Before impeaching facet joint injections and medial branch blocks, and thereby medial branch neurotomies, as well as lumbar transforaminal epidural steroid injections, Harris and Buchbinder should consider:

- interprofessional patient-centred approaches are key;
- pharmacological management is often ineffective;
- their view does not reflect the current practice of Australian pain medicine physicians;
- these procedures help people struggling to continue in social roles and maintain quality of life, so they help to reduce the economic impact of spinal pain on Australian society.

We support education to improve evidence-based practice of interventional procedures.

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Competing interests: All authors work in public pain medicine units and perform interventional pain procedures. Stephanie Davies has a private fee-for-service practice; Stephanie Davies and Malcolm Hogg are board members of the Australian Pain Society, which has a position statement on interventional pain management procedures published in March 2010.

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1 Harris IA, Buchbinder R. Time to reconsider steroid injections in the spine? *Med J Aust* 2013; 199: 237.

2 Sehgal N, Dunbar EE, Shah RV, et al. Systematic review of diagnostic utility of facet (zygapophysial) joint injections in chronic spinal pain: an update. *Pain Physician* 2007; 10: 213-228.

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5 Vad VB, Bhat AL, Lutz GE, et al. Transforaminal epidural steroid injections in lumbosacral radiculopathy: a prospective randomized study. *Spine* 2002; 27: 11-15. ❑

In reply: We thank Bogduk for his comments, but, based on previous reviews and some comparative studies,[1-4] do not consider the transforaminal route to be clearly and consistently superior to the interlaminar route for radiculopathy.

Further, we note that when the evidence for transforaminal injections is isolated to placebo-controlled trials, the evidence is based on very few studies. The largest of these showed marginal short-term (2-week) improvement in the steroid and local anaesthetic group over the saline group for the primary outcome (leg pain), an effect that was not sustained by 4 weeks.[5] Short-term relief is a common finding in studies that use local anaesthetic in the active group.

We consider the evidence for the effectiveness of transforaminal steroids over placebo to be neither strong nor consistent (within or between studies). We suggest that the gem in the bathwater be subject to more scrutiny and weighed against the risks and costs.

We thank Davies and colleagues for their comments about medial branch blocks and transforaminal epidural steroid injections. We have addressed the latter in our response above. Our article does not extend beyond the use of steroids to procedures such as neurotomy, so we have not commented on this procedure here.

Regarding medial branch blocks, we note that in a systematic review mentioned by Davies and colleagues, each of the randomised trials showed no significant difference in the response between groups treated with steroid and those treated with local anaesthetic alone.[6] This reinforces our point that steroid injections in the spine have no specific therapeutic effect beyond natural history, the effect of any concomitant treatment or any placebo effect.

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Competing interests: No relevant disclosures.

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1 Gharibo CG, Varlotta GP, Rhame EE, et al. Interlaminar versus transforaminal epidural steroids for the treatment of subacute lumbar radicular pain: a randomized, blinded, prospective outcome study. *Pain Physician* 2011; 14: 499-511.

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6 Boswell MV, Colson JD, Sehgal N, et al. A systematic review of therapeutic facet joint interventions in chronic spinal pain. *Pain Physician* 2007; 10: 229-253. ❑

> these procedures help people struggling to continue in social roles and maintain quality of life
>
> Davies et al

> steroid injections in the spine have no specific therapeutic effect beyond natural history, the effect of any concomitant treatment or any placebo effect
>
> Harris et al

Students as teachers

To the Editor: Silbert and colleagues highlight the benefits of peer-assisted learning (PAL).[1] They allude to the number of overseas medical schools that provide tutor training programs, and to the possibility that Australian medical students are missing out on this opportunity. We agree that PAL is useful, but not all Australian medical students have been deprived. Since 2008, Monash University has been running VESPA (Vertical Study Program), an optional PAL program.[2] Initiated by a group of medical undergraduate students, it continues to be largely student-driven, with faculty support. Further, our program has had international impact.[3]

VESPA is open to all students in the 5-year undergraduate and 4-year graduate-entry streams. Students meet after hours to discuss a case, which is authored by students and reviewed by a medical graduate. The objectives of our program are to provide an effective forum for revision in the setting of vertically integrated assessment, to develop a culture of collaboration and peer support, and to foster the development of teaching and facilitation skills of pre-intern participants.[4]

Our model emphasises facilitation rather than didactic teaching; we provide optional, small-group facilitation training for senior students. This is far less comprehensive than the Teaching on the Run model,[1] yet we hope this "taster" encourages students to seek and practise their teaching skills in other settings.

PAL is a valuable learning strategy, which should be more widely used to optimise medical graduates' education and communication skills. Future doctors who are eager and able to teach may alleviate the forecasted medical educator shortage.[5]

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1 Silbert BI, Lam SJP, Henderson RD, Lake FR. Students as teachers. *Med J Aust* 2013; 199: 164-165.
2 Kam J, Mitchell R, Tai J, et al. A peer-assisted vertical study program (VESPA) for medical students: results of a pilot study. *Focus on Health Professional Education* 2010; 11: 76-79.
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4 Kam JK, Tai J, Mitchell RD, et al. A vertical study programme for medical students: peer-assisted learning in practice. *Med Teach* 2013; 35: e943-e945.
5 Hu W, McColl G, Thistlethwaite JE, et al. Where is the next generation of medical educators? *Med J Aust* 2013; 198: 8-9.

To the Editor: Silbert and colleagues propose that teaching skills training should be compulsory for all medical students, to be used in peer-assisted learning programs and later in postgraduate roles.[1] As the quality of student training will have an enduring impact on the provision of quality care and patient safety, the responsibility for this important role should be entrusted to a select group rather than an obligation imposed on all.

Those undertaking teaching roles must possess a commitment to teaching[1] and be good role models who can build trainees' self-esteem, and foster a supportive and safe environment.[2] The choice of a select group with the right characteristics to be effective teachers will benefit the quality of student training, and affect the quality and safety of health care in the future.

The knowledge and skills competency of students must also be ascertained before placing a teaching burden on them. Where a person is on his or her personal learning curve will influence that person's ability to teach.[3] As a result, it is essential that medical students and junior doctors are deemed competent in performing a task before the responsibility of teaching is thrust on them.

To ensure safety and high-quality health care provision, the role of a trainer must be given to a select group with the right attributes, competence levels and passion for teaching. It is this group that needs to be trained, allocated time, resourced and rewarded.[4] The responsibility to teach should be an honour bestowed on a few rather than a rite or obligation for all.

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1 Silbert BI, Lam SJ, Henderson RD, Lake FR. Students as teachers. *Med J Aust* 2013; 199: 164-165.
2 Kendall ML, Hesketh EA, Macpherson SG. The learning environment for junior doctor training — what hinders, what helps. *Med Teach* 2005; 27: 619-624.
3 Derrick S, Badger B, Chandler J, et al. The training/service continuum: exploring the training/service balance of senior house officer activities. *Med Educ* 2006; 40: 355-362.
4 Landau LI. Quality junior doctor training, improved workforce outcomes and patient safety. *Aust Health Rev* 2007; 31 Suppl 1: S106-S108.

To the Editor: The articles by Hu and colleagues[1] and Silbert and colleagues[2] highlight the imperatives for medical educators. The future requires the ability to teach as a distinct set of skills that need to be identified early and then encouraged throughout one's career. Silbert et al advocate a comprehensive, vertically integrated student teaching program using peer-assisted learning (PAL).[2] The Royal Australasian College of Surgeons (RACS) strongly supports this approach to teaching theoretical information as well as clinical examination and procedural skills.

Despite curriculum frameworks such as CanMEDS[3] clearly outlining the expectations for the competence of "scholar", the work required to develop an ongoing cohort of willing and skilled surgical educators remains substantial. Development of a comprehensive array of educational programs is the current focus of the RACS Academy of Surgical Educators.[4] The Academy provides curriculum delivery with oversight, as well as the exchange of educational ideas through a combination of workshops, face-to-face activities and digital delivery.

> "the skills for being an educator need to be developed early"
>
> Tobin et al

However, as Silbert et al highlight, the skills for being an educator need to be developed early. There is increasing focus on the early postgraduate years and the Australian Curriculum Framework for Junior Doctors provides clear expectations for self-directed learning, teaching, supervision and career development. However, like many other key skills, the time to start this development is in undergraduate medical courses. It is here that programs such as those highlighted by Silbert et al or courses like Teaching on the Run are critical.

Along with other medical colleges, RACS is now becoming more specific about the requirements for potential trainees. With the substantial increase in medical schools (now 18) and graduates (expected to be 3832 per year by 2017),[5] variability in graduate attributes and skills is increasing. RACS is responding by having more clearly specified expectations of the experiences that potential surgical trainees should have. Being a competent teacher is one of them. Formal programs in education and documented teaching experience are both important if we are going to be able to answer the concerns raised about medical educators and their career paths.[1]

The more skilled our potential trainees are in teaching, as well as in understanding (their) learning, the better Australian postgraduate training will be. This will help achieve a connection to better workplaces and improved patient care.

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Competing interests: We are all members of the RACS Academy of Surgical Educators.

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1 Hu WC, McColl GJ, Thistlethwaite JE, et al. Where is the next generation of medical educators? *Med J Aust* 2013; 198: 8-9.
2 Silbert BI, Lam SJP, Henderson RD, Lake FR. Students as teachers. *Med J Aust* 2013; 199: 164-165.
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5 Medical Training Review Panel. Medical Training Review Panel: sixteenth report. Canberra: Department of Health, 2013. http://www.health.gov.au/internet/publications/publishing.nsf/Content/work-pubs-mtrp-16-toc (accessed Nov 2013).

In reply: We agree that the quality of student training and competence of those delivering it are of utmost importance. However, we disagree with Pearson's opinion that teaching "should be an honour bestowed on a few rather than a rite or obligation for all" and that only these "honourable few" should be trained.[1] Involvement in any teaching confers benefits to both tutors and tutees[1-3] and, although some may stand out, all junior doctors are involved in peer teaching on an almost daily basis and should be trained to do so. Supporting this, the Bridging Project — an Australian initiative to develop a vertically integrated curriculum — has defined "doctor as educator" competencies beginning at the medical student level.[4] Finally, it should be recognised that senior clinicians who do much of the teaching and supervision of students are not assessed on their competence to teach.[5] Until we "assess" our senior teachers we cannot assess our junior teachers, but should take an approach to improve the quality of all.

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1 Silbert BI, Lam SJ, Henderson RD, Lake FR. Students as teachers. *Med J Aust* 2013; 199: 164-165.
2 Dandavino M, Snell L, Wiseman J. Why medical students should learn how to teach. *Med Teach* 2007; 29: 558-565.
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Advising pregnant women to avoid alcohol

To the Editor: I thank Cameron and colleagues for their timely report,[1] particularly in the context of publicity for a new self-help book by economist Emily Oster, which questions advice about avoiding alcohol during pregnancy.[2,3] I note with interest that Cameron et al's study reports that proportionally more of the women who consumed alcohol beyond the first trimester were older and more highly educated.

Oster has commented in the media on the lack of randomised controlled trials and poor evidence of causality, even where there is a proven association.[2,3] While unsurprising that someone without a health background can misunderstand how evidence is used clinically, it is concerning that responsible health advice is being questioned on this basis. The concept of a clinical trial of a recreational substance (such as alcohol or caffeine) to see if it causes any harm in pregnancy is plainly ridiculous.

Alcohol is a known neurotoxin that crosses the placenta.[4] Studies of the effects of alcohol have consistently shown that even intermittent moderate to heavy (binge) drinking during pregnancy increases risks of cognitive and behavioural problems for the child. Although no correlation has been shown between light drinking during pregnancy and developmental problems in the child, methodological inconsistencies between studies limit meta-analysis of combined data.[5] A safe level of alcohol consumption in pregnancy has not been established.[5,6]

> "The concept of a clinical trial of a recreational substance ... to see if it causes any harm in pregnancy is plainly ridiculous"
>
> Soh

Women seek pregnancy information from many sources, and more highly educated women will have access to more information sources. Doctors need to be aware of what information is out there and be willing to counter misinformation when it arises. Consumption of alcohol has no health benefits in pregnancy, so when weighed against known and unknown (but plausible) possible risks, surely the best advice that we can give our patients is to avoid alcohol during pregnancy.

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1 Cameron CM, Davey TM, Kendall E, et al. Changes in alcohol consumption in pregnant Australian women between 2007 and 2011. *Med J Aust* 2013; 199: 355-357.
2 Oster E. The pregnancy studies to take notice of. *Essential Baby* 2013; 31 Aug. http://www.essentialbaby.com.au/action/printArticle?id=4708242 (accessed Sep 2013).
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CORRECTION

Incorrect footnote: In "*Australia is continuing to make progress against cancer, but the regional and remote disadvantage remains*" in the 4 November 2013 issue of the Journal (*Med J Aust* 2013; 199: 605-608), there was an error in Box 2 (*page 607*). There should be two separate footnotes for Box 2A and Box 2B: the footnote to Box 2A should state "Based on age- and sex-specific rates for metropolitan areas", and the footnote to Box 2B should state "Based on age- and sex-specific rates for Australia for 1997–2000".

There was also an error in the year groupings described in the Methods (*page 605*). This should read: "The expected number of deaths was obtained by applying the 5-year age- and sex-specific mortality rates for 1997–2000 to the corresponding age- and sex-specific populations for each subsequent year through to 2010."