SUMMER</td>
<td>May</td>
<td>5th March</td>
</tr>
<tr>
<td>AUTUMN</td>
<td>August</td>
<td>5th June</td>
</tr>
<tr>
<td>WINTER</td>
<td>November</td>
<td>5th September</td>
</tr>
</tbody>
</table>

Copy is best submitted by email, or on disc if the file size is large, in any version of Microsoft Word, although it should be possible to accommodate other formats. Submissions on paper by snail mail will also be accepted. Illustrations should be sent as JPEG digital images or hard copy prints. Please do not embed images in your text. Send them as separate files.

Please send email submissions direct to the editor at julianburton@doctors.org.uk
Hello dear reader. As I write this in mid-June the sun is shining, the flowers in the garden are coming into bloom and the birds are keeping schtum in fear of the prowling death that is Milly, our young cat. It seems odd to be writing for an Autumn issue when it is not officially quite Summer, especially as the issue will land on doormats in Summer rather than Autumn. Nevertheless, that’s how it is and here we are, or rather there you are, for I will be off on my honeymoon when you receive this, which is of course terribly exciting (for me, if not for you).

Time and money
It is hard not to notice how expensive everything is these days. I suppose things aren’t helped by oil prices, house prices and the recession but crikey! And with university fees set to rise next year for many it’s only going to get worse. Going back as far as I can, my genetic stock derives from North and South Yorkshire, and so I have adopted my native battle cry of “HOW much?!”. Until this year I had always thought that the stress people suffer organising a wedding must somehow be exaggerated. Now I know better. We wanted something small, simple and relaxed for our do. Well, we started planning thinking that it wouldn’t take much time to organise and that it wouldn’t be very expensive. We were wrong on both counts. Now that we’re all done it has become fun again but I have been astonished at the details which needed sorting and dismayed at the cost of pretty much everything. People have asked how I know that the person I want to tie the knot with is “the one”. I think that if you have a relationship which can survive wedding preparations, you’re probably ready. Mostly we survived by agreeing to only consider wedding-related planning issues for a maximum of 15 minutes per night. This meant we dealt with everything in bite-sized chunks and I only had to inflict my battle cry once every evening.

My “groomzilla” moments are fading and so I move on to my point, and our lead article in this issue. As life becomes more expensive the sordid topic of performing tasks for money becomes more important. Now, the Association of Clinical Pathologists, like the Royal College doesn’t play a role in banding negotiations but these are nevertheless of keen interest and importance for many of the ACP membership. It’s a difficult topic, with strong views on both sides but pathology training posts are increasingly losing their banding. Some junior and senior pathologists doubtless think that pathology training should not receive a banded salary, while others will be equally firmly of the opinion that they should. I don’t know the answer, but in this issue Mark Ong tackles the subject and considers the impact that the widespread loss of banding may have on recruitment into Pathology in the future.

Pathologists’ travels
For many, this time of year is when we do most of our travelling. It seems appropriate, therefore, that there is a strong travel theme in this issue. Carl Gray has been visiting fruit in Turin. Stuart Hamilton and Sarah Saunders have been performing autopsies in the Falklands, which puts my ten-minute drive to the mortuary into perspective. It’s perhaps worth noting that the Falklands’ penguins do not look up and fall over backwards whenever a fighter jet flies overhead. With support from the ACP, Preeti Chaudhri visited Washington DC, Mark Heatley went to San Antonio and Orla O’Mahony went to Ghent. The ACP alumni got together in Morecambe. I always find it interesting to learn what other people have been getting up to on their travels, and I hope you find these articles of interest too.

Elsewhere in this issue
Sometimes the views and experiences of those new to the profession can give us pause to reflect on our own practice. The novice sees things which the more experienced, and perhaps more jaded eye may miss. In the first year of the MBCChB programme in Sheffield students are sent on a two-week placement to see...
Editorial

medicine in action and discover the impact that disease has on patients. In pathology, our patients may arrive as endoscopic biopsies, surgical resections, bodily secretions, bodily fluids or cadavers. Interesting cases may be shown to colleagues, who ponder the material while you explain that “You will never see another one!” Mike Tonkins’ experiences serve to remind us that there is a patient on the other side of the microscope.

I lose track of when examinations are happening. They seem to be a constant feature in my diary, albeit that they are for undergraduates. I don’t doubt though that some of you will soon be faced with either writing or answering extended matching questions (EMQs). To many who grew up with multiple choice questions, EMQs seem somewhat alien. I present you therefore with my advice on how to approach them, be you candidate or question writer. And in case you wonder why there is no mug-shot attached to that article, it is because I believe one reproduction of the editor’s glorious visage is sufficient to uplift any issue.

Continuing with the educational theme, Alison Finall presents her top ten tips for improving your undergraduate tutorial teaching and Ed Carling describes how he made the transition from trainee to consultant.

All in all, lots to keep your interest, I hope. We also have a crop of book reviews, and of course our columnists have been keeping busy too. Enjoy! I had better sign off as I can hear Milly coming up the stairs and there is more chirping than normal, so a rapid intervention may be in order.

Printer’s Apology

Despite our efforts towards perfect production of ACP news we are aware of four copies that were defective with missing pages in the last issue. Our machine operators were especially vigilant after a similar prior instance and did perform constant spot checks. The machines have many varied error detectors, to allow them to run at speeds up to 15,000 per hour, but in these instances both man and machine failed. After isolating any issue we do introduce additional preventive measures where possible. There is a new check we will introduce on the next issue to try and achieve 100% perfection.

Evolve is always happy to replace a defective copy.

www.pathologists.org.uk
ISSN No. 0260-065X
Trainees, banding and the future – Mark Ong

At a time of intense cost cutting, few will be surprised that many hospital trusts have withdrawn or are planning to withdraw banding supplements for Histopathology trainees. In the current financial climate, this may seem entirely reasonable, but are we jeopardising the longer term future of Histopathology to save several thousand pounds in the present?

The Origin of Banding
In the 1990s, it was common for junior doctors to work long hours, in some cases in excess of 100 hours a week. In 1991, acknowledging the potential detrimental effects of long hours on doctors, patients and training, a voluntary agreement was reached by all parties to reduce working hours, the so-called “New Deal”.

Several years passed and little changed, in part because hospitals paid for out-of-hours work at a lower rate than standard daytime work. In 1999, with a ballot for strike action in the offing, negotiations for a new contract began and were concluded in 2000.

The contract remunerated longer hours and out-of-hours work through pay supplements that were allocated by bands, these bands being determined by the total number of hours worked and the proportion of these done out-of-hours (see Table 1).

Table 1: How pay bands are calculated

<table>
<thead>
<tr>
<th>Band</th>
<th>Pay supplement</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unbanded</td>
<td>0</td>
<td>&lt;40 hours, between 7am and 7pm</td>
</tr>
<tr>
<td>Band 1A</td>
<td>50%</td>
<td>40-48 hours. Rota with duty periods between 7pm on Friday and 7am on Monday one weekend in four or more frequently, and 50% or more of out of hours duty periods involve working after 7pm, working at least 4 hours or more, or being resident for this.</td>
</tr>
<tr>
<td>Band 1B</td>
<td>40%</td>
<td>40-48 hours. Defined by exclusion of Band 1A and 1C criteria.</td>
</tr>
<tr>
<td>Band 1C</td>
<td>20%</td>
<td>40-48 hours and on-call rota of 1 in 8 without prospective cover (or less frequent) and not required to be resident, for clinical or contractual reasons.</td>
</tr>
<tr>
<td>Band 2A/2B</td>
<td>80%/50%</td>
<td>&gt;48 hours. EWTD non-compliant.</td>
</tr>
</tbody>
</table>

 Critics at the time pointed out that, were working hours to decrease in the future, junior doctors' pay would fall correspondingly. Perhaps the short term financial gains were too generous to refuse, or perhaps jaded and exhausted junior doctors simply felt that any change had to be an improvement. Whatever their reasons for voting "yes", the contract was accepted.

What critics of the contract predicted has come to pass. Junior doctors are no longer exempt from the European Working Time Directive 48-hour limit. Posts in Bands 2 and 3, with a few exceptional derogations, have ceased to exist. Most jobs are now in Band 1. The contract, as it stands, was negotiated with busy hospital training posts in mind. In acute specialties where rotas entail working nights and at weekends, posts attract Band 1A or 1B. In Histopathology, with little or no out-of-hours work, only two options are possible: less than 40 hours is unbanded, more than 40 hours qualifies as Band 1B; there is no in between.

Service
The general arrangement for trainee salaries is that the Deaneries pay the basic salary component and the hospitals pay the national insurance and banding supplements. Traditionally, the ST1 year (formerly the SHO grade) is
focussed on training rather than service and so ST1 posts have been unbanded. Beyond ST1 some registrar posts do attract banding in recognition of the hours worked and service provided to the trust, but an increasing number no longer do and many more are at risk. At 40%, each Band 1B trainee costs the hospital about £15000 (the basic salary for an ST2 starts at £31523). In a heavily supervised specialty like Histopathology, managers are questioning what value the hospitals gains for their £15000, spent so that trainees can be in the department from 9am to 6pm rather than 9am to 5pm.

Framed as a question, what proportion of work done by trainees constitutes service and is it enough to justify the extra salary? Clearly, this varies between departments, but most larger departments with a reasonable complement of trainees depend heavily on trainees to do the majority of surgical cut-up. Trainees also provisionally report slides, generate reports and manage immunohistochemistry and extra work requests. This frees up limited and more expensive consultant time. More senior trainees teach junior trainees and are able to prepare frozen sections as well as organise and lead multi-disciplinary team meetings. Finally, trainees, particularly those with full FRCPath, report independently and frequently “act up” as consultants towards the end of their training. For many of the listed activities, it is impossible to draw a sharp distinction between training and service. Unsurprisingly, there are no formal studies quantifying the service contribution of the average Histopathology trainee, but a survey on ENT surgical trainees showed that their activity brought in substantial income for the hospital trusts. Histopathology trainees are unlikely to generate the same income as craft-based specialties like surgery, but the paper challenges the commonly held notion that trainees are a financial liability.

Training
Another argument for paying trainees to work longer hours is that experience is gained by “shifting glass”, so to speak. While not all hours worked are educationally useful and teaching slide sets can compensate for shorter hours, all things being equal, the trainee who has worked a 45-hour week for 5 years will have significantly more experience than one who has worked a 39-hour week for the same duration. In some unbanded jobs, one half-day a week is rostered in order to ensure that the hours remain safely below the 40 hour threshold. Anecdotally, trainees in some unbanded jobs are fully supernumery: consultants and senior Basic Medical Scientists cover most of the cut-up and trainees are only given as many cases as can be comfortably finished within the limited hours. If your entire training consists of being supernumery and receiving only as much work as you can cope with between the hours of 9am to 5pm, how prepared will you be for the realities of working as a consultant?

Recruitment
Workforce planning is a notoriously difficult. At present, data supplied to the Centre for Workforce Intelligence points to an overall shortage of consultant histopathologists. There is training capacity for up to 100 histopathology trainees a year, but the number of trainee places offered has been much lower, in part because of a dearth of suitably qualified candidates. This year, there were 130 applicants for 60 posts, continuing a downward trend in competition ratios starting in 2006. Could the loss of banding be a contributing factor?

The financial circumstances of emerging medical graduates have changed significantly from a decade ago. Maintenance grants have long been abolished, tuition fees have crept up to the present rate of £3290 p.a. and will increase up to £9000 from 2012. Student loans taken out to pay tuition fees and living costs mean that medical students graduating in 2010 had an average debt of £23909. Free accommodation for FY1s has been withdrawn, study budgets have been cut, GMC fees run at £420 and there has been a salary freeze this year, with inflation, effectively a pay cut. As most training rotations are based around big cities, accommodation and commuting is expensive. To get an idea of how much money an unbanded trainee would earn, the current basic salaries and “take home” amounts are shown in Table 2 (based on trainees entering Histopathology direct from Foundation programme).

It is true that most pathologists will become consultants

Table 2: Considering trainees’ salaries

<table>
<thead>
<tr>
<th>Grade</th>
<th>Basic Salary (£)</th>
<th>Monthly ‘take home’ ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY1</td>
<td>22412</td>
<td></td>
</tr>
<tr>
<td>FY2</td>
<td>27798</td>
<td></td>
</tr>
<tr>
<td>ST1</td>
<td>29705</td>
<td>1880</td>
</tr>
<tr>
<td>ST2</td>
<td>31523</td>
<td>1983</td>
</tr>
<tr>
<td>ST3</td>
<td>34061</td>
<td>2127</td>
</tr>
<tr>
<td>ST4</td>
<td>37448</td>
<td>2214</td>
</tr>
<tr>
<td>ST5</td>
<td>37448</td>
<td>2319</td>
</tr>
</tbody>
</table>
before many of their contemporaries, but I suspect that many junior doctors will think long and hard before committing to 5 years of unbanded training, given that they will not have earned enough in their 2 Foundation years to pay off their student debt. Is it reasonable to ask those considering a career in Histopathology to defer a reasonable quality of life until they secure a consultant job, a minimum of 12 years from the time they entered medical school?

The Royal College of Pathologists has adopted a *laissez-faire* stance on the issue of banding, stating that this is a local issue for individual hospital trusts. A similar position was taken on the issue of preserving on-calls for Microbiology training. As the Microbiology curriculum had no specific requirement for trainees to do out-of-hours experience, banding issues were, once again, felt to be the prerogative of local trusts. For a new generation of Microbiology trainees, their first experience of being on-call will be as new consultants. For Histopathology, the equivalent dystopian product will be a generation of consultants raised on a 39 hour week with a 9 to 5 mentality. Do we want consultants who have merely satisfied the recommended number of cases or one who has surpassed them?

Oscar Wilde said "A cynic is a man who knows the price of everything and the value of nothing". £15,000 is the price for paying a trainee to learn and gain experience for several extra hours a week. Can you calculate the value of this to future patients?

For now, a plea: Consultants, your support for banding is vital. Banding cannot be removed without approval of the educational supervisors and consultants, but once lost, it is extremely difficult to reclaim. Trainees, if you still have banding, pull your weight in your departments and make full use of all opportunities to combine service and training. Formalise these commitments, if necessary, to demonstrate that your banding is justified. For Histopathology to flourish it needs to attract good doctors and then train them to a high standard. The loss of banding threatens this.

**Acknowledgements**

Thanks to doctors.net.uk Pathology & Pathology Trainees fora for ideas and suggestions.

**References**

The external doors to the anaesthetist’s room opened, and Mrs Jones was wheeled in on a bed. She sat fairly upright, and appeared alert as she surveyed the contents of the small white room. We greeted her cheerfully, and she smiled in recognition. The room was crowded, and at the anaesthetist’s request my fellow student and I slipped out, through the internal doors and into the theatre.

We had met Mrs Jones earlier in the day, in order to seek her consent for our presence in theatre. In the hectic round of pre-surgery tests, we had finally caught up with her in the deserted medical physics department. After introducing ourselves, we told her of our request – which she readily granted. Unwilling to leave her alone, we stayed and chatted. Mrs Jones was 71, and had worked for most of her life as an auxiliary nurse in a cottage hospital. She and I found common ground in our shared experience of Scotland, and chatted of the River Dee, Ballater, and Aberdeenshire. We talked of her family and her retirement, and she asked us about our experience of medical school.

Before long a radiographer appeared to collect Mrs Jones, and we left her in their hands.

Back in theatre, it wasn’t long before the internal door to the anaesthetist’s room opened once more, and Mrs Jones appeared again. The anaesthetist, the surgeons, and the scrub practitioner took their places. My colleague and I positioned ourselves where we could see the action. An assistant operating department practitioner busied herself in the background. “Ok to start?” asked the surgeon, and the operation began.

I did not think about Mrs Jones once in the next two hours. Two operations were performed on her unconscious body: a mastectomy and a laparoscopic cholecystectomy. Although I watched both procedures intently, not once did I think beyond the small area of visible flesh. I was engrossed in the possible clinical sequelae of her breast cancer, but I never considered what the disease and its disfiguring treatment meant for her. The technique and anatomy of the laparoscopic cholecystectomy was hypnotising; it did not cross my mind that for her this could be the end of years of recurrent biliary colic.

The final suture in place, Mrs Jones was taken to recovery. My colleague and I thanked the surgeon, washed our hands, and went home. Only later did I realise that, through my absorption in the operations being performed on her body, I had completely failed to consider Mrs Jones herself.

Challenging attitudes and behaviour
This event was significant to me because it challenged my ideas about myself: the type of person I am, and the type of doctor that I am becoming. In addition, it raised questions concerning the nature of the relationship between healthcare professional and patient. Finally, it highlighted a significant gap in my knowledge of breast cancer.

A patient must always be thought of, first and foremost, as a person. I do not believe it is possible to “treat patients as individuals and respect their dignity” if the physician thinks of patients as cases, or malfunctioning biological systems, rather than as people. It is not this value which has been challenged per se, but rather my beliefs about applying it. I used to believe that this value would be easy to realise in practice, and was shocked at how quickly I abandoned it.

Closely aligned with the value described above is another value: that holistic care is the concern of all healthcare professionals. Once more, the event described above is not significant because it has made me question this value. Rather, I used to believe that almost all healthcare professionals would share this value, and would employ it to “make the care of the patient [their] first concern”. The ease with which I developed tunnel
vision, focusing only on Mrs Jones’ pathology, has made me consider the obstacles to maintaining such a broad awareness of the patient.

The third reason this event was significant is because it highlighted a large gap in my knowledge of breast cancer. It is not obviously not possible to "provid[e] a good standard of practise and care" unless a doctor knows about the diseases that he/she treats. I was ignorant of almost everything about breast cancer: the screening programme, its prevalence, its pathology, its treatment and its psychosocial and clinical sequelae. I have never thought of myself as either sexist, or disengaged from large-scale issues; however I suspect that my lack of knowledge is at least in part due to the fact that I am male.

Lessons for the future
I have learnt that it is not enough to simply hold a certain value, and expect it to inform one’s practise. It is always necessary to consciously assess yourself, and judge whether a value is in fact being applied. The General Medical Council states that doctors have a duty to “recognise and work within the limits of [their] competence”\(^1\). This competence does not just include clinical skills, but can be extended to include our competency at relating to patients, and seeing the whole (holistic) picture. Being aware of our limits demands that doctors “be honest and open and act with integrity”\(^1\). Once more, this requirement for probity does not just apply to doctors’ dealings with others; they must also be open and honest with themselves. I now am much more disciplined at keeping a reflective journal, and am practising using different reflective cycles to find one which suits me. I believe that becoming proficient in a reflective process will be a useful skill, which will help me to realise my values in future practise.

How can the conflict between the patient as an individual, and the patient as a clinical case be resolved? Reflecting on this experience has reinforced my belief that healthcare professionals must primarily relate to their patients as people, rather than clinical problems. All that is humane and altruistic about the medical professions disappears unless we first recognise that it is not a "case" sitting in front of us, but (part of) a living, suffering human being. However, my reflection has also modified and matured this belief to a degree. I now understand that at certain times – such as during an operation – this humane foundation of the relationship must yield to more immediate clinical necessity.

Thirdly, I have learnt that the ideal of holistic care is understood and applied differently by different healthcare professionals in different circumstances. For example, the surgeons who performed the operation on Mrs Jones were empathetic and sensitive in their conversations with her prior to the operation. However, in the operating theatre they seemed not to spare a thought for anything but clinical details. On the other hand, the operating department practitioners had never met Mrs Jones before the surgery, and did not see her afterwards. I suspect that, since their role is primarily concerned with the technical, they have little use for holistic principles in their day-to-day practise.

Practise points
How has my practise been changed?

- I will always remember, before meeting any patient, that they are not a "case" but a living, suffering human being.

- I will make this belief the foundation of my relationship with patients, even during times when clinical considerations must take priority.

- I will ensure that I do my best to follow up patients whose surgery I have observed.

- I will keep a reflective diary, recording significant events and applying a reflective cycle to them.

- I will be more aware of the role of the multi-disciplinary team. Medical textbooks do not often mention the role of healthcare professionals other than doctors, and I will make a conscious effort to redress this imbalance in my learning.

References
“After Bologna, I believe that Torino is the most underrated major city in Italy. It receives very few tourists, yet it is full of style, glamour, personality, magnificent art, and culture. It has many of the finest cafès anywhere, wonderful promenades, a strong sense of history, of the value of work, and of itself.”

Thus spake Fred Plotkin, the guru of gourmets: the man who knows how to enjoy Italy.

This year is the 150th anniversary of the unification of Italy as one nation - *il Risorgimento* - and the country is suitably festive with the iconic green, white and red Italian flags. Even the Mole Antonelliana is sporting these colours as neon bands around its tower. And everywhere you see the ugly mugs of Vittorio Emanuele II, first king of Italy, Garibaldi the soldier and Camillo Cavour, the visionary statesman who invented the place, who now have their images on tea towels and, er, mugs.

Italians are celebrating their national unity; which is strange because no country offers such diversity and fierceness of regional identity as Italy. Stop the man in the street in Turin and he will say he is firstly a Torinese, secondly a Piemontese, and only lastly an Italian. Torino [Turin] is quintessentially Italian; the home of FIAT, Juventus, Grissini, and the seat of chocolate and coffee making since the 18th Century. It has more than thirty-six listed museums and galleries, including the Museo Egizio, the second largest Egyptology Museum in the world, after Cairo. The Pharonic loot is well presented and perennially popular, with long queues outside the door on bank holidays.

Super as a city break: who would not want to arrive at Torino Porta Nuova, second grandest railway station in the country and wonderfully developed and restored last year? But Torino has its dark side. Various relics are claimed to be hidden there and of course the Turin Shroud is now kept in the dark in the Duomo - after the mysterious fire in the Capella Sindone, its previous home in an extravaganza of black marble. There is a black magic tradition and indeed boundaries exist on the ground between Black and White Turin. Mumbo and every other form of Jumbo are popular with other esoterica.

Black and white magic in Turin: anatomy, criminal anthropology and fruit – Carl Gray

Dr Carl Gray is Medical Director, Harrogate and District NHS Foundation Trust, Harrogate, North Yorkshire, HG2 7SX.

Email: carlgray@btinternet.com.

Il Museo di Anatomia Umana “Luigi Rolando”

Three floors above the entrance from the Corso is the Museum of Human Anatomy. Founded in 1739 by the eponymous Dottore Rolando, who was so keen that he left his own skeleton for exhibition, this must be the most traditional anatomical museum left in the world. Thousands of human specimens are kept unlit and unlabelled in magnificent cabinets and glass cases. Wonderful prospected cadavers, organs and anatomical wax models show human anatomy inside out. Dusty and dull, these are nevertheless excellent dissections which were the state of the art in their day. There is a strong emphasis on naughty bits and obstetrical anatomy. Clearly one of two strands of inspiration for the dreaded von Hagens - the other is the Musée d’Anatomie Delmas-Orfila-Rouvière in Paris - these Torinese anatomists were opening doors on the body and showing us things from all angles from the 18th century onwards. Dreadfully unfashionable, this is the classical example of an anatomical museum. It holds extensive collections of anatomical specimens, skeletons, comparative zoological specimens, the inevitable embryological deformities, instruments and documentary archives.

There are some oddities. One case holds phrenological specimens (*frenologia*) including plaster casts of skulls and death heads of notable individuals. There are plaster
The museum is a beautifully presented collection of macabre nonsense. In addition to Lombroso’s memorabilia - including his own preserved skeleton which he gamely willed for later study and which is on show - are collections of portraits, and measurements of criminals, instruments, human remains of noted criminals, death masks, gallow and prison materials. Examples of “material evidence” include a world-class collection of used daggers, stilettos, garottes, blunderbusses, poisons and other offensive weapons and criminalia of all types from notorious cases. Fascinated with the criminally insane mind, Lombroso collected remarkable artefacts, clothing and records made by inmates of prisons and asylums.

Altogether, the collection is weird, alarming in its demonstration of human cruelty and suffering and strangely endearing. Alas, Lombroso was wrong, as shown already by the brains of the child delinquents’, criminal behaviour has no scientific basis in quantitative anthropology. Criminals have the same range of individual variations in brains and skulls as the rest of us. His theoretical views of regression to the primitive condition, although typical of his period, now seem racist.

The curators of the museum do know this and their leaflet acknowledges that Lombroso did not in fact advance knowledge as he had hoped. In fairness, his method was fundamentally scientific, using data to test theory, although his conclusions now seem adrift on nature and nurture in criminal causation. But Lombroso, a scientist and criminologist, was one of the first to bring scientific methods to the study of criminals and crime and he raised important questions, and was a respected figure, “...Who embodied the hopes and contradictions of a period that strongly influenced the transition to modern society.”

Il Museo di Antropologia Criminale “Cesare Lombroso”

Entered from the via Pietro Giuria on the opposite side of the palace, lies the Museum of Criminal Anthropology. This is a tribute to the work of Dr Lombroso, whose life’s work was the quantitation of physical features in correlation with madness, delinquency, criminality and genius. Lombroso conceived his “Theory of Atavism” by revelation in 1870. This held that defective biology was the cause of criminality. In particular, he studied the skull of a notorious brigand, Villella, captured and duly executed, and formed the view that his criminality originated in the size of a fossa in the base of the skull. The boundary between black and white Turin

heads of the nasty Napoleon Buonaparte, once Emperor of France, and the man he called, “A shit in a silk stocking,” the princely Prince Talleyrand, the only political survivor of all the revolutions. Boney is a bit of a big-head with a bumpy bonce. Talley is more of a wizened crone with a skull as smooth as his tongue once was.

A long-gone anatomist had a special interest in the dried brains of delinquent children. These specimens have turned black and hundreds, each with their separated hindbrain, line cabinets and shelves.

As a bench-marking exercise and to gain international perspective, each inspector of the Human Tissue Authority should spend a day here. In comparison with our histological samples “the size of postage stamps,” this immense Noah’s ark of tissue and bones must weigh several tonnes.

Il Museo della Frutta “Francesco Garnier Valletti”

Across the entrance corridor from the madhouse, lies the charming Museum of Fruit. Exactly as it says on the tin, this celebrates the history of botanical and agricultural research, the Burdin family who were a dynasty of nurserymen in Piemonte, and chemistry applied to agriculture.

The centrepiece is the museum within the museum: the pomological collection of more than 1000 wax fruits modelled by Francesco Garnier Valletti (1808-1889).
A magical afternoon
So if you like old and odd museums; you will like these three old and very odd museums. There’s no tea shoppe and the bookshops are fusty. The single toilet (for the whole building?) is in a very strange basement with doors locked on horror storage rooms beyond. You would not want to spend the night at these museums.

As an exposition of both dark and light, good and historically outmoded science, this is exemplary. If you have at your disposal, with suitable consent, the preserved skeleton of someone who suffered a deformity following an assault with a piece of fruit by a criminal lunatic, then I have just the place to put it on show.

If you want to see hundreds of dried brains, the plaster death head of Talleyrand, dozens of actually-used bladed weapons and a thousand wax fruits, come to Torino, the kids will love it.

Contacts
Museo di Anatomia Umana
corso Massimo d’Azeglio 52, 10126 Torino, Italy.
www.museounito.it/anatomia

Museo di Antropologia Criminale
via Pietro Giuria 15, 10126 Torino, Italy
www.museounito.it/lombroso

Museo della Frutta
via Pietro Giuria 15, 10126 Torino, Italy
www.museodellafrutta.it

Hours: 1000-1800 Monday to Saturday; closed Sunday.

Reference

Beautifully exhibited in elegant cases and excellently lit are hundreds of type examples moulded from life in life-like coloured wax of named varieties of apples, pears, peaches, apricots, plums and grapes. They are good enough to eat. Pomes (apples and pears) are extremely well-represented with over 700 different varieties, but stoned-fruits or drupes - as we call peaches, apricots and plums at Sainsbury - are plentiful. Fungi and rotten fruit are also modelled along with some pests. These models are simply brilliant and it would be worth writing a thriller with the denouement set in a wax fruit museum simply for the purpose of seeing the film made here.

You may like your “William” or your “Conference” but the genealogy of lowly pears for the masses originates in romantic Piemontesi orchards stocked with “Fondante de la Maître École” (No. 639) and its varietals and humming with bees, serious nurserymen and botanists. To understand the bio-diversity of pome and drupe you have to see over a thousand different examples in one place.

One foot in the grave
I spent over an hour at the wife’s grave this morning.

Bless her, she thinks I'm digging a pond.
It is a truth universally acknowledged that attending meetings is a sure way to be given more work, and in forensic pathology as often as not this means travelling somewhere to perform an autopsy. It is unusual for this to be a long journey, although it can be a bit of a trek at times. When you’re asked if you’re free to go to the Falkland Islands, that’s a very long trek indeed (about 8000 miles in fact!).

The Falkland Islands are a British Protectorate in the South Atlantic. The population is only 3000, mainly centred in the capital Stanley. There is a single 27-bedded hospital with a small accident and emergency department, an acute ward with a two-bedded intensive care unit, an isolation unit, and a maternity bed. The hospital is staffed by five resident medical officers with one general surgeon and an anesthetist. There is no histopathologist or forensic pathologist. The Islands have a Coronial system, so any sudden, unexpected or unnatural death will require a medicolegal autopsy, and when such a death occurs it’s time to find a pathologist with time and inclination to make their way. In 2010 there were 10 deaths on the islands which generated three inquests.

Which is how we found ourselves obtaining passes to be allowed onto RAF Brize Norton in order to board the Sunday evening “airbridge” flight to Mount Pleasant Airport via Ascension Island. Being a military flight, it was unlike most of the flights we’d taken before. As if flying 8,000 miles to do an autopsy wasn’t strange enough, looking at an Air Seychelles airliner chartered by the Ministry of Defence surrounded by military aircraft was very odd indeed. The other two flights out that night were to Camp Bastion in Afghanistan. Fortunately we didn’t get mixed up as to which one to board! Entering the departure lounge was rather like mixture of flying [name of really bad budget airline redacted] and a school trip. We lined up in alphabetical order to go into the gate and then sat.

And sat.

Then the rather well built scary uniformed man informed us that as the weather between the UK and Ascension Island was “beyond the tolerance of the aircraft and we would not be flying that evening”. We could hear the italics. But at least they were going to put us up overnight in the “Gateway Hotel”. Or barracks, as we soon discovered. They also decided not to offload our luggage. Sarah, being female, was well supplied with a change of clothes, toiletries, and makeup, resulting in her

Sarah Saunders has an audience
looking like a L’Oreal advert the following morning. Stuart, being male, was well supplied with a PC and an iPod and having had to share a room with a man who snored like an adenoidal elephant looked like he’d been dragged through a hedge backwards.

But eventually we boarded, and after 18 hours including a 90 minute refuel at Ascension Island being held in a “cage” (which was very much what it sounds like!), we landed in the Falklands at Mount Pleasant Airbase.

Rather disturbingly, as we handed over our passports and immigration cards, the immigration officer waved over the very official looking policeman who asked us if we were the pathologists… Oh heck. Admitting that we were, his face lit up and he introduced himself as one of the senior police officers who’d come to personally escort us to our hotel. Expecting very little (especially after our experience at the last “hotel”) we were pleasantly surprised to find a modern, comfortable hotel, the Malvina House (Malvina is politically correct, Las Malvinas less so…). Having collapsed into wonderfully comfortable beds for a few hours, we were feeling refreshed enough to deal with the business end of the trip. By our arrival, the workload had increased to two cases. We first went to the Police Station where the investigating officers provided us with a comprehensive set of documents (and a nice cup of tea), then off to the Coroner’s Office to meet the Coroner. If only the hospital, Coroner and Police Station were in easy walking distance in most places in the UK! We’d been wise enough to check that useful things like an electric saw were available, but we already knew that there was no anatomical pathology technologist (APT). Evisceration was no problem, but it was quite a while since Stuart had sawed heads or sewn up, not to mention washing down the bodies. He was therefore pathetically grateful to have an enthusiastic forensic pathology trainee present who was a good stitcher. The years of her professor insisting on learning how to reconstruct a body unassisted proved invaluable. The fact that how we left the bodies would be how the family would see them was a very real concern for us. It brought home the very real emotional impact the results of our work may have on a bereaved family. We (and by we, we mean Sarah!) made a fine job of it though, although we were far from quick. It certainly reminded us of the excellent job our APTs do.

The autopsy room (also known as the fridge room) was small, but clean and everything we needed was either...
there or was found for us. We’ve worked in far worse conditions far closer to home, and we even got freshly made sandwiches between cases. In the hospital (and indeed throughout our stay) the people were without exception kind and welcoming, although being such a small community they were understandably keen to avoid being involved in the more practical aspects of our examination.

We finished the work around 6pm, and then it was time to plan the next couple of days. We had Wednesday and Thursday, with the flight back early Friday morning. As it turned out, the Registrar of births, deaths and marriages’ wife arranged bespoke tours so the next morning we were collected for a day of exploration. As many of the roads aren’t paved four wheel drive off road vehicles are a necessity not a fashion accessory. There were one or two small urban cars on the island but few enough to be worth noting. The grand plan was to go out to the coast to see the elephant seals and penguins. This involved an hour on unpaved roads followed by an hour off road entirely (being from Devon, and having more experience of off road driving than Stuart [i.e. any at all!], Sarah was much less concerned about suffering an extradural haemorrhage banging her head in the vehicle as it bounced over the rough terrain). It is possible that we were following established tracks, but in some places that didn’t seem certain!

There are some things in life which are difficult to describe but incredible to experience. The elephant seals were certainly one of those things! These aren’t the cute little fellows you see bobbing around near the Farne Islands, more like 5 tonne lumps of meat whose life seemed to predominantly revolve around lying on the beach and snorting (horrid flashbacks to the Gateway hotel occurred). We could get within a few metres of them and they seemed docile enough, but we were warned not to get between them and the sea. It doesn’t take the FRCPa in forensic pathology to realize that a creature like that could cause significant crush injuries without malice aforethought, and going home one pathologist short of the number that had set off would be difficult to explain to our colleagues…

Lunch consisted of sandwiches and homemade cake in the Land Rover overlooking the South Atlantic and the more enthusiastic seals swimming and fighting. At that point, sewing up your own bodies seemed a small price to pay for such an opportunity.

Although everyone seems to think of penguins when they think of the Falklands, they weren’t as entertaining as the seals. The penguins certainly smelt a lot worse on their nests of faeces and feathers!

On our way back to Stanley it would have been easy to think you were in the Highlands of Scotland, with the rugged countryside, but the occasional feature reminded us we weren’t at home, the most startling being the road signs. It’s not every day that you need to be warned to
slow down as there are minefields either side of the road. Although some have been cleared in the years since 1982, we were strongly of the view that a well-marked uncleared minefield may well be safer than a cleared one. Would you want to be the first one to walk through it? Even back in Stanley, there were the differences that made the place familiar but different. Yes, there was a Waitrose, but there was also a street named in honour of Margaret Thatcher. No matter what your politics are, I can’t imagine many of those back home. With only two restaurants and a fish and chip shop, we both felt the lack of an Indian or Chinese takeaway was significant downside to living here. The next day we explored the town, including the small museum, which is to be commended for dealing with all aspects of the islands, not just the conflict.

Having bought the obligatory stuffed penguins, it was time to plan for the return trip. Fortunately no delays this time and by Saturday morning we were back in Leicester, the whole thing now just a memory.

Although the trip was tiring, it was an incredible experience and one which we were very glad we decided to undertake. In some ways it was very different to working at home, particularly when considering the effect a death may have in a very small community compared to the sorts of populations covered by a Coronial jurisdiction in England, but in others it was very similar to performing a Coronial autopsy in a small district hospital (minus the APT).

We extend our thanks to Mr Trevaskis and his wife for their hospitality, as well as all the police staff and the staff at King Edward VII Memorial Hospital for their kindness.

Sarah denies this claim. Stuart claims that she is a biased observer. Sarah doesn’t think the middle of an article is the place to have this argument. Stuart says she’s probably right.

More oddities from Christopher Allen (Christopher.Allen@worcsacute.nhs.uk)

In what way?
“The spleen weighed 320gm and was different on slicing.”

You little temptress
“A section of left anterior descending coronary artery shows an eccentric atheromatous plaque that is fibrotic with no evidence of rupture and seduction of the lumen by approximately 30%.”
Examinations are a fact of life in medicine. As you get older and move up the ranks you gradually make the transition from having to sit them to having to set them, and it is hard to know which role is the more onerous. This article sets out to shed light on Extended Matching Questions (EMQs) and to help you irrespective of which side of the examination desk you are sitting at.

**Why on Earth have we moved to EMQs?**

There is every chance that you grew up having to sit examinations in which you were faced with Multiple Choice Questions (MCQs) where you had to select the one correct option from the four or five presented to you, or Multiple True/False questions (MTQs) in which you were presented with stems followed by four or five options, for each of which you had to decide whether they were true or not. These types of questions were popular with examiners for several reasons. They are pretty easy to write, and can be written quickly. They readily lend themselves to being marked by computer, and so that is quick too. More importantly, that makes them cheap. It is no wonder these questions were so popular for so long.

Unfortunately there are important downsides to MCQs. Assessment is one of the factors which drive learning, and MCQs drive superficial rote learning. The questions provide cues to the memories of the candidates and they lack professional authenticity. As the number of options presented is small, candidates will be able to score a significant percentage of the marks available by guessing alone, unless some sort of negative marking or guessing correction factor is employed.

It perhaps then isn’t surprising that many medical schools and royal colleges have moved away from MCQs and adopted EMQs in the past 10 years or so. This has been driven in part by pedagogical research and in part by guidelines from regulatory bodies such as the General Medical Council.

**What on Earth are EMQs?**

EMQs are questions in which candidates must choose the correct answer from an extended list of choices. Phrased correctly, they test forward thinking and problem solving as well as rote learning, and so require candidates to have understood as well as memorise the information. Because the list of answers to choose from is longer, the chances of doing well by guessing are reduced, and so the need for negative marking is reduced/eliminated.

Most people who have to write EMQs (myself included) find them more time consuming to construct than MCQs. (A “good” EMQ usually takes me about 40 minutes to write.) If you find yourself faced with having to write or answer EMQs, there is first of all some good news. In some ways, these questions are similar in format to MCQs. EMQs come in sets of questions. Each set has a single stem, a number of options for the candidate to choose from and a series of questions (Box 1).

The EMQ should have between 10 and 20 options for the candidates to choose from. Increasing the number of option choices above 20 does not increase the reliability or validity of the examination. The options can take almost any form, but there are some simple rules to follow. They should all be of approximately the same length, the set must be congruous and each option must potentially be the answer to all of the questions. This means that you could have a list of carcinogens, a list of anatomical structures, or a list of enzymes to choose from.

A mixture of anatomical structures and enzymes, however, would not work as a question which seeks an enzymatic answer could not be realistically answered by any of the anatomical choices. Present the potential answers in alphabetical order. You can see in Box 1 that while the list of answers given are a mixture of biological agents, chemicals and forms/sources of radiation, all are carcinogens.

The stem gives the instruction to the candidate, for example: “For each of the following patients, select the carcinogen from the list presented which is most likely to have played a role in the development of their tumour.”

Next come the questions. An EMQ will typically have between three and five questions, the precise number being determined by those responsible for the construction of the examination. Each question must have only one correct answer, but an answer can be correct for none, one or more than one of the questions. This means that if you have 10 options “a” to “j” and you use option “c” to correctly answer the first question there are still 10 possible options to choose from for questions two, three and four. The questions are typically framed as short clinical scenarios or vignettes, each five-to-six sentences long. They should be detailed, including as required the patient’s symptoms, examination findings and laboratory results. Paradoxically, the more detail you include in the questions, the more difficult and discriminatory they become. In the example EMQ presented in Box 1 the questions have been carefully constructed to ensure that the candidate is looking for a particular carcinogen, but...
Box 1: A simple EMQ.

a. Aflatoxin B1
b. Chelonorchis senensis
c. Crocidolite asbestos
d. Human herpes virus 8
e. Human papillomavirus
f. β-naphthylamine
g. Polycyclic aromatic hydrocarbons
h. Schistosoma haematobium
i. Thorotrast
j. Ultraviolet light

For each of the following patients, select the carcinogen from the list above which is most likely to have played a role in the development of their cancer.

Q1. A 72-year-old woman, whose husband worked as a boiler maker between the ages of 22 and 37, is referred by her general practitioner to a respiratory physician as she has had several episodes of haemoptysis. She has lost 5.4Kg in the last three months. A CT-scan reveals a solid invasive tumour in the upper lobe of her right lung. She and her husband are life-long non-smokers.
   Answer: C – Crocidolite asbestos

Q2. A 49-year-old Egyptian male accountant who is a life-long non-smoker presents to his general practitioner with a one-month history of haematuria. He moved from Egypt to the United Kingdom three years ago. A cystoscopic biopsy reveals that he has a malignant mass in his bladder.
   Answer: H – Schistosoma haematobium

Q3. A 47-year-old woman with known Hepatitis C presents to her general practitioner complaining of a rash which has been progressively worsening for two months. Examination reveals multiple painless erythematous and violaceous plaques and nodules on her upper trunk and legs. She also has an identical lesion on her left buccal mucosa.
   Answer: D – Human herpes virus 8

Q4. A 92-year-old man presents to his general practitioner complaining of shortness of breath on exertion. Examination reveals that the base of his left lung field is dull to percussion and lacks breath sounds. A CT-scan reveals that the upper lobe of his left lung is encased in a solid tumour 10-12mm thick, which invades the chest wall.
   Answer: C – Crocidolite asbestos
that the answer could be a biological agent, chemical or type of radiation.

EMQs become easier to write with practice, but they are difficult to write well by committee. Nonetheless, it is very useful to have a panel of examiners meet to consider the questions which have been written. Questions should be scrutinised to make sure that they are fair, test the knowledge that is intended (that is, are the questions valid), and that the language used is unambiguous.

**How on Earth do you answer EMQs?**

It is very tempting to think, when sitting an examination, that the examiners are trying to fail you. Well, I suppose they might be but in general examiners try to set fair questions and see if the candidates will fail themselves. There are three ways in which candidates often fail themselves. The simplest is enter the examination having not undertaken sufficient preparation, but that is a rookie mistake and you probably won’t make it. You shouldn’t really be entering an examination hall if you haven’t done the work and done some ground work to familiarise yourself with the format of questions asked.

More difficult to address is not reading the question carefully enough or over-reading the question. Many EMQs will contain distracters in the list of answers which “almost” fit, but don’t quite. Candidates who under- or over-read the question will dig deep holes for themselves.

Let us go back to our example in Box 1. Focus on the third question – the skin cancer. Now, we should be able to easily discount several of the possible answers fairly easily. We should know that aflatoxin, asbestos, *C. sinensis*, naphthylamine, Schistosomiasis and thorotrast are carcinogens but they are not associated with the development of skin cancers. The candidate who has not read the question carefully will think “Aha! I know that skin cancer is associated with exposure to UV light. That must be the answer”. Wrong.

One of our candidates will remember that Sir Percival Pott recognised that squamous cell carcinoma in chimney sweeps were due to the practice of keeping soot-laden (and so polycyclic aromatic hydrocarbon-laden) rags in their trouser pockets. Bingo! That’s the answer. Um, no it isn’t. That doesn’t fit the rest of the history given and for it to be the correct answer you are going to have to invent a whole back-story for this woman to explain exposure.

But hold your horses. The description of the tumours isn’t really that of melanoma, squamous cell carcinoma or basal cell carcinoma, and you don’t get much UV light exposure inside the mouth. The candidate who over-thinks the question will then think “Ahhhh – but what if one lesion is the primary and the rest are all metastatic melanomas”. Well, I *suppose* so – but that isn’t really a typical presentation of melanoma either, and none of this really explains why we’re being told that she has Hepatitis C.

The winning candidate keeps working the problem, thinking “Now hang on a minute – there are other malignancies that affect the skin. How do you catch Hepatitis C? Oh yes – and if you catch that then you can catch HIV. Hmmm. Now – is there a skin cancer associated with HIV? YES – Kaposi’s sarcoma! Does that fit with the clinical history? Yes. What is the carcinogen? Hurrah – it’s Human Herpes Virus 8”.

You see, I was awake when I wrote the question. I am not trying to “catch you out” but I am looking to see if you will misinterpret the question. To get it right, you have to work the problem forward but all the information you needed was there. The correct answer makes use of all of the information given. The golden rule is simply this: if you have to ignore bits of the question, assume information you haven’t been given or generally wiggle the answer about to make it fit, you have chosen the wrong answer and should read the question again.

**Dr Julian Burton is a Senior Teaching Fellow at the University of Sheffield and Coronial Pathologist at The Medico-Legal Centre, Sheffield.**

**Email:julianburton@doctors.org.uk**

---

**Bananas**

I autopsied a man who worked as a cook and fried bananas all day every day.

Turns out he frittered his life away.
Ten Top Tips for Floorless Undergraduate Tutorial Teaching – Alison Finall

1. Walk around the building long enough and you are sure to find your class in the hallway eventually. Turning up late with toothpaste on your tie and a few soggy cornflakes stuck in your beard/lipstick on your teeth will endear you to your students.

2. Forget to introduce yourself to the class. In any case they don’t need to know what name to call you by as you don’t intend to let the students ask you any potentially testing questions. If they absolutely insist in interrupting your monologue full of gems with a question they can just use a respectful, “Sir/Miss?” with a Grange Hill-like droning intonation.

3. You will be the only person asking questions in this session. Get the attention of particular students by employing a spotlight in the dimmed, airless room and warn them that if they get the answer wrong that everyone in the room will laugh at them and their career is practically over before they’ve graduated whilst holding an L-shaped hand gesture up against your forehead. A little bit of humiliation goes a long way in reinforcing an important educational point.

4. Get to know your students. Refer to them by some distinguishing physical feature such as the ampleness of bosom or amount of facial acne. Being familiar with your students with help promote good rapport. But don’t be too friendly and certainly don’t smile before Easter.

5. Don’t worry about planning lesson content too much. Have a vague notion of the subject and break them in gently with an exceptionally amusing story about next doors’ dog and how Margery said that she hadn’t washed and combed the dog for a week before the local dog show and that this was against the regulations issued by Crufts for standard of care required for a showing breed but Derek disagreed and he’s had about 11 years, 3 months, 2 weeks and 4 days more experience showing dogs and he didn’t really care what she thought anyway. Besides he uses this new fur lotion on his dog, Angus, and the irregular bald patch shaped a bit like a Christmas tree has all grown back since that unfortunate incident with the policeman, the tutu and the sausage. Erm, where were we?

6. Make sure you cover as much material as possible. That way you won’t need to do more than one tutorial. If...
you speak as quickly as possible you’re sure to cram in as much as, say, the whole of cardiovascular pathology in to a one hour session.

7. Effective teaching is all about making sure your students remember facts and plenty of them. Wild gesticulation and speaking in a monotonous and slightly inaudible voice will help them maintain attention and retain factual information for longer.

8. Make sure the students understand that every word you are about to utter is pure educational gold and consists of totally unquestionable truth. As such, the students should try to write down every word you say, and not bother critically analysing evidence. Certainly they needn’t do any further reading. Generally speaking, students today are extraordinarily gifted in shorthand techniques and can get around 60 words per minute down on paper so there is no need for a handout or provision of references. Indeed, they need not need to know more than you are willing to tell them.

9. Develop a habit of touching part of your ear, clearing your throat at regular intervals or some other such entertaining trait. This will engage your students and help maintain attention. Furthermore regular use of the pausing words “err” and “umm” will give time for educational reflection and further note taking. (See guidance on note taking in point 8 above.)

10. Remember that reading your fact-filled PowerPoint slides is the only way to be 100% sure that they will learn what they need to learn. Group discussion is a complete waste of time. Using size 8 font or smaller will mean you can get more essential facts onto your slide. Slides should be typed in the Wingdings font. Reinforce the importance of your slide content by telling the students that it will all be in the exam. Time is of the essence; you need to get through it all as quickly as possible.

11. Don’t worry if your session overruns. Planning how much time to allocate to each subject area is unnecessary. And besides, as soon as your tutorial is finished they’ll probably all be boozing their livers into a fibrotic state of no return at the local pub. Consider yourself their hepatic and life-long learning saviour.

Disclaimer
Any resemblance to persons living, dead, fictional, imaginary or in the office next door is unintentional. And remember, your teaching performance can go up OR down.

Ten puns for educated minds...

I thought I saw an eye doctor on an Alaskan island, but it turned out to be an optical Aleutian.

She was only a whiskey maker, but he loved her still.

A rubber band pistol was confiscated from algebra class, because it was a weapon of math disruption.

No matter how much you push the envelope, it’ll still be stationery.

Time flies like an arrow. Fruit flies like a banana.

Atheism is a non-prophet organization.

A sign on the lawn at a drug rehab centre said: “Keep off the Grass.”

The soldier who survived mustard gas and pepper spray is now a seasoned veteran.

A backward poet writes inverse.

A vulture boards an airplane, carrying two dead raccoons. The stewardess looks at him and says, “I'm sorry, sir, only one carrion allowed per passenger.”
In July 2009, Preeti visited Johns Hopkins University, Baltimore USA. Her report languished on the editor’s desk for some time and in this issue we put that right.

I started my first consultant job here at Path Links in 2006 with my special area of interest being Uropathology. Having settled in to my first consultant job and despite a year of subspecialist training post CCST, I felt the steep learning curve during my first two years as Consultant Pathologist. I decided I needed to expand my horizons and gain more experience. It was then that I decided to ask Dr Jonathan Epstein to allow me to spend a month at Johns Hopkins which is the centre of excellence in Uropathology, with Dr J Epstein having one of the biggest Uropathology referral practices.

I wrote to Dr J Epstein and he agreed to have me over for one month. With all the paperwork formalities done, I then decided to apply for the ACP Career Development award. My sincere thanks go to the ACP for granting me the award towards my travel to the Johns Hopkins. It was a fantastic experience being able to spend a month at there as a part of the genitourinary team under the guidance of Dr Jonathan Epstein.

It is only fair to say that I am missing the hospitality, my new friends I made while I was there, the warm weather, well just about everything. Give me another chance and I will be packed and ready to go in 10 minutes (well, maybe 20 minutes, as it takes a bit of thought as to what to pack for a whole warm month in the States!).

Landing at BWI airport in Baltimore, Maryland, after a delayed connecting flight from Boston and dealing with the customs, I could finally take a breather and relax. After a year of planning and preparation my time at the Johns Hopkins was about to begin.

The month seemed to blur as the daily caseload kept everyone on their toes, including myself. Dr Epstein’s consult service deals with various genitourinary cases from around the world and the work flows at a dizzying pace which could easily intimidate the faint hearted pathologist! Averaging close to 60,000 specimens a year, the diagnostic skills of Dr J Epstein and his team are exceptional.

A typical day started early with lectures for the residents and specialist sign-out for the fellows. I was fortunate to share the excellent reporting experience one gets when signing out cases with Dr J Epstein. Sign-out started at 8am, going through each of the consult cases which the fellows and myself had very diligently screened before taking it for the final diagnosis. Dr J Epstein spent a great deal of time in teaching and explaining the rare entities and also answering my very frequent questions that went with each case owing to the differences in practice...
between the states and the UK.

During my last week there, reporting started at 7am and me having been used to a rather easy start to my day here, a 7am start was rather challenging. However, with the warm weather, the sun shining bright and the incentive of the excellent teaching I would be getting, a 7am start was rather attractive. I was enjoying myself. The 7am start was because Dr J Epstein was spending a week on the inside cases, which means the routine cases going through the department including all organ systems. This was interesting as I got to learn the things other than genitourinary pathology.

Every day at 2pm, all the trainees, fellows and the consultants would gather around the multi-headed microscope to discuss interesting, difficult and sometimes routine cases which I thought was very helpful. Although we at Lincoln show our cases around, I thought that having a conference benefits everyone as everyone gets to see all the cases that go through the department which are interesting and educational.

Dr Epstein also has an enormous study set which I looked at and he was happy to discuss any doubts I had. There was also a teaching session which Dr Epstein does for all his fellows on Wednesday afternoon going through all the slide sets and teaching each of the entities at length. This was by far one of the best teaching experiences I have had.

Another activity that I was a part of when I was there was the journal club, which happened on a Tuesday morning at 7am. It was a rather interesting journal club as several of the fellows and research fellows would present the essentials of a recent study and discuss the feasibility, the clinical application and the authenticity of the research design.

Grossing is carried out by the well-trained BMS staff who are familiar and well-trained in sampling protocols and carry out the cut-up with accuracy. The reading material present in the department is amazing and everyone has access to practically every journal of pathology there is.

That is as far as the teaching experience goes! Being the keen traveller that I am, all the charm of Baltimore could not hold me back on the weekends. I travelled to New York, which was a pleasant 3 hour bus journey from Baltimore and also went to Washington which has the best museums and of course had to see The White House. The Smithsonian museums have a free entry and they are excellent. I had the time only to visit two, the National Museum of Natural History and the National Air and Space Museum which were absolutely amazing. I did see the Hope diamond which I can say with pride originated in India but is now sat at the museum in Washington, but the Kohinoor diamond here is bigger and better (also from India). One weekend was spent lazing on the sunny beaches of Tampa, Florida and the other was in Boston which reminded me much of the UK (weather et al).

Having been back since, I have been able to share with my colleagues some of the interesting differences in pathology I observed during my time there and I hope to implement some of the changes and ideas I believe would benefit patient care.

In the end, I cannot emphasise enough that these visits are immensely valuable in gaining insight and understanding my profession in another country.

I feel privileged to have met the best health care professionals at the premier institute of USA, and sharing their experience in the changing times of USA health care system which was enlightening.

An experience which will last in my mind forever and hopefully the knowledge too!

My gratitude goes to ACP for granting me the travel award. Thanks to Dr Scott (Medical director) and Dr Clark (Clinical director of Path Links) for granting me special leave for the month of July and last but not the least I would like to thank all my colleagues.
The Association of Clinical Pathologists very kindly sponsored my attending the United States and Canadian Academy of Pathology Meeting in San Antonio, Texas in February 2011.

This is the premier surgical pathology meeting combining proffered platform papers and posters detailing recent research with courses run by specialist pathologists from the United States, Canada and beyond.

After a 14 hour trip from Manchester, including a two hour stop over in Atlanta Georgia, I arrived in my hotel and promptly collapsed on the bed and fell asleep. I had discovered that none of the hotels in San Antonio is an integral part of the conference centre which meant that I was able to find an economical hotel with no greater inconvenience than if I had stayed in one of the recommended conference hotels. As a bonus a complimentary breakfast was provided each morning and ice tea through out the day. Fortunately all the major centres including hotels and conference centre in San Antonio are connected by the “river walk”.

There had been long-standing plans to spruce up the San Antonio river, a waterway so significant that for most of their rule in Texas the Spanish did not even realize it existed! After some major flooding at the beginning of the last century the city fathers installed a flood protection system, part of which involved lining the banks of the river, where it passed through the city, with concrete. Making a virtue from necessity they created a walkway which they planted attractively with flowers and trees. Subsequently bars, cafés, restaurants and a few souvenir shops developed in relation to this walkway, which provides a pleasant aspect as well as shade from the mid-day sun. It connects most of the areas of interest in the city.

The conference itself was most interesting and it is difficult to quantify all the major topics that were covered. High-grade endometrial stromal sarcomas appear to be making a reappearance. Interestingly this lesion, or a new lesion using an old name, was identified by genetic testing resulting in characterization of a typical morphology, immunohistochemical profile and identification of a specific prognosis although it is too early to identify whether any different treatment is effective. The topic of early neoplasia in the fallopian tube particularly the fimbria continues and a host of new entities with synonyms like SART, DART and but as not yet FART have been described. A sensible approach to frozen sections, particularly of the ovary, was also described. Basically don’t do them unless there is a clear clinical indication for the need for a frozen section after a full diagnostic work up. If such a work up has not been done and frozen section is requested the recommendation is that the pathologist refuses or he dissuades the clinician from proceeding with the operation as it is likely that they do not have the necessary experience to perform the appropriate surgery.

Many exhibitors were attending the meeting showing the latest addition to their technology (both hardware and software). Vertical integration of the health care industry seems to be increasingly on the cards and I had the interesting experience of being kept late for one of the platform sessions because I had to describe to a salesman, affiliated with one of the major providers of microscopes, the difference between a frozen section and a paraffin section, their uses and relative advantages and disadvantages. Overall there appears to be a great ignorance on the part of the people who were selling stuff – and I wondered if the people buying it were as badly informed.

I was entertained to lunch by an organization that is seeking to help local pathologists from losing work, or even recovering it from the large combines. It did occur to me that this was the opposite to the United Kingdom situation where very often specialist units loose work to smaller peripheral units which “cherry pick”. The conclusion seems to be that clinicians and patients still like local pathology.

What else can I advise – make sure that you are at the boarding gate in plenty of time particularly if you only wish to take carry on baggage. Ladies would be advised to wear skirts and men kilts, commando and in the highland manner respectively, as American loos seem to be full to the brim with water, resulting in quite lot of splashing!
I was to go to Ghent to present a poster at the 6th Joint Meeting of the British Division of the International Association of Pathologists and the Pathological Society of Great Britain and Ireland, or so I thought.

The week started unpropitiously. My supervisor, Dr Going, who had hitherto provided tireless statistical advice/common sense/grammatical solutions, phoned me with bad news. He had been indisposed, and although now recovered, he was unable to travel. Would I mind dreadfully delivering his talk in his stead? I remembered the many times I had inconvenienced him with requests for tutorials on statistics…

One could be forgiven for expecting that a nation which has exceeded Iraq’s world record delay in forming a government would be somewhat in crisis, or at least in disarray. Incredibly, to the casual visitor, there is no evidence of this. The trains and trams run on time and the country quietly carries on. Belgium is not known for creating a fuss or –heavens forbid - drawing attention to itself. (Let us avoid the inevitable – name 5 famous Belgians jokes)

And so I found myself arriving in Brussels airport, and, conveniently, catching the (hourly) train to Ghent without even leaving the building. Those clever Belgians! Then it was a rather less comfortable taxi ride to the hotel in the city centre (the taxi driver had the outward appearance of a mild mannered middle-aged man, but the need for speed of a man 25 years younger). The hotel receptionist greeted me with the friendliness I was to grow to expect of the locals, and gave me a potted history of recent events in Belgian politics, along with the advice that it was best to refrain from attempting to speak French in Flanders!

The meeting opened in the beautiful Refter room of Het Pand, the old Dominican monastery which is now part of the University of Ghent. I steeled my nerves with a black coffee and an apple pastry, before delivering Dr Going’s presentation. In summary, this study showed that automated analysis of ER and PR status in breast cancers using a Histoscore gave results in excellent agreement with visual analysis using Histoscore or Allred score, and equally effective prediction of survival and tumour recurrence. This received interested and positive feedback, which I was happy to relate to Dr Going on my return.

Then it was time for some advances in gynaecological pathology, with valuable updates on immunohistochemistry and mutations in gynaecological tumours, and an interesting review of gestational trophoblastic disease, from international experts in the field.

After that, the temptation of a new city beckoned. Armed with a map which I blithely ignored, I wandered through the streets and crossed canals bathed in warm sunlight, until I came to Patershol. This newly revived area of the city with its winding streets is home to a rich variety of restaurants: Thai, Japanese, traditional Flemish...

By this stage I was starving, and ready to take on the local specialty of Waterzooi, a chicken stew made with alarming quantities of double cream. (It is delicious, unsurprisingly). This was served in industrial quantities, and despite my valiant efforts, eventually defeated me.

The next morning, the theme was Inflammatory Disorders, with talks on pulmonary, GI, pancreatic and hepatic manifestations. The emphasis, as ever, is on...
Bursary Reports

Clinicopathological correlation and good communication with clinicians. I was interested to learn, from Prof Kieran Sheahan’s talk on refractory coeliac disease, that collagenous sprue may have a better outlook than previously thought. During the coffee break I was delighted to meet with fellow trainees from Liverpool, Manchester and Dublin, and to discover mutual acquaintances.

The poster presentations loomed after lunch. More super-strength coffee, and a last read of my notes. I presented my review of “Biopsies of the Normal Colorectum – Limited Clinical Value?” to a rather larger audience than expected! We found (and here many thanks to my collaborators Dr JJ Going and Dr M Burgoyne) that biopsy of an endoscopically normal colorectum has a low, but not negligible, yield of histopathological abnormalities, and that patients over forty years are more likely to have definite pathology. Biopsy of endoscopically normal terminal ileum mucosa, however, has an extremely low yield of histological abnormalities, and may be unnecessary, given that photography of the ileocecal valve reliably documents complete colonoscopy. It was encouraging to find that this topic was received with enthusiastic discussion and pertinent questions.

The hard part over, we repaired to the Refter Room for informative updates on pulmonary pathology, including small airways and interstitial lung disease, and the hot topic: EGFR mutations in lung cancer.

The public lecture, “Old and New Challenges In Public Health” was then given by Prof Peter Piot, an alumnus of University of Ghent, now Director of the London School of Hygiene and Tropical Medicine. In addition to co-discovering the Ebola virus, Professor Piot was Under Secretary-General of the United Nations until 2008. It was fascinating to learn that the cost of Highly Active Anti-Retroviral Treatment (HAART) in Uganda has fallen from about $12,000 to about $85 per person/year, largely due to pressure on drug companies from international aid organisations. In a talk that touched on the HIV epidemic, the growing insolvency of health systems and the aging demographic of the West, he feels that climate change is the biggest global health threat of the 21st century.

From the new agenda for global health, to the history of medicine. It was time for the guided tour of the

The Het Pand Museum of the History of Medicine

Ghent’s enchanting city centre
Museum of the History of Medicine in Het Pand. This is a comprehensive collection, with enough gory images - we particularly enjoyed the maquettes of dermatological conditions, medical devices and skeletons - to keep us entertained until the beer was deemed sufficiently chilled to invite us down to the cloisters for the reception. (As a Glasgow trainee, I was gratified to see memorabilia on Joseph Lister and his antiseptic technique!) Here, prompted by Dr Sheppard, Prof Cuvelier of Ghent University related the story of the beguinages. These mediæval convents, which originated due to the surplus of women during wars, allowed women enter religious communities, with the proviso that they could leave when they wanted- an enlightened agreement in the middle ages!

Thursday saw the hepatic symposium, dealing with hepatic adenomas, dysplastic nodules and hepatocellular carcinoma. In addition there were oral communications on Sudden Cardiac Death, extrapulmonary small cell carcinoma and cervical adenocarcinomas - it was a busy morning! The trainee’s session on preneoplastic lesions of the breast was very informative, with helpful hints on distinguishing the various lesions.

After absorbing quantities of information, it was time for a spot of sightseeing with Anne Marie, a colleague from Manchester. We escaped into the cool interior of St Baaf’s Cathedral, home to the awe-inspiring painting, Adoration of the Mystic Lamb, by the Van Eyck brothers. The incredible beauty and detail of this masterpiece goes some way towards explaining its tumultuous history; after surviving multiple owners in the Middle Ages, it was seized by Nazi forces and hidden in salt mines before being eventually recovered and restored to Ghent after the war. An absolute highlight of any visit to Ghent!

The conference dinner took place in the Augustine Monastery, which along with a splendid library, houses a spectacular dining hall. With exquisite canapés and the finest cava and beer (produced on site) on offer, we settled down for an evening of fine dining. Mid way through dinner, I was stunned and delighted to receive the first prize for best poster from the BDIAP. After a great evening, with much hilarity occasioned by the speeches (I particularly enjoyed the Corkonian jokes from the President), it was time to wend my way home with Liverpool colleagues Carol, Sally Ann and Kath.

The large attendance at the trainee Urology symposium next morning was testament to the quality teaching that was on offer. From cytology to gross handling; the talks were highly instructive and practical. Prof Cuvelier closed the proceedings with the George Cunningham lecture on the Terminal Ileum and M cells. I enjoyed the company of Dublin trainees Sangeetha, Lindsey and Brian on the train back to Brussels, and both they and the Glasgow trainees gave positive feedback on the “cuberdons,”(raspberry flavoured sweets), Ghent delicacies I had brought back for the reporting room!

All in all, the meeting was held to be a great success by all who attended. The organisation was impeccable, with excellent talks and educational sessions. Ghent is a wonderful venue, full of winding cobbled streets and canals with interesting history and easily navigated by foot. It remains for me to thank the ACP for their support in allowing me to attend the conference, Dr JJ Going and Dr M Burgoyne for their encouragement, and finally, thanks to Prof Cuvelier and the teams in BDIAP and Pathsoc for organising a highly enjoyable meeting. I hope to be back!
I’m a histopathologist with an interest in lymphoma, autopsy pathology and medical education and I love my job! I talk passionately about it to anyone who will listen. I think passionate people make great teachers. I can sit and listen to the physicist Brian Cox waxing lyrical about astrophysics, the vast majority of which is way beyond me, and yet he is so enthusiastic as to be compelling and I sit wide eyed and lap it up. I think people who know me would say that passion and enthusiasm is what makes me a good teacher and it’s what makes me want to help other people understand. A Masters level degree in Medical Education is not about becoming a good teacher – in our own ways we were all good teachers when enrolling – this is about going beyond teaching. It’s about understanding learning, understanding the complexity of curriculum design and implementation, how to assess, evaluate and feedback, and discovering that these are different things!

So why do a degree? I was always interested in education, in teaching and in understanding a bit more about how it all came to be. I think junior doctors are always keen to protest when things change in their training and I was no exception. But as I challenged things like workplace based assessments I became more interested in understanding the background, understanding what training involves and how you develop it, monitor it and enhance it. I was also frustrated and needed to know more to be able to further my own opinions. The degree has equipped me for all of this and more.

There is a shift towards the professionalism of training doctors and this is something I welcome and want to be a part of. Cardiff University appreciated this in 1988 when they established the first Masters level degree in Medical Education in the UK. Medical educational change has continued at quite a pace over those 20+ years, and current specialty training demands us to train doctors better and in a shorter space of time. Gone are the long hours and reliance on apprenticeships and as a result of shorter working weeks and shorter training periods, the way in which we train junior doctors has had to change. Histopathology is no exception to this type of change, and in order to keep pace I applied to study a Masters in Medical Education at Cardiff University. Its reputation was impressive; the longest established course with international renown and accreditation by the Higher Education Academy, and the location was convenient.

I studied part time over two and a half years. Cardiff University offers the course as both a face to face course in Cardiff and an e-learning course. I chose the face to face course which involves 10 modules of three-to-four days based in Cardiff. It is open to all healthcare professionals and international students and my cohort included doctors from F2 to consultants, nurses, pharmacists and dentists from across the UK and several international students. The mixture of professions as well as a mixture of medical specialties was a great strength of the course – the ability to share experiences and learn from what others are doing. Our cohort was slightly too large – over 40 at the beginning – but I think the course organisers realised they had over-stretched the group size and subsequent intakes have had fewer students.

Another great strength was the philosophy of the course – learner centred with active participation – this is no lecture series. During the face to face modules we discussed and debated the ideas we were being introduced to, we challenged concepts and had to think critically. The diversity of our group made for wild debate at times! Then each module was followed by a period of self directed learning and reflection, usually accompanied by an assignment.

Essays! Oh no, not again! I hadn’t written an essay since medical school. Yes, I am old enough to have still had to write essays for exams at medical school, but young enough to have escaped essays for the FRCPPath exams. The thing is these essays are completely different: this is social science. You have to write in the first person, talk about touchy feely stuff and even the referencing is different. But there is help with all of that from tutors and other University staff. What there isn’t help with is time – you can’t make the days and weeks longer, and studying for a Masters level degree whilst doing a full time job and...
settling in as a new consultant isn’t easy. The suggested input is six-to-eight hours per week, although one module assignment in particular – the media project – required at least 60 hours work. Although it was time consuming and several late nights were necessary, it was all worth it to develop a standalone professional workbook on breast pathology. Previous students have developed their projects with media experts sufficient to publish it!

The crowning glory of the taught course is the development and delivery of a short course on professionalism. The first years became our students and we experimented on them. The photo shows our group before they threw rotten tomatoes!

The course now finished. The next step is a piece of educational research and a 20,000 word dissertation. And I thought it was tough so far! Maybe I’ll write about that in a future edition of ACP news.

Finally I would like to thank the course organisers Lynne Allery, Janet MacDonald, Lesley Pugsley and Liz Anderson, my fellow students for tolerating my Devil’s advocate approach on more than one occasion and the ACP for the funding.

---

**The perfect dinner date**

A man is dining in a fancy restaurant and there is a gorgeous redhead sitting at the next table. He has been admiring her since he sat down, but lacks the nerve to talk with her.

Suddenly she sneezes, and her glass eye comes flying out of its socket toward the man. He reflexively reaches out, grabs it out of the air, and hands it back.

“Oh my, I am so sorry,” the woman says as she pops her eye back in place.

“Let me buy your dinner to make it up to you,” she says.

They enjoy a wonderful dinner together, and afterwards they go to the theatre followed by drinks. They talk, they laugh, she shares her deepest dreams and he shares his. She listens.

After paying for everything, she asks him if he would like to come to her place for a nightcap and stay for breakfast. They had a wonderful, wonderful time...

The next morning, she cooks a gourmet meal with all the trimmings. The guy is amazed. Everything has been SO incredible!

“You know,” he said, “you are the perfect woman. Are you this nice to every guy you meet?”

“No,” she replies...

“You just happened to catch my eye.”
## GLOUCESTERSHIRE GASTROINTESTINAL PATHOLOGY COURSE

<table>
<thead>
<tr>
<th>DATE</th>
<th>Friday, 7 October 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>VENUE</td>
<td>The Gold Cup Suite</td>
</tr>
<tr>
<td></td>
<td>Cheltenham Racecourse</td>
</tr>
<tr>
<td></td>
<td>Prestbury Park</td>
</tr>
<tr>
<td></td>
<td>Cheltenham</td>
</tr>
<tr>
<td></td>
<td>Gloucestershire, GL50 4SH</td>
</tr>
<tr>
<td>LEAD ORGANISER</td>
<td>Professor Neil A Shepherd</td>
</tr>
<tr>
<td>FACULTY</td>
<td>Professor Paola Domizio</td>
</tr>
<tr>
<td></td>
<td>Professor Stefan G Hubscher</td>
</tr>
<tr>
<td></td>
<td>Professor Marco R Novelli</td>
</tr>
<tr>
<td></td>
<td>Professor Neil A Shepherd</td>
</tr>
<tr>
<td></td>
<td>Professor Bryan F Warren</td>
</tr>
<tr>
<td></td>
<td>Professor Geraint T Williams</td>
</tr>
<tr>
<td></td>
<td>Dr Judy I Wyatt</td>
</tr>
</tbody>
</table>

Wow! We have now reached ten years of the Gloucestershire Gastro-intestinal Pathology Course. It will take place, once again, at the fabulous Cheltenham Racecourse on Friday, 7 October 2011. There are excellent facilities including a free car-park for 1500 and lunch in the Panorama Restaurant overlooking the course and the glorious Cotswolds. In addition to the usual team of Novelli, Shepherd, Warren and Williams, we have three guest speakers. We welcome again Dr Judy Wyatt, from Leeds, and the liver component is also greatly enhanced by one of the UK’s top hepatopathologists, Stefan Hubscher. In addition Paola Domizio with speak on paediatric GI pathology. There will be a mini-symposium on dysplasia in the gut and updates on immunohistochemistry, GISTs, endocrine tumours, BCSP pathology and treated IBD. We will also have our “Hot Topics in GI Pathology” feature and the now familiar Quiz, with marvellous prizes, and “Questions and Answers” sessions. The RCPath has approved this course for 7 CPD points.

This course is very popular and we advise that you book early to avoid disappointment. We look forward to seeing you in gorgeous Regency Cheltenham & glorious Gloucestershire! Details and the registration form are available on our website at [www.glospathology.com](http://www.glospathology.com)

### COURSE FEE: £125.00

### FOR FURTHER INFORMATION PLEASE CONTACT:

<table>
<thead>
<tr>
<th>Name</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor Neil A Shepherd</td>
<td>Direct Line: 0044- (0)8454-223314</td>
</tr>
<tr>
<td>Professor of Gastrointestinal Pathology</td>
<td>Fax no: 0044- (0)8454-223318</td>
</tr>
<tr>
<td>Gloucestershire Cellular Pathology Laboratory</td>
<td>e-mail: <a href="mailto:neil.shepherd@glos.nhs.uk">neil.shepherd@glos.nhs.uk</a></td>
</tr>
<tr>
<td>Cheltenham General Hospital</td>
<td></td>
</tr>
<tr>
<td>Sandford Road</td>
<td></td>
</tr>
<tr>
<td>Cheltenham</td>
<td></td>
</tr>
<tr>
<td>Glos, GL53 7AN, United Kingdom</td>
<td></td>
</tr>
</tbody>
</table>

For all booking details, please view the website at [www.glospathology.com](http://www.glospathology.com) or contact the Course Organiser, Ms Pauline Baker, on pauline.baker@glos.nhs.uk
This year’s meeting covered the full range of challenges that we are facing. Prof Allyson Pollock from Edinburgh University was the first speaker and she addressed the issue of privatisation of the NHS in England. Readers may be familiar with her work that has been published in the British Medical Journal together with her book that analysed the increasing role the private sector had developed under the previous Labour government. As part of her analysis she is predicting the end of the NHS. She is not the first academic at an ACP meeting to do that. On last year’s ACP Management course Prof David Hunter from Durham University had reached the same conclusion.

Prof Pollock outlined five stages of “reforms” in the NHS since its inception. The first phase started in the 1979 following the election of Margaret Thatcher. A number of changes were implemented not least of which was the Griffiths report that heralded the introduction of general management and the dreaded cost improvement plans. This was followed by vertical disintegration that was part of the 1991 reforms under John Major’s government that launched the internal market with the split between purchasers and providers. This was shortly followed by the introduction of the private finance initiative (PFI) that allowed the private sector to build and run hospitals for contracts lasting many decades. The financial analysis of these PFIs has shown that as a result of the high costs of the finance (when compared to government funding) reductions in beds and staffing are needed in order to balance the books. In 2000 the Labour Government under Tony Blair launched the NHS plan that had many strands. This included unbundling of services, a term that we had only come across in relation to payment by results where the costs of some services such as radiology are unbundled from the tariff. However it appears that unbundling of services in the public sector is a standard method of introducing private provision in the public sector in general and has been used in other services such as water, gas etc. This phase also included ongoing efforts by the government at de-professionalisation and deregulation with the removal of autonomous professional practice. The private sector was also actively encouraged to compete for services particularly in elective surgery through the independent sector treatment centres. Prof Pollock outlined an analysis of the effectiveness of this initiative and challenged the government’s conclusion that they provided better value for money than the public sector equivalent. The final phase is about to start with the abolition of the NHS. However what is meant by this? It depends on your definition of what encompasses the NHS. If it is defined as a service that is free at the point of delivery and is provided by the public sector then this may be the end. Certainly within our specialty there are now several examples of the private sector running pathology services for the NHS in England.

Ian Barnes (National Clinical Director of Pathology at the Department of Heath) gave an update with progress in the implementation of the Carter report. Not surprisingly some Strategic Health Authorities (SHA) have made significant progress while some have really to start. All SHA plans except for one have included some degree of consolidation. The consensus seems to be that two to three networks will evolve in each SHA. Some of
Tradecraft and Meetings

these are been driven by the providers i.e. the pathologists, while other are been driven by the commissioners. Failure to engage in the process particularly where the commissioners are leading could be a risky strategy as the commissioners do have the option of moving the direct access GP work. Subsequent to this meeting one of us attended another ACP sponsored session at the British Society for Haematology annual scientific meeting. Beverley Rowbotham, immediate past president of the Royal College of Pathologists of Australasia, gave an overview of her haematology service in the private sector based in Brisbane. Their pathology service (Sullivan Nicolaides Pathology) covers a vast area up to Cairns and Darwin. Even with this area to cover the turn round time for a blood counts is impressive being two hours for a sample from Brisbane to eleven hours for a sample from Cairns (the equivalent in flying a sample from Latvia to Rome!). She presented evidence of the cost differential between higher cost small laboratories versus the lower cost consolidated larger laboratories in this service that covers over twenty hospitals. So will our efforts in developing localised pathology networks be enough to survive the forthcoming financial pressures?

Prof Eric Bolton, currently Acting Director for the Regional Microbiology network for HPA, gave an update on the new proposals for Public Health in England. At first glance it may appear that this has little to do with laboratories but it includes Public Health Microbiology, formerly provided by the “Public Health Laboratory Service” (PHLS) and more recently by the Health Protection Agency (HPA) laboratories. The HPA was set up in 2003 as an independent UK organisation to protect the public from threats to their health of infectious diseases and environmental hazards. From April 2012 the HPA will become part of Public Health England.

The formation of Public Health England is proposed in the government white paper “Healthy Lives, Healthy People”, published at the end of November 2010, for consultation until 31 March 2011. The aim is to create a “wellness” service and to strengthen both national and local leadership. Key to the changes is that Public Health England will be an integral part of the Department of Health and will be accountable to the Secretary of State. Other fundamental changes include the Directors of Public Health being employed by the Local Authorities (as PCTs and SHAs will disappear). Different Public Health Systems will be developed in Wales, Scotland and Northern Ireland.

With regards to Public Health Microbiology this will still include Porton Down (Centre for Emergency Preparedness and Response); Colindale (Centre for Infections) and Regional laboratories through England. Other sections of the HPA – Centre for radioactive, chemical and environmental hazards, National Institute for Biological standards and control (NIBSC) and Health Protection services will also be part of Public Health England. The conclusions following the consultation are awaited.

Most readers will have heard at least of some of the proposed changes to the organisation of pathology services and the outsourcing of cervical cytology screening that has occurred in the Republic of Ireland. Prof Connor O’Keane (Dean of the Faculty of Pathology at the Royal College of Physicians in Ireland) gave a comprehensive overview of the changes and how the faculty of pathology had responded. In relation to the cervical cytology screening programme in 2001 fourteen laboratories were providing the service, they were not accredited and the turn round time was months not weeks. A number of reviews of the service were undertaken but eventually the Health Service Executive (HSE) asked Quest to reduce the backlog. Following a tendering process, reading of the slides was taken over by Quest and these slides were flown to North America for reporting. Although the turn round time for reporting was reduced, other outcomes were not so good. Training for
pathologists and biomedical scientists could no longer happen in the Republic of Ireland. There was little correlation between the cytology and histology, and the number of colposcopies increased. Following representations by the faculty a new tender was prepared in 2010. As a result Quest and Sonic will share the contract and reading of slides will be brought back to Ireland. Training is also part of the contract and a new national training centre has been established.

The second major change was the restructuring of the Irish public laboratories. The HSE commissioned Teamwork Management Services (UK) to carry out a review of these laboratories. The report was eventually made public two years after it was completed. This proposed that the existing forty six laboratories should be reduced to three regional automated centres responsible for carrying out GP work and eight to fourteen hot laboratories. The view from the profession was that would lead to a very fragmented pathology service. The faculty set about developing an alternative approach. This started by establishing ten principles on which any reconfigured pathology service should be based. This resulted in an alternative model that was based on eight networks linked to service delivery of newly formed clinical networks. The HSE has accepted this alternative plan and has appointed a national lead for pathology. This seems to have been a very positive outcome for the pathology services in Ireland. The faculty seem to have played a key role in shaping the future of pathology services resulting in a positive outcome in that the pathology service will be linked to the clinical networks that the service supports. A good example of leadership in action.

Paul Stennett (chief executive of UKAS and CPA (UK) Ltd) outlined the recent changes in the organisation of CPA. UKAS now own CPA but the brand is being retained. The CPA Sheffield office has now been closed and CPA activities are now based at UKAS headquarters in Feltham. For readers that have recently undergone an assessment the improvement in reporting times will not come as a surprise. Following the introduction of electronic reporting reports are now produced within two weeks rather than six months. CPA has undertaken a series of meetings with the Arms Length Bodies that are involved in regulation (HFEA, HTA, MHRA, CQC etc). The aim of these meetings being trying to reduce the number of visits pathology has to undergo. Surely we must be the most heavily regulated / inspected speciality in the NHS. Is it any surprise that consultant “productivity” as assessed by the Audit Commission has apparently fallen when we face such a vast amount of regulatory bureaucracy? The CQC (Care Quality Commission) now wish to be informed of any department that fails the CPA assessment. No doubt this will appear as a red flag on that Trust’s quality risk profile that the CQC now regularly produces for all Trusts in England. The result is that Trusts are then expected to inform the CQC as to what action is been taken to address that risk. EU legislation never ceases to amaze us. Apparently due to “non-compete” requirements accrediting bodies cannot compete with another accrediting body in any one European country. So CPA will have to pull out of the Republic of Ireland as there is an Irish National Accreditation Board who will now have to take on the accreditation of pathology laboratories. CPA is however expanding its activities outside of the EU into the Middle East.

The last session of the day was a new session in which three speakers were given a ten minute slot to provide quick updates. This was a tall order as the ten minutes
Tradecraft and Meetings

included questions. Terry Jones (Director of Workforce Planning at the RCPPath) was unable to attend so Barbara Isalska stood in and gave an update on the College electronic workforce data base. The Workforce Review Team has now been disbanded and replaced by the Centre for Workforce Intelligence (CfWI). Each specialty is now working with the CfWI to refine workforce plans. Of course the CfWI has to rely on the Colleges workforce data, a fact that was not apparent in the recent Department of Health’s consultation document on developing the Healthcare Workforce. Lance Sandle (Director of Professional Standards at the RCPPath) gave an update on the progress (or lack of it) with revalidation. Having spent much of the last year developing detailed standards for pathology to support revalidation he is now leading on rewriting them as part of the new simplified approach that the GMC require! Apparently revalidation is going to start late in 2012. Archie Prentice (Chair of the International Committee and Vice President, RCPPath) gave an overview of how the College is working at an international level. The College international committee had been in place for eight years. However it was felt that the College had lost touch with the international members As a result and international manager has recently been appointed and a post Director of International Activities is also being developed.

The meeting was well attended with good feedback for all the speakers. It is hoped that next year’s programme will be as stimulating and attract interest from all branches of Pathology. If you want to keep up to date with the many challenges we face this annual meeting is a good place to start.

Mike Galloway, Consultant Haematologist, Sunderland Royal Hospital
Angela Galloway, Vice President, ACP

Report of the ACP Alumni Meeting in Morecambe
May 2011 – Bryan Corrin

This year the alumni gathered at the rejuvenated wonder that forms the Midland hotel in Morecambe. With partners we numbered 43, the alumni themselves being Bruce Addis, Hoschang Barucha, Geoffrey Birchall, Reg Britt, Bryan Corrin, David Davies, Brian Edwards, Henry Fell, Paddy Fitzpatrick, Lynn Jones, Fred Lee, Barrie Murphy, Hugh MacKay, Arthur Mclay, John O’Shea, George Pennington, Ashley Price, Hugh Reid, Phil Roberts and John Tighe.

An advance party paid homage to local hero Eric Bartholomew who took the name of the town and joined one Ernie Wiseman to form Morecambe and Wise. Engraved at the foot of Eric’s statue (cast in characteristic pose, Figure 1) are some of his memorable lines e.g. “I made Ernie out of a kit but ran out of wood when I got to the legs”. The celebs of the day (over 25 years in fact) competed for the guest slot on their show, expecting to be insulted and never disappointed in this, to whit, an aside from Eric to Ernie “For another quid we could have got Lulu”. Some of us sang Eric’s signature tune, “Bring me sunshine”, and lo a strong wind arose and blew the clouds away.

The main party convened at Leighton Hall, Carnforth for a tour of the house and gardens, which have an idyllic setting. In the house we were rather unusually enjoined to sit on the chairs for this is the home (by direct descent through the female line) of the Gillows of Lancaster, furniture makers who were joined by a Liverpool upholsterer named Waring to form the firm of Waring and Gillow, which is still trading today in Tottenham Court Road. Every generation of Gillows except one adhered to the catholic faith, one Gillow fighting on the losing side at the battle of Preston in 1715 in support of the absent Old Pretender and consequently spending 15 years in Liverpool Castle. On his release he found that a friend had bought his estate for him, but it was in ruins. By judicious marriages subsequent generations restored the family fortunes and we were able to enjoy a tour of this gothicised and extended 1246 residence and its beautiful gardens, which are now in spanking condition.
That evening we took time to admire the perfectly restored Art Deco Midland Hotel, built in 1933 by the London, Midland and Scottish railway but in ruins by 1946. The building was then worthless, its 16 x 10 foot bas relief mural of Odysseus being welcomed from the sea by Nausicaa and her handmaidens with a bunch of grapes, carved in situ from a slab of Portland stone by Eric Gill and valued at £2million at that time, having taken a walk. It was fortunately retrieved from the back of a van in Yorkshire and has been replaced as part of a recent £8million restoration. You have probably seen the hotel on a Poirot episode or another film requiring a thirties décor.

The alumni were torn between the wonders of the hotel and the view across Morecambe Bay to the Lakeland hills to the right and distant Barrow-in-Furness ahead. Morecambe Bay is a vast area that experiences 30-foot tides and largely empties on the ebb. The volume of water in a spring tide would take a month to pass over Niagara. As the bay is rather flat the tides race in and out, but first unseen gullies cutting off one’s retreat fill deeply.

That evening our guests were Cedric Robinson and his wife Olive. Cedric fished the bay as a lad but for 50 years he has been the Queen’s guide to the sands, with a salary of £15 per annum augmented by a rent-free house and small holding. In this capacity he has led the humble and mighty across the bay at low tide, the latter including his landlady’s husband driving a coach and four. Worse than the rising water are the quicksands, which we learnt are formed by eddies keeping the sand in suspension. A long pole to prod the ground ahead is useful for the quicksands constantly shift their position. A helicopter sent to recover one unfortunate descended rather than rose as the rescue cable shortened and was only effective when water was injected through a high pressure lance passed through the sand to the victim’s feet, by which time the sands had reached his lips. Cedric has seen quicksand swallow horses and tractors but he has not yet lost a traveller across the sands. Nevertheless, no alumnus elected to accompany him across the bay.

The next day we travelled north to cross the bay’s principal feeder, the river Kent, much higher up and quite a detour compared to the route across the sands taken by horse-drawn coaches in the past. We travelled through pretty Grange-over-sands where John Middleton told us the last wolf in England had been cornered and slain. And then on to Cartmel-in-Cark-in-Furness and still in Lancashire although administered by something called Cumbria. Cartmel is minute but very pretty and noted for an enormous priory church, a National Hunt racecourse, one of the best five restaurants in England and a claim that it is the original home of sticky toffee pudding. But we were lunching at nearby Holker Hall, the home of Lord Cavendish, an appropriate follow-up to last year’s principal outing, Chatsworth where another Cavendish holds sway. In the library is Henry Cavendish’s microscope, the sole remnant at Holker of his scientific equipment and laboratory records which all went as part of a large endowment to the eponymous laboratory in Cambridge. Holker Hall is another ancient building but following a fire the interior was kitted out in high Victoriana. Outside, the gardens are magnificent and we were again blessed with excellent weather to see amongst many other delights one of England’s 50 “remarkable trees” (a lime).

We dined again at the Midland and entertained ourselves in traditional fashion, Stanley Holloway still being a favourite alumnorum. Many affirmed their intention of uniting again next year, same dates, different venue.

Emeritus professor Bryan Corrin is a pulmonary pathologist, formerly at St Thomas’s Hospital Medical School and now working part-time at the Brompton campus of Imperial College as honorary senior clinical research fellow.

Email: b.corrin@imperial.ac.uk

Figure 1: Morecambe in Morecambe, Photograph courtesy of Hugh MacKay
30th Annual Meeting of the British Association for Ophthalmic Pathology – Caroline Graham

The 30th Annual Meeting of the British Association for Ophthalmic Pathology (BAOP) was hosted in Manchester on 7th and 8th of April 2011 by Drs Luciane Irion and Richard Bonshek. The grand surroundings of the Education Centre of the Central Manchester University Hospitals NHS Trust lent themselves to the occasion without compromising the friendly, informal atmosphere which is characteristic of this meeting.

We were honoured to have speakers from overseas, Dr Godfrey Heathcote from Nova Scotia and Dr Mozhgan Kanavi from Tehran.

The talks were fascinating and varied and included case reports of unusual entities such as an eccrine syringofibroadenoma of the eyelid and metastatic breast carcinoma to the orbit with histiocytoid differentiation.

Dr Hardeep Mudhar told us about “in-transit” metastases of conjunctival melanomas, a novel method for sampling iris and vitreous tumours and also about the use of FISH for problematic conjunctival naevi.

It is always interesting to have a clinical perspective at the BAOP and this year we were fortunate to hear presentations by several ophthalmologists, whose talks ranged from periocular pyoderma gangrenosum following the lancing of a trivial lesion by a member of staff in a walk-in NHS clinic to rhabdomyosarcoma masquerade syndrome in children.

The BAOP lectures were delivered by ophthalmologists. Professor Paul Bishop spoke about the role of genetic and environmental factors in age related macular degeneration and Professor Graeme Black enlightened us about brittle cornea syndrome.

One of the highlights of the BAOP meeting is the (almost) annual presentation by Mr John Mould, veterinary ophthalmologist, who showed a wonderfully illustrated case of a myelolipoma of the iris in a Scottish terrier. We learned that these are very rare in dogs and are more likely to be found in the spleen of captive cheetahs than any other animal!

It would be remiss of me not to mention Richard Bonshek’s talk with a forensic twist and the curious title of “Kill Bill?” This was a gripping, gory account of eye gouging.

Dr Keith Robson gave a slick account of the results of the two ophthalmic EQA circulations from the preceeding year. Despite some rather tricky cases there was surprisingly little controversy about the scoring!

The meeting concluded with the AGM, chaired by our newly elected president, Dr Peter Smith.

There was plenty of opportunity for the delegates to catch up with one another during coffee breaks, lunch and notably at the reception and delicious dinner which was held in a private dining room at the famous Midland Hotel in the centre of Manchester.

Next year’s meeting will be held on the 29th and 30th March 2012 in Sheffield and if you would be interested in participating in this or future meetings and/or would like to learn more about BAOP, please contact the Secretary via the email address at the start of this article.

Dr Caroline Graham is the Secretary of the BAOP and works in the Department of Cellular Pathology at Stoke Mandeville Hospital

Email: caroline.graham@buckshealthcare.nhs.uk

Somewhere on the path to enlightenment...

The Dalai Lama walks into a pub and asks for a pint of beer.

“That’s £2 please sir”, the barman says.

The Dalai Lama hands over a fiver.

The barman rings up money and walks away.

“Hang on,” says the Dalai Lama “where’s my change?”

“Ah,” replies the barman “but change must come from within...”
Making the transition from trainee to consultant – Ed Carling

Dr Ed Carling is a Consultant Histopathologist at the James Cook University Hospital, Middlesborough and is an Assistant Editor of ACP news
Email: edcarling@doctors.org.uk

Back in the dawn days of my career as a doctor, just as I was about to graduate from the venerable institution of medical school, our class was treated to a farewell lecture. Bright eyed and bushy tailed, a hall of two hundred eager young student doctors sat in a seemingly ancient lecture theatre and listened to a seemingly equally ancient, and considerably more spheroid being whom I only remember as “The Senior Consultant”. This squat, hirsute pillar of the university hospital community spoke for an hour. I remember two things; his walrus moustache, and a warning. I paraphrase from a memory over a decade old, but the warning went along the lines of “Beware your first year as a doctor and your first year as a consultant. These will be the most stressful years of your life. If you are going to break, that is when you will break.”

He was right about that first, pre European Working Time Directive house officer year. I remember that time only as a blur of exhaustion, beer, and more exhaustion punctuated by crystal clear, Post Traumatic Stress Disorder like moments of fear. The fear of the new, of the unexpected, of responsibility and professionalism, and of my own failings and inadequacies in the face of seemingly a relentless tide of human suffering. However, I got used to it as we all did, gradually, and the fear faded into the routine.

So, one year ago almost to the day, when I was finally released from the Karmic wheel of seemingly eternal improvement, reflection and assessment that is a modern specialist registrar’s lot in life, and was admitted to the twin higher planes of the specialist register and consultanthood, I remembered the old academic and his warnings. Then I found out how right he was.

In my experience, being a trainee in histopathology was a social, communal activity in a large histopathology department. At work we dwelled in an open plan “trainees’ area”, modelled by a Private Finance Initiative designer on either a provincial airport waiting lounge or an ancient Roman bear-baiting pit (I could never decide which). The place constantly hummed with whispered communications. Slides flowed between alcoves, and we always, always talked to each other.

Then the longed for CCT arrived, and away I ran to my eagerly awaited first job as that previously mythical beast, the Consultant. I was a locum in a much smaller hospital, in a much smaller department. Suddenly I had my own office, and was struck by the oppressive silence of it. It seemed a self-contained isolation unit, in which to practice a monastic regime of solitary diagnosis. Silence seemed the only proper response. This was not of course the serene silence of a contemplative monk at meditation or prayer, but instead a state of silent anxiety. This was when it hit home: You are on your own now lad, it is your name on these reports, and you who will get it in the neck if you make a mistake.

So, I did what I had been trained to do: I made sure I was safe. The number of extra level requests in our small lab must have doubled. I doubt whether the immunohistochemistry budget will ever recover. I developed idiosyncrasies like nervous ticks, the most memorable being the ability to imagine amyloid or basement membrane material in almost any slide. Shares dividends from Congo Red dye suppliers must have risen sharply given the amount I used. Slides were set aside to be forensically re-examined at repeated intervals, either ever earlier or ever later in the day. Cytology smears were screened at ever higher power to avoid missing that one mildly abnormal cell. Ever rarer and more bizarre differential diagnoses became inexplicably more likely to my feverish imagination. These increasing hours of deliberation brought increasing mental and physical strain, visible as an ever more furrowed brow and the thousand micron stare of a veteran ‘scope jockey. Strangely, these fears did not extend to specimen dissection or to the post mortem room. These larger, lighter spaces somehow never seemed so oppressive.

So, over the space of a couple of months, my previously efficient practice became ever more sloth like. I was however rescued from this pit of inefficient over activity by some very understanding senior colleagues, who I now know had seen it all before. The problem was of course the indefinable “confidence”, a most personal of attributes that is very difficult to quantify. I can’t tell you exactly how mine waxed, waned and then re-grew over several months, I can tell you that, for me, the most important aspect of the transition from trainee into responsible
independent practitioner was the support of more experienced colleagues, and I am forever grateful to them. Not for being soft, but for demanding I grow into the role and for knowing that, given time and support, I would.

One year on, I do understand that old graduation warning, and I think that it still holds true for new consultants. We are more scrutinized than ever, and learning by making mistakes is not the accepted apprenticeship that it once was. Whilst it is still fresh in my memory, I will offer what little I have learned as advice to those about to go through the same process.

Do not go through the process alone, hiding in your new office cell with only slides for company. The days when we were badly dressed, shaggy-bearded basement dwelling Beige Morlocks should be consigned to the distant past. We humans are social creatures, even when we become pathologists, and a group perspective of any issue is a great insulator against the stresses of your new role. I have been very, very lucky in my colleagues, and believe they are the single most important factor in any medical career. Try to choose yours with great care.

Secondly, try to get some experience of working independently whilst still within the registrar cocoon. I know it is difficult these days, but it is well worth the effort and will save you a lot of future anxiety. Thirdly, recognize that this first year will be very stressful. If possible try to avoid any other major life-changing events, especially in the first few months. As always, any other tips are gratefully received.

---

**Triple dose**

A man went to the doctor’s office to ask for a triple dose of Viagra.

The doctor told him that he wouldn't allow him a triple dose.

"Why not?" asked the man.

"Because it's not safe" replied the doctor.

"But I need it really bad," said the man.

"Well, why do you need it so badly?" asked the doctor.

The man said, “My girlfriend is coming into town on Friday, my ex-wife will be here on Saturday and my wife is coming home on Sunday. Can’t you see? I’ve got to have a triple dose!”

The doctor finally relented saying, “All right, I’ll give it to you, but you have to come in Monday morning so that I can check you to see if there are any side effects.”

On Monday afternoon the man dragged himself into the doctor’s office ... his right arm in a sling.

The doctor asked, “Good heavens! What happened to you?”

The man said ...  

“No one showed up!”
Clinical pathologists are faced with a plethora of pathology-related books to choose from to assist in their training and continuing professional development, to accompany their undergraduate teaching, and for their own amusement and enjoyment. The review section is here as your guiding light and presents brief critical reviews of up and coming books (and perhaps one or two you thought you knew) in the realms of pathology, medical education and medical history.

**Soft tissue tumors: a multidisciplinary, decisional diagnostic approach.**

J Klijanienko and Réal Lagacé

Wiley Blackwell, 2011

ISBN 9780470505717

£100 400pp

This 421 page monograph is physically well produced and bound with an eye-catching cover featuring a collage of microscopic images. It is essentially a European effort, with some North American input, mainly from Réal Lagacé, who spent a year on sabbatical in the Institute Curie, Paris. It includes a distillation of an extensive experience of diagnosis, majoring on fine needle aspiration cytology. The advantages and disadvantages of both core needle biopsy and FNAC in preoperative diagnosis are well reviewed, but the main thrust of the presentation is in the cytological aspects. With each entity presented in the “particular aspects” chapter (290 pages) there are subsections on Histopathology, Cytopathology, Differential Diagnosis, Comments, and FNA Key Features. Three of these sections deal mainly with FNA appearances, and the histopathological descriptions are not specifically needle core biopsy orientated. This results in an unbalanced text, which might have worked better, for example, as an atlas of FNA appearances of soft tissue tumours with histological correlation.

The text is littered with spelling errors and, inexplicably, could not have been put through a spellchecker. This pales into insignificance when compared with the grammar and usage of English, often incorrect, clumsy, over-elaborated, confusing and sometimes even comical. I cannot understand why the authors and/or the publishers did not insist on proper revision in these regards. It is a major detraction from the quality of the book.

There are many quality photomicrographic illustrations of histology and cytology. The captions could have been used to better effect, for example explaining how to recognise the cells, rather than just naming them. Pathologists dislike inaccuracy: this book is full of it. Fig. 6.214 has the caption “Well differentiated pleomorphic liposarcoma...” There is no such entity. This is in a section on well differentiated liposarcoma, but the illustration seems well out of place. Subsequent Figures 6.216-8 all purport to show well differentiated liposarcoma, but are highly cellular fields with pleomorphism and mitoses. This is simply implausible; there is an uncanny resemblance to the illustrations of smears from a pleomorphic liposarcoma, 6.299, 6.301.

I have some experience of FNA of soft tissue tumours and I respect the experience and erudition of these authors. FNA is not, however, a mainstream technique for diagnosis of sarcomas in the UK, and I would not recommend this book for the practising pathologist. It might be of interest to someone with a niche role in the cytology of soft tissue tumours, but that’s about all. There are better alternatives, both comprehensive textbooks and biopsy manuals, for general use.

Charles Keen
Both of these books are Atlases of Head and Neck Pathology written by experienced and internationally respected American Head and Neck Pathologists. Neither purports to be as comprehensive as larger books although all significant common and many uncommon conditions are discussed and major practical problems addressed. Both are extensively illustrated and references are more limited as befits atlases. Each includes chapters on the oral cavity, larynx, sinonasal tract, salivary glands and the thyroid, in each case set out logically with inflammatory and non-neoplastic diseases followed by benign and malignant tumours.

Although all important conditions are covered in both books, there are differences in lay-out. For example, the Robinson book has separate chapters on the ear, mass lesions of the neck, as well as squamous carcinoma and pre-neoplasia, and the Brandwein-Gensler one has separate chapters on the jaws and nasopharynx, but not one on the ear. I particularly like the comprehensive table of contents at the front of each book, supplemented in each case by an easy to follow index at the back, making quick reference easy for everyday practice. This is true of both books, and especially so with the Brandwein-Gensler one which I found very easy to navigate.

There are differences: for example the foundation of the Robinson book is surgical pathology, but it lays particular emphasis on fine needle aspiration and there are plentiful histological and cytological images all of a high standard. The Brandwein-Gensler book includes some cytology, but is aimed more at pure surgical pathology.

Both are excellent works which will rarely disappoint. Defects are few: some of the recent developments in HPV-associated oropharyngeal carcinoma are not covered in the Robinson book, and the section on squamous dysplastic lesions does not mention the Ljubljana system, more widely used in Europe than North America. In the Brandwein-Gensler book, most photographs illustrate their topic very well, but a small number have a poor colour balance, slightly detracting from the high technical standard generally.

Which one of these very good books should one buy? The answer is that both have a place with general surgical pathologists (those with or without a special interest in head and neck disease) as well as trainees, and they will find frequent and ready use beside the microscope. In addition, either could also be most useful to otolaryngologists or oncologists specialising in head and neck cancer. If one had to choose only one, that would be a matter of personal preference. For cytopathologists, I think the Robinson one is likely to be of particular value in correlating surgical pathology and FNA findings. The Brandwein-Gensler book is possibly a little more comprehensive in its coverage generally. As for the bottom line of value for money, both are relatively cheap for pathology textbooks these days (Robinson £133, Brandwein-Gensler £95), but the latter perhaps represents more bang for your buck.

Roderick Simpson
Diagnostic Pathology: Soft Tissue Tumors
C Fisher
Amirsys Inc, 2010
ISBN 9781931884501
£197 700pp

Given the complexity of soft tissue tumours, this textbook is kept to a manageable size by the series’ concise format of using bullet points under the expected headings that include clinical features, imaging, macroscopic and microscopic features, ancillary tests such as immunohistochemistry and cytogenetics, and differential diagnosis. In the past, I have always preferred textbooks based on long sentences with relatively few headings, but I must admit that having used this textbook now for a few months, it is exceedingly simple to extract the relevant information from it and I’ve found it very helpful. The most important areas are highlighted in even more concise fashion in “key facts” sections. The photographs are of high quality and of modest but adequate size so that six can be packed into a single page. Again, this prevents the book from becoming excessively large. The book covers reactive/inflammatory states pertinent to the differential diagnosis of soft tissue tumours. I found the chapter on genital stromal lesions particularly useful, an area often relatively neglected. Mesothelial proliferations are also covered.

All in all, though I don’t generally like this book’s type of format, I was rather won over by it, mainly on the basis of it being comprehensive and up to date, very easy to extract information from, and having lots of nice photos. I would recommend it.

Mark Smith

Stocker and Dehner’s Pediatric Pathology, 3rd edition
JT Stocker, LP Dehner, AN Husain
Lippincott Williams and Wilkins, 2010
ISBN 9780781766692
£230 1298pp

In the field of paediatric pathology there are very few dedicated textbooks. It would be impossible to cram a detailed review of all conditions that might be encountered as a paediatric pathologist into a single book, but Stocker and Dehner’s text includes a more comprehensive review of both paediatric surgical and perinatal pathology than most.

It has been almost 20 years since the publication of the second edition of Stocker and Dehner and the third edition has a very modern feel. Many of the illustrations are now in colour and the number and quality of these is high. In most cases the chapters have been revised to reflect changes in recognition and classification of organ pathologies, although disappointingly, the degree of revision does vary widely. The chapter on forensic pathology for example shows minimal change from the previous edition. As before the book is divided into two sections, the first on general techniques in paediatric pathology and the second on organ system pathology, although these
Book Reviews

are now incorporated into a single volume. The topics covered are very similar to the previous edition with the addition of a useful section on transplant pathology.

As with many new pathology books the index has shortened substantially which does increase the time it takes to find the information needed. Happily the authors have not adopted the annoying habit of simply referring the reader to other terms in the index instead of supplying the relevant page number. Purchasing the book also entitles the reader to full access to the online version which is relatively easy to use.

The range and relevance of the conditions covered in this book remains good and Stocker and Dehner’s Pediatric Pathology is an excellent base from which to start when working in paediatric pathology and will be indispensable for anyone training in paediatric pathology.

Dawn Penman

Readers wishing to become book reviewers for ACP news should contact: Dr Ian Chandler, ACP news Book Reviews, Department of Pathology, Royal Devon and Exeter Hospital, Exeter EX2 5DW. Email: ianpchandler@doctors.org.uk. Please specify which areas of pathology/medical education/medical history you would be prepared to review books on. Non-histopathologist reviewers with an interest in chemical pathology, medical microbiology, haematology, neuropathology, forensic pathology, and the history of medicine are especially welcome. Reviewers may keep the book and are asked to submit their review within 4-6 weeks of its receipt. Reviews are requested to be 200-250 words long, but space restrictions mean some reviews may need to be cropped by the editors. We welcome suggestions for titles to be reviewed, but regret that unsolicited reviews cannot be accepted.

Things are not always as they seem

My neighbour knocked on my door at 2:30 am this morning, can you believe that... 2:30am?! Luckily for him I was still up playing my Bagpipes.

My girlfriend thinks that I'm a stalker. Well, she's not exactly my girlfriend yet.

Went for my routine check up today and everything seemed to be going fine until he stuck his index finger up my ass! Do you think I should change dentists?

I was explaining to my wife last night that when you die you get reincarnated but must come back as a different creature. She said she would like to come back as a cow. I said, “You're obviously not listening.”

The wife has been missing a week now. Police said to prepare for the worst. So I have been to the thrift shop to get all her clothes back.
I was recently presented with a mug depicting the words “Mad Cat Lady”. I accepted it (one of course never turn down presents) albeit gracelessly and indignantly because I’m not a mad cat lady, right? Firstly, I smell rather pleasant, am almost certainly not mad about the cat and I only have the one cat. Not three, not five, not a whole stable. Now this one cat may be impeccably groomed and get first dibs at dinner (and lunch and breakfast), and eats out of better quality dishware than I do but I’m not mad, I simply care for its welfare. This term “mad cat woman” surely refers to elderly spinster types who hoard cats without the ability to properly care for them and then get eaten by said cats. And I’m still intact.

That got me thinking, how did this so called disease come about? It is apparently caused by the protozoan *T. gondii*, and as we are all medical types it will probably be stating the obvious but nevertheless toxoplasmosis is a parasitic disease. Harmless to healthy adults whence it may cause a flu-like illness, it wreaks havoc to those with weak immune systems.

Toxoplasma can infect many species but reproduces only in the digestive tracts of cats. Transmission can be either due to infected raw or partially cooked meat or via cat faeces. The little blighters then form cysts in the brain, liver and muscle.

In order to perpetuate their line, these creatures have to take over the brain of their intermediate hosts, in particular rats (and potential mad cat ladies). This causes rats to become attracted to the smell of cat urine, losing their inhibitions and drawing attention to themselves. With slower reaction times and becoming less fearful of new situations, the unlucky rat is then eaten by the cat, enabling toxoplasma reproduction and propagation of the species. Non-infected rats on the other hand avoid anything to do with the cat. Mad cat ladies however get madder and madder and succumb to self neglect and then malnourishment and then get eaten by the cat.

Recently, researchers in Leeds analysed toxoplasma DNA and discovered that two of the protozoa’s genes encode the enzyme tyrosine hydroxylase, which is involved in dopamine production. Whilst dopamine does not have any known function in protozoans, it acts in animals that have nervous systems and may explain the development of schizophrenia and bipolar disorders in genetically susceptible humans. Those infected appear to have poor reaction times, short attention spans and exhibit a proneness to guilt. A whole host of other studies also conducted found that toxoplasmosis causes more car accidents, “signs of higher intelligence” in women, whilst men apparently develop feminine traits (being more suspicious, jealous and morose). This suggests we can determine the national level of Toxoplasma infection by measuring levels of neuroses. Is Britain still stolidly phlegmatic? Are we becoming a more emotional nation, or is this only limited to Daily Mail readers?

So surely not all these spinster ladies have toxoplasmosis. I certainly haven’t. Although at this point in time I’m feeling really guilty for not having filled little Rorykin’s dinner plate up to its requisite levels. But that’s not related to toxoplasmosis.
Another few months, another column due: I don’t know how newspaper columnists think of things every week; it’s as much as I can do to think of something to write about every three months, and even that is difficult. I am currently crammed into a carriage on one of the Beardie’s trains heading for London. At least half of the train is completely empty because Virgin charges so much that no one is prepared to pay the extra £100 to go in the three first class carriages at the front and everyone is crammed in the three second class carriages at the back [which also includes the refreshments area – so actually it is only 2½ carriages]. On the Leicester line which I usually use, they only have a quarter of the carriages for first class and they are generally full because a first class ticket is not much more than a second class ticket, and in any case, a first class ticket is no dearer on the Midland Mainline than second class on a Beardie train. The train would be even more over-stuffed if it were not for the rules that mean that offpeak tickets are only valid when there is a ‘z’ in the day and you have sacrificed an animal before getting on board – which probably explains the goat killings in Tipton St John that were in the paper yesterday. Even though it is 11am, two people sat in the same carriage as me have just been ordered to get off at the next stop or face an extreme penalty charge, and one person has been arrested for boarding with no ticket, and no means of paying for a ticket. All this because of a crash part way down the M1 that has grid-locked Leicestershire meaning it made more sense to head down the M42 to Birmingham International to avoid the traffic.

Another problem with Beardie is that he uses Pendolinos – a train that seems designed to induce travel sickness. The old British Rail intercity trains used to be bumpy but at least they were pleasant to ride in. On the Pendolino, I can only read or type for about 20 minutes before it is necessary to stop for cochlear rebalancing. This is not as bad as being on a whale-watching trip in Iceland. That was 4 hours of pure torture, requiring a large Subway on landing. This was just before the Iceland currency crash – so Subway was about the only reasonably-priced food outlet in the country. The people in the adjacent veal pens seem to be attached to their iPhones. The only time they have not been texting, or reading texts to each other was when we were in a long tunnel and they had no signal. At this point they suddenly went silent, as if they themselves were solar powered and needed external electromagnetic radiation to keep their metabolism operating. They would certainly be bad neighbours for the woman who was described in the newspaper today who claims to be so sensitive to electromagnetic fields that she has had to remove all electric appliances from her house, and live by candle-light. She even says she has made her neighbours abandon their wi-fi systems because she cannot tolerate them. I once saw a similar patient, except her villains of choice were North Sea Gas and enzymes. She had symptoms of chronic fatigue and believed that it was the fumes from her next door neighbour’s gas fire that made her ill. She had removed the gas supply from her house and was irate that her neighbours refused to do the same – they lived in a detached house so there could be no cross-communication with her flue system. She also complained that when she came into contact with anything that had been washed in biological washing powder she suffered respiratory symptoms; so did not like it when the people next door hung out their washing! Oddly, we use biological washing powder and she showed no evidence of respiratory problems as she was able to tell me about her symptoms for hours.

Anyway, enough of the randomness. The reason for my trip to London? A Comprehensive Clinical Research Network Specialty Group meeting. I am the representative for the West Midlands (North) on the Metabolic and Endocrine (not diabetes) group. The (not diabetes) is important because diabetes is a large research area which, like cancer, has its own topic-specific research network so we don’t get any money for diabetes projects. The Metabolic & Endocrine group is one of the smaller specialties, with only about 50 studies active and recruiting. Of those a small number are what is now classified by the CCN (the co-ordinating centre for networks) as “red” meaning that they are not recruiting fast enough to meet the projected recruitment target by the expected end date. Here, I had some helpful news:
When we discussed the first of the red studies, I was able to announce that we at Burton were days away from opening that study so we could contribute to its recruitment. This is important because sponsors want to see projects fully recruited in a reasonable time scale. Therefore if your study is going belly up, sometimes the network can help.

I found out about the study of chronic pancreatitis (EUROPAC-2) by searching the network portfolio which is freely available on the net and wanted to take part because I have patients with chronic pancreatitis due to their inability to maintain low enough triglycerides because of their lipoprotein lipase deficiency. In the past I tried to get these patients involved in a study of gene therapy but due to their retaining partial (approx 15-20%) enzyme activity they were ineligible. It was thought to be risky to treat such patients because if the newly introduced gene induced anti-LPL antibodies, they may be even worse off than they already were.

One of my other hats is as R&D lead for my hospital. As a consequence of supporting research, by paying for research nurses, pharmacists, radiology scans etc., the research network expects something in return. We have targets for recruitment. These are deliberately much higher than we have achieved in the past to keep us striving to improve efficiency and to give more patients the opportunity to receive “the latest treatments” by being involved as research subjects. The model in Burton is to have a number of “generic” research nurses who are not dedicated to one specific specialty. They do have areas they concentrate on, but can be moved around if new studies open and old ones close.

This is where, as R&D lead, being a laboratory consultant is important. Our research nurses have the important job of scouring the portfolio for new trials that we may be able to join, but then they have to try to work out how they can identify patients. Last year one nurse identified a study of the genetics of Dupuytren’s disease. There were several options for identifying patients. One was to manually trawl through the last 6 years theatre books to find patients who had been operated upon for palmar release; another was to ask the clinical coding department for the hospital number of anyone who was recorded as having that particular operation. The coding method would have worked well except for the vagaries of the NHS. Out-patient episodes are not coded; only in-patient and daycase theatre admissions are, but for the last five years our daycase orthopaedics have been carried out in the NHS treatment centre in the car park. And they don’t care about research. We have tried to get projects run there: not interested; no profit. Although I could find their data manager, so I had asked the right person, could I get any coding information out of them? No! So, lab database to the rescue. All treatment centre histopathology goes via us, so I could search the histology database to identify patients. As a result we got 97 accruals in the CLRN statistics, which was a very significant addition to our recruitment last year.

There have been several other studies where the laboratory database has been helpful, or will be in future. I am currently investigating a thyroid cancer study [using thyroid FNA data], and in the past identified a group of poorly controlled diabetics using HbA1c data. These were studies that others had deemed too difficult to enter because they could not easily identify patients. Another study using a ‘different’ approach that we are starting is an isotretinoin in acne study where we have used the pharmacy database to identify over a thousand potential recruits.

Research is important so that we can continue to improve patient services. This time instead of my usually inventive conclusions, I simply want to encourage you to get involved with researchers at your hospitals: laboratories have a wealth of data that can often simplify others’ problems if viewed in an innovative way.
“A country of long shadows on county cricket grounds, warm beer, green suburbs, dog lovers, and old maids cycling to Holy Communion through the morning mist...” and, John Major might also have added, medical students writing essays in their examinations. Essay writing seems to have gone the way of so many traditions (cue brass band playing that bit from the slow movement of Dvorak’s 9th Symphony). In a previous job, I used to drive my wife to distraction as I would sit through long evenings continually tutting and harrumphing as I marked exam essays, furiously underlining in red pen, appalling spelling mistakes or other errors. Did you know that patients with chronic obstructive airways disease were prone to infective “exhashabations” in the winter months? Or that the spectrum of infections caused by *Legionella pneumophila* included the syndrome known as Pontefract (as opposed to Pontiac) Fever? (Well, they were students attending a medical school in West Yorkshire, so maybe this was an early example of localism in action). The morning after a particularly grisly marking session I would rant to colleagues about this but most of them would tell me, with a shrug of the shoulders, that poor spelling wasn’t such a big deal anymore. I should just accept it as a fact of life. There was no point in wasting time correcting it with a red pen either, as the medical student wouldn’t see the corrections and, in any case, students could not/should not be penalised for incorrect spelling.

Later, when I became a card-carrying academic I was packed off to a week-long course in teaching and learning in education. It was here I learned that correcting students when they were wrong was, er, wrong. It could affect the delicate flowers’ self-esteem and stifle independent thinking and creativity. Accuracy: schmaccuracy. Precision? Pah! Everyone, it seems, had a right to be wrong. This would seem to include the good people at the Department of Health and other high heed yins. I have given up counting the times in which official documents use “principle” when what is really meant is “principal” (or is it the other way round?).

But, even today, as I read through a set of case notes I still found it hard not to reach for the red pen and make the odd correction. What was I to make, for example, of the patient with a long-term neurodegenerative condition, who had been transferred from another unit where he had been admitted for “rest bite” care. This was not the first time I have come across this interesting term. In a way it’s understandable that some people might choose to spell respite in this way as it gives the impression that patients go off for a rest and perhaps a bite to eat. It all sounds rather convivial. Most people reading the notes would recognise this as an error and it is unlikely that it would result in any harm befalling the patient.

But what about the statement “patient sensitive to flucloxacillin”? At face value this could be taken to mean that the patient is hypersensitive to flucloxacillin and shouldn’t receive the drug. In fact, what the doctor responsible for this annotation really meant was that the bacterium grown from the patient’s joint aspirate was sensitive to flucloxacillin. So, depending on how this statement is interpreted it could lead to the patient continuing appropriately on the antibiotic or incorrectly being switched to another agent to which she was not “sensitive”. It is for this reason that I always use the term antimicrobial “susceptibility” rather than “sensitivity” when writing in the notes or teaching medical students, but then I’m a grumpy old pedant who should get out a bit more instead of stifling peoples’ independent thinking and creativity. Also if everyone started to use the term, susceptibility, it would mean the end for the old bumper sticker (whatever happened to them?) “Microbiologists do it with culture and sensitivity”.

So should I stick to my guns and stand like King Cnut trying to stem the tide before being engulfed by waves of spelling mistakes and other manglings of the mother tongue? (note to copy-editor, please be careful with that last sentence) Well maybe it really is time to give up. I have already modified the content of lectures to medical students. Why? Well it’s not just the more pedantic stuff like “disinterested” and “uninterested” which, of course mean two completely different things, it is also things like using “e.g.” and “n.b.” on PowerPoint slides. Some students have never encountered these abbreviations before. I know because they used to put their hands up in lectures and ask. While we are on the subject of...
abbreviations derived from Latin, a colleague of mine was once asked by a final year BSc student what you had to do to become an et al. She’d seen it in so many references but had never actually met someone who had one.

Many students don’t “get” irony either and will happily accept at face value what you are saying. I was talking to a group of students about infection control and observed (stop me if you’ve heard this one before) that hand hygiene was of fundamental importance in protecting patients from healthcare-associated infection. I noted that medics seemed to be particularly bad at hand hygiene and that practice seemed to get worse the more senior a doctor became, so that some consultants didn’t appear to have the need to wash their hands at all – the bugs were apparently magically repelled from their hands. OK, so not exactly Perrier Award-winning material, but there were a few smiles on the faces of members of the audience who were still awake. After the talk, a student came down to the lectern. “I was really, really interested in that bit about the hand hygiene” (“Ah”, I thought, “another example of how students are so appreciative of my entertaining lecturing style and the fascinating nuggets of information which I unearth for them”). I nodded in anticipation of the question he was about to ask. “Yeah, it was that bit about the consultants and the bugs being repelled from their hands”. I nodded again. “How does that work, then? Could you explain the mechanism behind it?”

I’ve just sat down again after a bit of a bop on the dance floor with a ball of pure energy that does public health for a day job. (Just because we’re introverts doesn’t mean we don’t like to party.) The music is coming from a singer with a voice that soars, swoops and swings around the room like a glorious bird. And the ballroom is weirdly dreadful in a Toad Hall sort of way. Bad Gothic on steroids with vertical dimensions that are utterly scandalous. I keep expecting Badger, Ratty and the team to pour out from behind one of the wall panels (here’s a pistol for Toad, here’s a pistol for Mole etc). In the meantime, it feels as if the two dozen Weasels and Stoats of TMP 2011 are having a really great time. Conversation is doing a bit of soaring and swooping and swinging too and there is a lot of laughter. More on laughter in a bit. It’s the last evening of week two of TMP - the King’s Fund Top Manager Programme. Three more residential weeks to go between now and the end of the year. Blimey.

Earlier in the day we were doing stuff with a Drama Queen of magnificent dimensions. In a good way, unlike the Hall. She introduced us to the diaphragm; the handshake; the walk; the eye contact. The warm-up and what to do with your shoulders and hips. And we all worked on how to help each other grab an audience and hold it. Yesterday – I think it was yesterday – I was explaining what a blue glazed Sake cup symbolised for me before going out into the gardens for a silent walk with a fellow member of the programme (mother, barrister and Irish in no particular order) and rediscovering the beauty of eucalyptus trees and primary colours. Last week we were making colourful collages based on images of that we had found during a quick five minutes of peaceful reflection. And doing the rounds of the National Gallery learning to look more deeply and see more effectively.

Simon Knowles is a pathologist in the West Country
Email: simon.knowles@nhs.net

A new definition of the word “fun”
Brilliant. What fun! Well that’s not exactly how it felt. Or
feels. Because I haven’t told you about the other bits of the programme yet. So back to laughter: I phoned home before we did the Music night. And was told in no uncertain terms by them back there that the men in white coats would be on their way instantly if I giggled in that hysterical way Just One More Time. I could feel another cackle brewing so, given that we’ve got a bunch of colleagues from secure mental health facilities on the programme, it seemed like a good idea to go and find myself a glass or two of something red. And thus I found myself singing a three part Afro-American spiritual harmony and dancing with the ball of fire. And others. So where did the scary laughter come from?

Well, if you log on to the King’s Fund website and find the Leadership section you can watch a brief video of the programme director, Nicholas Bradbury, talking about the TMP course. That probably gets as near to the heart of the programme as you can but, at the same time, actually doesn’t start to describe it (although it’s a pretty good introduction to Nicholas). The last two weeks have been amongst the toughest I can remember. Yes, there is a load of theoretical and workshop stuff to provide some of the framework for learning about leadership but the really hard labour is built around the group work. So, if I tell you the programme draws on dynamic and humanistic psychology, systems theory, social construction and complexity and emergence you’ll probably get the right impression. We aren’t just sitting there with our crayons and glue sticks or listening to lectures about GP commissioning, strategic vision or the Bonfire of the Quangos.

What we are doing feels like being taught to pull your own teeth, except that the instructions have been written in some strange alphabet and read backwards. Punctuated by silences – uncomfortable, peaceful, angry or disengaged and lazy – we are learning stuff about ourselves and others through doing stuff with others and ourselves. Stuff being largely about feelings. This is the Top Manager Programme so everyone on the course is hugely experienced and utterly determined. But emotional intelligence is a whole different world to tradecraft excellence, whether your background is nursing, social work, psychology, operations, medicine or whatever. And, truly, the Day Job in management isn’t about working with organisational charts, although we do work in organisations that sometimes do the strangest things. Mostly, we work with people and we work through relationships, some good, some bad, some virtually non-existent.

This week, helped on my way by the innocent recipient of a particularly nasty bit of behaviour on my part, I was able to get briefly in touch with a bit of my Inner Bigot. Not a pretty sight and I’m sure there’s more of that to come. ’Nuff said. In the future, I don’t think I’ll have the nerve to come home after a hard day and say I’m feeling emotionally drained unless I’m aware of the emotions I think have been drained. And from whom. And who (or what) did the draining. If I do then I hope I’ll sit down and try to work out what was really going on and why I felt the way I did. Then, when I can do that competently, I may be able to do it in real time and get the most out of me and everyone around me. So at least some hints that I’ve been promoted from a state of unconscious incompetence to one where I am conscious of my incompetence. There’s progress for you.

And talking of spirituality, which we almost were, here are the lyrics to the three part harmony we sang on the music night at Toad Hall this week:

\[
\begin{align*}
\text{Ain't gonna let nobody} & \quad \text{turn me around} \\
\text{turn me around} & \quad \text{Ain't gonna let nobody} \\
\text{I'm gonna keep on walkin'} & \quad \text{keep on talkin'}
\end{align*}
\]

In the increasingly constrained world we live and work in, we all need a bit of freedom to do the things that feels right and not just correct. I’m trusting that, by the end of the year, the people on the King’s Fund Top Manager Programme 2011 will have pointed me in the right direction. If so then the support the ACP is providing me with will have been a tremendous investment.

I’ll keep you posted.

Funding support for TMP is being shared between the ACP (thanks again), Yeovil District Hospital, Taunton and Somerset NHS FT and by the family Knowles.
Do you believe?

An atheist was walking through the woods.

“What majestic trees! What powerful rivers! What beautiful animals!”, he said to himself.

As he was walking alongside the river, he heard a rustling in the bushes behind him. He turned to look and saw a 7-foot grizzly bear charge towards him. He ran as fast as he could up the path. He looked over his shoulder and saw that the bear was closing in on him. He looked over his shoulder again and the bear was even closer.

He tripped and fell on the ground, rolled over to pick himself up but saw that the bear was right on top of him, reaching for him with his left paw and raising his right paw to strike him....

At that instant the Atheist cried out, “Oh my God!”

Time Stopped. The bear froze. The forest was silent.

As a bright light shone upon the man, a voice came out of the sky. “You deny my existence for all these years, teach others I don't exist and even credit creation to a cosmic accident. Do you expect me to help you out of this predicament? Am I to count you as a believer?”

The atheist looked directly into the light, “It would be hypocritical of me to suddenly ask you to treat me as a Christian now, but perhaps you could make the BEAR a Christian?”

“Very well,” said the voice.

The light went out. The sounds of the forest resumed. The bear dropped his right paw, brought both paws together, bowed his head and said:

“For what I am about to receive, may the Lord make me truly thankful, Amen.”
Melanocytic Proliferations Symposium
October 6 2011, Wythenshawe Hospital, Manchester

Lectures to include:
- Molecular alteration in melanocytic tumours: “How does it help histopathologists?”
- Malignant histological mimics of melanoma
- Benign naevi which may be mistaken for melanoma
- The term atypical as applied to melanocytic pathology - does it have any merit?
- Clinical appearances of melanocytic lesions with particular emphasis of dysplastic nevi
- New entities in melanocytic pathology

Speakers
Dr Phillip McKee, USA
Alistair Robson, UK
Gerald Saldanha, UK
Dr Colin Fleming, UK

Course Fees
Trainee rate - £90
Consultant rate - £155

Venue
Lecture Theatre 1
Education and Research Centre
University Hospital of South Manchester NHS Foundation Trust
Wythenshawe Hospital Manchester M23 9LT

Philip McKee
Principle Lecturer and Trainer
Author of the award winning 3rd edition of Pathology of the Skin.
Currently residing in the USA.

For further info’ visit: www.londondermpath.com

Contact us on:
info@londondermpath.com (+44) 161 980 8882

This Joint Symposium is organised by ACP and London Dermatopathology Teaching Ltd., a not-for-profit Company formed to deliver high quality dermatopathology teaching in the UK and abroad.