...But now what? Some unresolved problems of training for general practice

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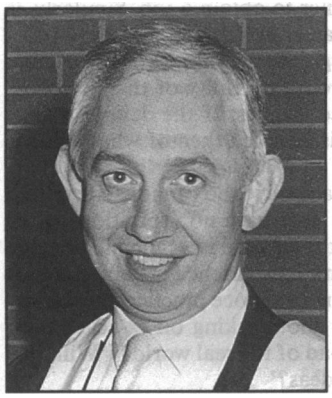

Introduction

WILLIAM Pickles died over 20 years ago in 1969. Nevertheless it is not difficult to get a clear idea of the sort of man and doctor that Pickles was. His concern for his patients and his enthusiasm for research and learning shine through the pages of his writings, and his life has been sensitively portrayed for us by John Pemberton.[1] His achievements over the years were great — particularly his contributions to understanding the epidemiology and infectivity of Bornholm disease, dysentery, influenza and infectious hepatitis. He was the first president of the Royal College of General Practitioners and was one of those who guided it through its difficult early years.

There is one particular aspect of the life and work of William Pickles that I wish to emphasize as an underlying theme. It is relevant to all of us as general practitioners whether in rural practice or congested inner city, whether practising in the first half of this century as Pickles did, or towards the end of it as we do today. It relates to his ability to learn as much as possible from the things that were closest to hand. His lessons were learned from the commonplace — he recognized the importance of what most of us would overlook.

In the first James Mackenzie lecture,[2] which he delivered in November 1954, he described 'the simple things, everday happenings and elementary deductions drawn from them'. His remarks were about research into infectious diseases in general practice but I wish to apply them to our system of medical education. What are the lessons that we can learn from close to home about our present arrangements for education and training for general practice? What are the problems and difficulties that are so commonplace that they tend to be overlooked, and their solutions disregarded?

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The young doctor's question

The title for this lecture comes from that of a poem by Ogden Nash,[3] *Good riddance — but now what?* The poem itself is very short, written at the end of the old year for the beginning of the new:

> 'Come children, gather round my knee;
> Something is about to be.
> Tonight's December thirty-first,
> Something is about to burst.
> The clock is crouching, dark and small,
> Like a time bomb in the hall.
> Hark, it's midnight children dear.
> Duck! here comes another year!'

For me, this poem, sums up many of the uncertainties that face us at significant points in our lives and careers. When I read it, there comes to my mind a picture of the young men and women who, on completion of their vocational trianing, wait apprehensively on the threshold of their new lives as principals in general practice. There they stand — their pockets bulging with statements of satisfactory completion — brimming over with prescribed or even equivalent experience; each clutching a Joint Committee on Postgraduate Training for General Practice certificate like some sort of security blanket.

What lies ahead for them and what are their thoughts as they ponder on two recent government white papers that will have direct and dramatic effects on their lives, as well as the new contract to add to the unknown? Perhaps as they are saying 'Good riddance — but now what?', we might say to them 'Duck! here comes the rest of your career!' For undoubtedly, the years ahead will be testing ones for us all.

The teachers' dilemma

Before reviewing some of the unresolved problems of training for general practice, I would like to consider the earlier stages of medical education and in particular an important overall aim that is rarely addressed in an explicit way. It is this: medical education at all stages must help future doctors to develop the ability to adapt to the changes in medical practice that are inevitable throughout a professional lifetime. Further, medical education should prepare tomorrow's doctors not only for adapting to change, but also for recognizing when it is needed and for being able to initiate it. Only in this way can the quality of care available to patients continue to improve.

Tomorrow's doctors must be able to do this for themselves for today's teachers cannot predict in detail how practice will have developed 10 years, let alone 30 years from now. Our teachers had the same problem; few of them could have predicted the tremendous changes in general practice that we have seen in the last 20 years, and which are likely to accelerate in the future. Few could have forecast today's greater emphasis on the general practitioner's responsibility to care for the practice as a population as well as to meet the needs of its members as individuals. Could any of the teachers of 10 years ago have predicted our likely future roles as health care rationers as well as health care providers, and the important ethical implications associated with this? Certainly if any of them did it was never reflected in their teaching. Today's teachers, both undergraduate and postgraduate, must ensure that tomorrow's doctors have the

abilities to undertake tasks, and to carry responsibilities, that are beyond us at present.

Le Carré in his book *The Russia house*[4] describes how an English publisher visiting Russia unwittingly becomes entangled with a network of British and Russian spies. At one stage, the British train him as a spy for themselves, and it is only by hoodwinking his British masters that he is able to outmanoeuvre them and to survive. As Le Carré says, 'the apprentice has become heir to the spells of his masters, but his magic was more potent than theirs had ever been'. So the magic of today's trainees will have to become more effective than ours. Our skill as educators is to ensure that this is possible. Our system must not act as an obstacle to the development of the sort of future general practitioner that we would want to succeed us — in every meaning of that word. I suspect that today's system of medical education and training would not score too well on scrutiny based on the needs of Le Carré's magician's apprentice.

Good riddance ... to the undergraduate years

The inadequacies and inappropriateness of a young doctor's experience at medical school, and in the first three or four years as a junior hospital doctor are common knowledge. We take them for granted and ignore the lessons that stare us in the face. This is the first example of how we choose to overlook the commonplace in current medical education. Let us consider what we might do to develop a better system for the future.

A young doctor entering general practice will have spent at least nine years preparing to be a principal. Of these nine years, only one will have been spent in general practice. This anomaly was highlighted as long ago as 1974 by Byrne.[5] He drew attention to the fact that for eight years future general practitioners were being taught by people who had little or no experience of work in general practice. Yet, 16 years later we seem to have done little to address this problem which has become more serious with major changes in clinical practice and in the organization of health care services since 1974. Medical education persistently fails to take account of these changes and the gap between medical education and the delivery of health care is widening. Nowadays, more patients who were managed in hospital are being cared for almost entirely in general practice while hospital care has become increasingly skewed towards the highly specialized and esoteric. As a result the teaching hospital is no longer appropriate as the main setting for the acquisition of basic medical knowledge and skills.

As general practitioners there is much that we can do to ensure that a doctor's years as a medical student prepare him or her appropriately for a career in any branch of medicine. But first there needs to be a radical review of the undergraduate medical curriculum, the arrangements made for teaching it and indeed the whole philosophy that underlines basic medical education so that it can better meet the needs of our society.

For too long, undergraduate teaching has been concerned primarily with the cramming of knowledge and the acquisition of a few basic clinical skills. In too many schools there continues to be neglect of opportunity for reflection, for the pursuit of special interests and for the promotion of personal and professional development, all of which lie at the heart of any educational process. The aim to encourage attitudes and skills that will sustain learning throughout a lifetime of professional practice is consistently overlooked.

By clinging to the current format, medical educators have demonstrated their failure to appreciate that undergraduate eduation is the beginning and not the end of learning, and that medical education is a continuum that lasts a lifetime. Too few medical schools have recognized that their responsibility is to inspire continuing learning, and that they no longer have to produce a competent doctor who, on qualification, is able to enter general practice without further training. Too many still fail to recognize the significant developments that have taken place in postgraduate education in the last 20 years and how, in consequence, they must modify the content of their own undergraduate programmes to take account of these.

Changes in medical practice that result in more health care being delivered in general practice mean that more medical student teaching should take place in this environment, but even in 1990 most medical students will have had but limited contact with those who provide medical care in the community. In 1984 the Association of University Teachers in General Practice[6] showed that 16 of the 20 educational objectives identified by the General Medical Council[7] for basic medical education cannot be achieved to any reasonable level without a contribution from general practice. More recently, in 1988, Fraser and Preston-Whyte[8] demonstrated how the full educational potential of general practice has yet to be realized in this regard.

These serious omissions result in deficiencies in many medical students that fall into two main areas. The first is that on qualification they may have problems in communicating with patients, in appreciating each one as a person and in understanding the relationship between the patient, the illness and the patient's environment. General practitioner trainers and course organizers consistently recognize these difficulties in young doctors at the beginning of vocational training. There is a need to introduce a greater social awareness into basic medical education and the Edinburgh declaration[9] of the World Federation for Medical Education recognized that this is a worldwide defect. It is one that general practice is well placed to overcome.

The second deficiency relates to clinical logic and problem solving skills, and an inability to develop a critical and scientific attitude to the practice of medicine. Skills in these areas are essential given the rapidly changing nature of medical practice. This deficiency needs to be addressed directly at all stages of medical education as well as earlier in the senior school years.

The RCGP has pressed and must continue to press government and universities to ensure that the resources are available for each medical school to develop an academic department of general practice that is adequately staffed so that the undergraduate medical curriculum can be a balanced one with a substantial contribution from those who care for patients in the setting of general practice. There are considerable long term benefits to be gained from this in terms of the quality of care for patients and the cost effective use of health care resources. These benefits far outweigh any increase in short term expenditure.

Good riddance ... to the hospital years

Having qualified at the end of their days as medical students what awaits young doctors? The one year pre-registration house officer phase was introduced in 1953 but as an educational experience it has hardly been a success.[10] Most doctors arrive confused by what will be expected of them, each works for long hours with little teaching, and nearly all leave feeling weary and disillusioned. In 1975 the committee of inquiry into the regulation of the medical profession[11] commented on the inadequacies of the pre-registration year — its lack of organization, the poor quality of supervision and its deficiencies as an educational experience. It recommended a new approach and a new organizational structure. However, progress has been slow and a recent survey of pre-registration house officer posts in the four Thames regions showed that the recommendations of the General Medical Council[7] for the pre-registration year are still not being fully heeded.[12] Much of the work of house officers has little educational value.

Recent literature[13-18] stresses the adverse effects of the long hours worked by junior hospital doctors, and the inadequacies of the educational provision made for them. The problems identified fall into two broad categories — those related to lifestyle and those related to the quality of education that is offered.

Difficulties of lifestyle

There is little doubt from recent published work that postgraduate training provides stressful experiences and a lifestyle that many doctors find difficult to endure. Dowie has shown[19] that house officers are on call for an average of 90 hours per week, with junior house officers actually working for 69 hours, and senior house officers 57 hours. When on call, the average period of rest at night was six hours; for a quarter of nights it was less than four hours.

Long hours and disturbed sleep cause tiredness, depression, irritability and feelings of low achievement. For some doctors there are difficulties in concentrating and in making decisions, in listening accurately and in performing well.[14,17,18] There may be feelings of depersonalization and a tendency to treat people as if they were objects. In extreme cases there may even be a positive dislike of patients. All this has serious implications. In the short term learning is compromised and the quality of care available for patients is adversely affected.[17] In the longer term the doctor–patient relationship may be undermined with concentration on the technical tasks of medicine and insufficient time for listening and explaining. Thus, unsatisfactory consultation habits and indifferent attitudes to patients may be acquired that last a lifetime.

Allen[20] has studied the opinions and working conditions of young doctors and has demonstrated quite clearly that most are disenchanted by their early experiences of medicine. Their main reasons for disenchantment relate to fatigue and exhaustion combined with the effects of their careers on their family and social lives.

Quality of education

One could argue that the stressful working conditions of the junior hospital doctor years are acceptable if they were balanced by high quality training and education. However, the two could hardly go together, since effective training needs a climate for learning that is not fostered by the lifestyle of a junior hospital doctor. In addition, there is no evidence of the ready availability of high standards of teaching during this time, indeed published work would suggest that the opposite is true.

Reeve and Bowman[21] in a review of the hospital component of vocational training in the north western region found that 85% of trainees received less than two hours of formal teaching a week in the hospital years. In 37% of posts there was no formal teaching whatsoever. They stated that improvements in both the quality and quantity of teaching were needed urgently. Grant and colleagues,[22] exploring aspects of teaching and learning at senior house officer level in the south east Thames region, confirmed many of the north western findings. They emphasized that the problems will persist until service and training are recognized as different functions, and that training needs to be planned for during the junior doctor years. They recommended that the content of training should be clearly defined and protected time must be set aside for it. These are principles that we have recognized for the general practice component of training for over 25 years. Their incorporation into hospital training posts is long overdue.

We should not be surprised by many of these findings as these are problems that all of us have been aware of for many years. I acknowledge that their solutions are not easy, but that is no reason why we should continue to disregard them. We cannot continue to overlook aspects of training for general practice that are so close to home.

How can training be improved?

What can be done to overcome the stresses experienced by young doctors during the house officer years and to improve the quality of their training? What can be done to capitalize on the educational opportunities with which these years are packed so that time spent as a junior doctor can be worthwhile?

First, many of the stresses on junior doctors would be relieved if the duration of their hours on call were limited in some way.[23] The hospital junior staff committee of the British Medical Association is pressing for a maximum availability of 72 hours in any working week[24] and the number of hours on call should be one of the factors taken into account before posts for training purposes are approved.

Next, there is the need to review the relationship between junior doctors and their senior colleagues. Young doctors want to feel valued for the work that they undertake[15] but all too often they do not know how well they are performing and they feel that their senior colleagues disregard their efforts.

McKegney[25] has likened medical education to a family system. The patterns of behaviour most commonly displayed in medical education resemble those of neglectful and abusive families. In each, there are unrealistic expectations, indirect communication, the denial of problems and a system in which the learners feel isolated. Negative judgement and blame are common and direct feedback with positive suggestions for improvement is rare.

In medical education mistakes have come to be regarded as something shameful, never to be revealed and the admission of ignorance or inadequacy is discouraged. The emphasis on punishing mistakes, often by ridicule, encourages learners to hide errors rather than to seek them out critically and learn from them. McIntyre and Popper[26] have described the importance of looking for and acknowledging error as the basis for extending knowledge. They argue for a critical attitude to one's own work, and to that of others, so that knowledge can grow. For this to happen we must acknowledge in our teaching that not knowing something is the most important thing to discover for this is the route to knowledge. T S Eliot, in his poem *East Coker,*[27] describes how:

> 'In order to arrive at what you know
> You must go by a way which is the way of ignorance.
> In order to possess what you do not possess
> You must go by the way of dispossession.'

It may be a massive leap from T S Eliot to medical audit, but the great benefit of audit is that it encourages and enables us to identify error and areas of ignorance and to learn from these. To succeed, both audit and education depend on honesty and trust. In neither is there a place for blame and punishment — for too long these have formed the basis for too much of medical teaching.

Another problem that needs to be addressed is the level of routine non-medical work that is undertaken by junior medical staff,[16] some of which need not be undertaken by doctors at all. Such tasks include arranging appointments, organizing admissions, constructing theatre lists, finding case notes and x-ray and laboratory reports, and delivering specimens, as well as routine clinical tasks such as phlebotomy and taking electrocardiograph traces. Too many young doctors describe how a large proportion of their time is spent in this way; time that would be better spent with patients and with learning.

The greatest scope for developing better quality educational

experience lies in the organization of junior posts. Each senior house officer contract should specify explicitly its educational content and how this will be fulfilled. Each consultant contract should identify the amount of teaching time that the consultant is obliged to provide. Protected time for learning should be clearly identified and the teaching and assessment methods to be used should be agreed by trainer and trainee. The competences that a young doctor can expect to acquire through holding each post should be specified at the outset, ideally in discussion between junior and consultant, and thereafter, at regular intervals, progress in working towards these should be marked by further discussion between these two.[15] In other words, the educational responsibilities of each appointment should be set out as clearly as the service responsibilities.

General practitioner trainees

For general practitioner trainees, there is a particular need to relate the teaching content of the hospital years to their career intentions. The 1989 national trainee conference survey[28] showed that for 57% of respondents there had been no general practice oriented teaching in their last hospital post.

We have been rather diffident in our attempts to have a direct influence on the the hospital component of training. We have deferred to hospital consultants, grateful to have been bestowed individual posts for our vocational training schemes, but this attitude needs to change. The quality of doctor who completes our vocational training programme is our responsibility; we must ensure that those who contribute to the training, be they general practitioner trainers or hospital trainers, make an appropriate contribution on our terms. This means that trainers and course organizers must have a direct influence[29] on the educational activities that form part of the hospital years. In some regions, a start has been made, and opportunities have been created for trainers and consultants to meet together to determine the educational needs of tomorrow's general practitioners, and to agree how the content of hospital training can be matched to these needs.

In addition, we must strive even harder for the regular attendance of trainees at half day release courses for these are important elements of our integrated programmes. The unavailability of these courses to 62% of trainees in their final hospital posts,[28] and the low level of attendance by those to whom these meetings are available, is a measure of our continuing failure in this regard. Unless we integrate our training programmes more there is a serious possibility of further reinforcing in trainees the attitudes and methods of practice that are more appropriate to the hospital setting than to general practice.

Given the scenario that I have presented — the pressures on young doctors and the difficulties that they have in balancing the effects of burgeoning service commitments with their own need for education and their private lives, then it is not surprising, that on completing training a young doctor might feel as did Ogden Nash, on New Year's Eve 'Good riddance — but now what?'

But now what? The early years in practice

What awaits new recruits to general practice in the future? At the end of vocational training what difficulties are they likely to encounter? How do they feel about the years ahead?

To answer these questions I undertook a simple survey of the views of six colleagues at the end of 1989. I asked each of them about the problems that they have perceived among young doctors in their early years in practice. Three of my colleagues are secretaries of large local medical committees and three have a special interest in continuing medical education, and in particular, in the development of higher professional training for young principals. For the views of young doctors themselves I called upon my own experiences as an MSD Foundation tutor on two recent courses for established principals in the south west of England and the Mersey area.

I have identified three types of problems that are experienced by young principals and which appear consistently and frequently throughout the country: problems encountered within the setting of the practice, difficulties encountered outside the practice within the wider organization of the health service, and anxieties that relate to family and professional life.

Problems within the practice setting

For many doctors, even after nine years of preparation, the transition from supervised post to independent contractor comes as something of a shock. This problem was identified as long ago as 1973 by Swift[30] and it still presents difficulties for a large proportion of new principals, to an extent that suggests that it has not been addressed satisfactorily during the vocational training period.

For some, there is a need to continue the deconditioning of many of the attitudes to patients that have been acquired during the hospital years. The limitations of previous education in preparing for the work of general pratice seem to need more than one year as a trainee to overcome. This would be less of a problem if the suggestions for a greater contribution from general practice to basic medical education were to be implemented but until this happens alternative provision must be made through voluntary higher professional training of young principals, as proposed by the RCGP[31] in its recent educational strategy.

In the *Front line of the health service,*[32] the RCGP's response to the government's green paper on primary health care,[33] proper emphasis was given to developing a coordinated approach through a multidisciplinary team to the provision of a broad range of primary care services through general practice. The RCGP identified the functional unit of such care as the practice based team. For many years we have emphasized the importance of teamwork but despite this, our belief in the team approach to patient care has yet to be adequately reflected in our training programmes. Training for and in teamwork needs to be addressed directly — it cannot be achieved as a by-product of activities that have other prime objectives. An important aspect of this neglected part of training is the deconditioning of the inappropriate attitudes of many young doctors to non-medical colleagues. We must find ways of developing opportunities for young doctors to learn together with those who work in other health and health related professions, and at all stages of medical education. The Centre for the Advancement of Interprofessional Training and the Marylebone Centre Trust have both taken initiatives in the field and their efforts should be encouraged and supported. Such work will enable all members of the practice team to develop a clearer understanding of each others' roles and points of view so that they can work together more effectively.

Many young doctors also have problems in their relationships with their partners. Naturally, during training, young doctors have not had the opportunity to work as partners, but most trainees work alongside partnerships and these should form the basis for an introduction to this difficult area. I suspect that many trainees are protected from the examination of partnership dynamics, but is it trainees, or our own sensitivities that we are protecting? Perhaps we all need a greater understanding of the dynamics of partnerships, and of the ways in which problems can be anticipated, prevented and dealt with effectively when they arise. There is little doubt that the quality of service that we are able to offer our patients depends to a large extent

upon the soundness of our partnerships and the quality of management that underpins our clinical activities. This is a sensitive area, but another that we cannot continue to overlook for partnership problems are of great concern to many young principals.

Difficulties outside the practice

Over the years, surveys undertaken by trainees themselves, and particularly by the organizers of national trainee conferences,[28,34] have shown that most trainees have little appreciation of or interest in the wider aspects of health service organization. Few understand the ways in which the various health service bodies work together, for example health authorities and family practitioner committees. Most are unclear about the work of such national organizations as the General Medical Council, the General Medical Services Committee and the RCGP, but the last two or three years have demonstrated the importance of political awareness, both within medicine and in society generally.

However, it is in their links with their local hospitals that many young doctors have the greatest problems, and in particular in their relationships with hospital consultants. This is a matter of major concern, for dysfunction in the relationship at this stage in a doctor's career can persist throughout it and can adversely affect clinical standards. Its origin lies in our medical student education and the vocational training that we undergo for general practice.

Marinker,[35] has described the hidden curriculum of training. It is not what we were taught that we remember most, it is those who taught us. Our teachers are models whose attitudes and behaviour we unwittingly refine for our own. Then comes the period of shock and confusion when we enter general practice and find that our earlier models, although appropriate for medical school and hospital, are not relevant to work in the community. We feel betrayed and angry; but the anger is tinged with feelings of unworthiness for our training has developed within us the feeling that the focal point of the health service is the hospital. These feelings are hard to overcome. Our current obstetric service, with its heavy hospital bias, is an example of the subtle influence of the hidden curriculum.

The relationship between consultant and general practitioner is not a hierarchical one, but the strong influence of hospital experience during basic medical education and vocational training has conditioned many of us to behaving as if it were. The perpetuation of the teacher–pupil relationship between consultants and general practitioners was identified by Balint in 1957.[36] He analysed its effect on the interactions between doctors and patients; these influences persist today. Even as educators there are times when we defer inappropriately to the consultant. Could this be the reason why we have held back for so long from critical review of the content and methods of the hospital component of vocational training?

We must recognize that young general practitioners have serious problems in their relationships with hospital staff and that these problems are the product of the training programmes that have been devised for them. In the interests of high standards of patient care, we must address these difficulties as part of the educational process for general practice.

Anxieties about family and personal life

The extent to which professional life will encroach into a doctor's family and personal time is a major worry for many young general practitioners as they contemplate their future careers. Given their experiences in training, particularly those of the hospital years, one can see how these fears arise. Paradoxically, on the one hand there is anxiety about professional bordeom and yet on the other fear of burnout from the intense pressures and pace of a hectic professional life.

Ours is a stressful profession yet, in general, we keep our own feelings bottled up. Walton[37] has described the 'invincibility ethos' that is developed within medical schools, and which makes it difficult for doctors to admit to personal problems or to discuss the stresses of their professional obligations. There may be a link between this trait and the difficulties that we have in admitting ignorance or error.

As teachers, we cannot continue to ignore the personal aspects of life in our teaching. In the last few years, it has become quite clear that these are issues that are of major concern to today's young doctors and methods for dealing with them need to be addressed as part of education for general practice.

What can educators do in the future?

I am conscious that this review of medical education and vocational training for general practice has at times been severe. Nevertheless, I believe that the system of training that we have developed for general practice is one of the finest for any medical discipline in this country, and for general practice is one of the best in the world.

But there is room for improvement. We can do more to work towards a system of medical education that properly balances health care service needs with the educational and personal needs of junior doctors. Our efforts to date have been directed to those areas that are solely the responsibility of general practitioners because these have been easier to tackle. In future we must influence those aspects of education and training where we work together with colleagues in other branches of medicine. Although my theme has been the difficulties in medical education and training that are commonplace yet overlooked, nevertheless, there is another strand. It is our relationship as general practitioner educators with educators in other medical disciplines — those who work in hospitals and in medical schools. We must now begin to work with them so that together we can improve the quality of experience for tomorrow's doctors. There are three goals that we must work towards. First, we have to secure a greater contribution from general practice to basic medical education. Secondly, we need to ensure that general practice has a greater influence on the content and teaching methods of the hospital component of vocational training. Finally, we must define more clearly the educational and clinical responsibilities of general practitioners and hospital consultants.

To achieve these goals we have to establish mechanisms with our hospital colleagues, both locally and nationally, so that we can communicate more effectively with each other about the problems of medical education at all levels, and so that together we can overcome the obstacles that inhibit the personal and professional development of young doctors. Until we do this our learners must continue to suffer and the standards of care that they are able to offer patients will continue to be compromised.

Higher professional training

There is a further area for which we as general practitioners have sole responsibility and which we can develop on our own initiative — the voluntary period of higher professional training that has been proposed for established principals in the RCGP's educational strategy.[31] Improvements to the undergraduate years and to vocational training will not meet all the needs of tomorrow's general practitioners and fulfil the objectives for Le Carré's apprentice magician. Learning will have to continue even after vocational training has been completed, in a doctor's early years in practice and throughout his or her medical career. The concept of voluntary higher professional training is not a

new one for the RCGP — it was identified five years ago in a policy statement.[38] Our immediate task is to develop the range of opportunities and methods for providing this training.

Just as the 1970s and 1980s saw the introduction and establishment of the pattern of vocational training that we know today, so must the 1990s see the introduction and propagation of a range of local opportunities for higher professional training for general practitioners throughout the country. The RCGP will have an important role in developing this.

Medical education: an exemplar for managing change?

William Pickles studied and drew lessons from everyday happenings. Our aim must be for tomorrow's general practitioners to be able to face the future with his appetite for serving patients, and for continuing to learn from the commonplace. If we are to succeed in this, then we ourselves must learn from those aspects of medical education that are close to home. We must openly acknowledge and address the problems that we have known about for some time. If we expect tomorrow's doctors to adapt their work to a changing world then surely we ourselves must lead the way by demonstrating how we can adapt our training programmes to meet the educational needs of the future.

Let us not forget the potency of the hidden curriculum. Our behaviour, whether we like it or not, is the model upon which the learning of young doctors is based. Let us make it, therefore, an exemplar for demonstrating how the need for change can be recognized and improvements implemented; from upholders of high standards of training, and of good quality patient care, nothing less will do.

References

1. Pemberton J. *Will Pickles of Wensleydale.* London: Royal College of General Practitioners, 1984.
2. Pickles WN. Epidemiology in the Yorkshire dales. *Practitioner* 1955; **174:** 76-87.
3. Nash O. *Collected verse from 1929 on.* London: JM Dent, 1978.
4. Le Carré J. *The Russia house.* London: Hodder and Stoughton, 1989.
5. Byrne PS. Medical education and general practice. *J R Coll Gen Pract* 1975; **25:** 785-792.
6. Association of University Teachers of General Practice. *Undergraduate medical education in general practice. Occasional paper 28.* London: Royal College of General Practitioners, 1984.
7. General Medical Council Education Committee. *Recommendations on basic medical education.* Issued in pursuance of Section 15 of the Medical Act 1978. London: GMC, 1980.
8. Fraser RC, Preston-Whyte E. *The contribution of academic general practice to undergraduate medical education. Occasional paper 42.* London: Royal College of General Practitioners, 1988.
9. Metcalfe DHH. The Edinburgh declaration. *Fam Pract* 1989; **6:** 165-167.
10. Parry KM. The pre-registration year: report of a conference. *Med Educ* 1984; **18:** 187-190.
11. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Report of the committee of inquiry into the regulation of the medical profession (Cmnd 6018).* London: HMSO, 1975.
12. Dent THS, Gillard JH, Aarons EJ, *et al.* Pre-registration house officers in the four Thames regions: a survey of education and workload in teaching. *Br Med J* 1990; **300:** 713-716.
13. Durnford S. Junior hospital doctors: tired and tested. *Br Med J* 1988; **297:** 931-932.
14. Mayou R. Burnout. *Br Med J* 1987; **295:** 284-285.
15. Firth-Cozens J. Emotional distress in junior house officers. *Br Med J* 1987; **295:** 533-536.
16. Lurie N, Rank B, Parenti C, *et al.* How do house officers spend their nights? A time study of internal medicine house staff on call. *N Engl J Med* 1989; **320:** 1673-1677.
17. Levinsky NG. Compounding the error. *N Engl J Med* 1988; **318:** 778-780.
18. McCall TB. The impact of long working hours on resident physicians. *N Engl J Med* 1988; **318:** 775-778.
19. Dowie R. *Patterns of hospital medical staffing (interim report). Junior doctors' hours.* London: British Postgraduate Medical Federation, University of London, 1989.
20. Allen I. *Doctors and their careers* London: Policy Studies Institute, 1988.
21. Reeve H, Bowman B. Hospital training for general practice: views of trainees in the North Western region. *Br Med J* 1989; **298:** 1432-1434.
22. Grant J, Marsden P, King RC. Senior house officers and their training. I. Personal characteristics and professional circumstances. *Br Med J* 1989; **299:** 1263-1265.
23. Delamothe T. Juniors' hours of work. Eightysomething is too long. *Br Med J* 1990; **300:** 623-624.
24. Hospital Junior Staff Committee of the British Medical Association. Angry juniors to meet minister on long hours. *Br Med J* 1990; **300:** 683-684.
25. McKegney CP. Medical education: a neglectful and abusive family system. *Fam Med* 1989; **21:** 452-457.
26. McIntyre N, Popper K. The critical attitude in medicine: the need for a new ethic. *Br Med J* 1983; **239:** 1919-1923.
27. Eliot TS. *Four quartets.* London: Faber and Faber, 1979.
28. Crawley H, Levin J. Training for general practice; a national survey. *Br Med J* 1990; **300:** 911-915.
29. Tait I. Agreed educational objectives for the hospital period of vocational training. *J Assoc Course Organisers* 1987; **2:** 179-182.
30. Swift G. Education for responsibility. *J R Coll Gen Pract* 1973; **23:** 389-399.
31. Royal College of General Practitioners. *An educational strategy.* London; RCGP, 1990 (in press).
32. Royal College of General Practitioners. *The front line of the health service. College response to 'Primary health care: an agenda for discussion'. Report from general practice 25.* London: RCGP, 1987.
33. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771).* London: HSMO, 1986.
34. Ronalds C, Douglas A, Gray DP, *et al. Fourth national trainee conference. Report, recommendations and questionnaire. Occasional paper 18.* London: Royal College of General Practitioners, 1981.
35. Marinker M. Medical education and human values *J R Coll Gen Pract* 1974; **24:** 445-462.
36. Balint M. *The doctor, his patient and the illness.* London: Pitman, 1957.
37. Walton J. The Harben lecture, 1988. Illness in doctors and their families. *Health Hygiene* 1989; **10:** 51-62.
38. Royal College of General Practitioners. *Quality in practice. Policy statement 2.* London: RCGP, 1985.

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