

Letters to the Editor

JOHN SNOW, CHOLERA AND CHLOROFORM ANAESTHESIA

Sir, I read with great interest the paper on chloroform anaesthesia by Dr Wedgewood and Professor Spence (*Proceedings* 1997; 27:575-91). Since they mention John Snow's valuable contributions to anaesthesia and cholera some additional information on his contributions to both fields may be of interest. Although many believe that Snow's genius in both fields was recognised early on,¹ he did not achieve the recognition he deserved at the time.

Snow pioneered obstetric anaesthesia with chloroform and gave it to Queen Victoria for the birth of Prince Leopold in 1853. Although the birth announcement was signed by the physicians who attended the birth, Snow's name was not included on this official birth notice although he probably contributed more to the well-being of the patient on that occasion than any of the other doctors in attendance. He was either not regarded as sufficiently eminent or, more plausibly, looked upon merely as an accessory.

On the 1854 cholera epidemic, Snow worked closely with his friend and collaborator, the Reverend Henry Whitehead, and it was the latter who discovered the source of the contamination of the Broad Street pump. In his paper on the subject,² Whitehead went on to remark that, although the removal of the pump handle by the local vestrymen (not, incidentally, by John Snow himself) the day after Snow addressed their meeting, had no effect on reducing the epidemic, it did in fact prevent a second one. Snow's genius lay in deducing the source of contamination from his theory on epidemic diseases,³ which carried germ theory as far as anyone did before the advent of the science of bacteriology. In Snow's day, of the important sanitarians, only Budd accepted his theory. Simon and Farr prepared material for a report which Simon made to the General Board of Health in 1856 on the cholera epidemics, which implicated polluted water, but does not mention Snow. Snow was a genius in both anaesthesia and epidemiology. Unfortunately this was not really appreciated at the time; the article by Wedgewood and Spence helps to give him the recognition he so richly deserves.

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- ³ Snow J. On continuous molecular changes, more particularly in their relation to epidemic diseases. London. Churchill, 1853.

CME

Sir, The recent resurgence of interest in continuing medical education (CME)¹ justifies its inclusion in the correspondence columns of our journal, so as to highlight the flaw which is fundamental to the current version of CME, namely its dissociation from routine clinical practice, and the apparent dichotomy that appears to exist between the acquisition of factual knowledge and the exercise of clinical problem-solving. What we often fail to communicate to our juniors is that even a 'routine' clinical episode, whether elective or acute, can be an opportunity for learning, and for advancement of CME, if it is characterised by the use of problem lists and the targeting of investigative and therapeutic modalities at specific items on that list. Some problems should then generate literature searches, and the factual knowledge acquired in this manner will be more easily retained, because of its relevance to the problems within the compass of one's own experience. This is the first step on the road to experiential learning² which, for me, is the 'holy grail' of genuinely worthwhile CME. In its fully-fledged form it should even include the use of ongoing registers of disease categories which are perceived to be uniquely relevant to one's own clinical practice. Appropriate literature searches can then provide important insights, amplifying one's understanding of these disease categories, whilst gaps in conventional wisdom can, in turn, become a focus for prospective studies and research. Finally, a comparison with published practice could be a starting-point for an audit of one's personal practice and ultimately an audit of departmental practice as well.

Critics of this educational approach will protest that if such activities cannot be monitored they do not justify characterisation as CME activities. Herein lies another fundamental flaw, because even activities such as enthusiasm for reading medical journals or for teaching juniors, which enhance personal standards of clinical competence through 'ownership' of the factual knowledge acquired thereby to a much greater extent than knowledge passively acquired through attendance in seminars and lectures, do not qualify for inclusion in CME.

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- ² Discombe G. Medical education (letter). *BMJ* 1988; 297:68.