Brief encounter*

Factors and fallacies in learning and teaching the science of consultation for the future general practitioner

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FAMILY doctoring is not a field in which sheep may safely graze. Its clinical practice and the preparation of younger men and women for it, are for me passionate affairs very close to the centre of my life.

I am honoured, grateful, and surprised that the Council of the College has asked me to give this lecture. Honoured, because I have always, since my student days, held this College in the very greatest affection and admiration for the many ways it has helped to raise and maintain the standards of care in our branch of medicine. I am grateful for the special pleasure it gives me to be asked to perform a difficult task by my professional brothers, and a little surprised that the Council has asked one who is neither a fellow, council member, nor a tutor of the College. It would please me therefore, to think that I spoke for the great middle range of general practitioners doing their job to the best of their ability, struggling to learn to teach, and very much subscribing to the aims of our College.

I was asked to talk on an educational theme. In its wisdom, Council has decided this year to depart from what has become a tradition. Hitherto this lecture has been delivered by an elder statesmen from the vantage of great experience and the gravitas of a senatorial perspective. I possess no such high impartiality and lack of prejudice. I admit to the bias of a family-centred generalist, a passion for clinical medicine and a belief in, and fascination for both the task and process of education.

Council in asking me, must have been aware of my deep scepticism of many current ideas of what is thought to constitute progress. I am unhappy about the so-called rational reconstruction of general practice by the central executive of Government. I am also unhappy with those within the profession who lack that necessary discipline, both of living in, and even more important, of being served by the structures that they propose to build.

Three caveats

Because some of what I wish to say may appear as critical, even though I intend it as constructive, I would like at this stage to enter three caveats. My first, that I am only too aware of the aura of certainty that words, both spoken and written possess, and that they have no right to possess. Secondly, that I am aware that what I wish to change is not deliberately malign, but is mainly the unintended consequence of the actions of good, sincere men. Third, that I am continually looking to the future; to the training and education of the future general practitioner.

An institution has most to lose when it has gained most. In our brief 21 years we

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have gained what others took centuries to achieve. That we have done so is a monument to the superhuman energy and wisdom of our founding fathers. I believe that in the next 21 years there is a good chance that we may lose more than we have ever gained. The real tragedy, should that happen, is that I fear that neither we nor our patients may be aware of its going. As Solzhenitsyn said recently, "We do not err because truth is difficult to see. It is visible at a glance. We err because it is more comfortable."

Watching doctors

I intended, as indeed I had a duty so to do, to give you some idea in both title and subtitle of the area I wish to explore. Strange, perhaps not so strange, is the large number of doctors who are bird watchers. Even more strange is my habit of doctor watching. I have in the last 23 years lost no opportunity to indulge in my favourite fascinating pastime. Far more difficult than watching and learning from others is introspectively to examine one's own performance in the consultation—somehow, in some measure, to know oneself. Such personal perceptions clearly have dangers; but I believe that they can be learned, and taught and their main dangers guarded against.

In the long run, contrary to current educational credo, subjective evaluation is of infinitely greater value than any so-called objective assessment. This is the central thesis I wish to present.

SHIFTING PARADIGMS AND BAYES THEOREM IN ACTION

The consultation

I have called my talk *Brief Encounter*. For me it symbolises two things. The first, a certain poignancy in the consultation—that most curious and fascinating of micro-social systems, where, under a burning glass the symbolic interaction between patient and physician can be examined. There can be few human encounters, where so much active

psychic and intellectual work is done as in a difficult consultation. It is a process requiring training, great discipline and a rigorous approach.

We are too often bludgeoned by the commonplace into underestimating the importance to our patients of that meeting. "We mark with light in the memory," said Emerson in 1838, "the few interviews we have had, in the dreary years of routine . . . with souls that made our souls wiser, that spoke what we thought, that told us what we knew, that gave us leave to be what we inly were." I have never come across a better definition of what counselling in the consultation really means.

The second thing that my title reminds us of, is the appalling brevity of our average consultation—5·2 minutes. One of the insoluble agonies of general practice is that it is unlikely to be much longer in our lifetime. We have no option but to tolerate the doubts and ambiguities involved.

I have spoken on purpose of the science of consultation. "There is nothing," said Shaw, "that is mysterious. A mystery is only a reasonable logical state of affairs with the reason not yet discovered." To describe the consultation as an art is partially to abdicate the responsibility we have to analyse, to conceptualise, to improve our skills in teaching that science. There are many factors and fallacies in learning it, and teaching it. There can be no end to its exploration. The understanding of it must be won and re-won every single day of our professional lives. The fascination and excitement we have in discussing our cases is an index of the imperative need so to examine the interaction between ourselves and our patients. When we tire of that, *rigor professionis* has begun.

"Unlike puppets, we have the possibility of stopping in our movements, looking up and perceiving the machinery by which we have been moved. In this act," says Berger, "lies the first step towards freedom." Freedom you may ask, for what? Freedom from as much as is possible of natural bias. To learn to evaluate the effects of our intervention upon our patients in the consultation, so that we may teach, and help others to learn.

The Popperian notion of science is that it is open, it is not mystified; we can communicate our ideas and findings. The consultation in general practice is an open system. I would like to adopt three perspectives: sociological, architectural and educational, to examine some factors and fallacies in learning and teaching that science; not to us here, but to those men and women who follow in our wake. If they are not better than we are we will have failed. That in itself may not matter—but what does, is that we will have failed our trainees, generations of patients, and our College. These matter very much indeed.

The major purpose of teaching is to enable learning to be more effective and efficient. Watching our trainees carefully, I now believe that during their training they save about five years in getting to where we did. It is mainly under the stimulus of the need to teach that the necessary systematisation of a discipline is achieved. Much of this lecture is abstract and analytical. It is of overriding importance that such concepts be tested against the harsh reality of clinical experience in the real world of general practice if they are to be used to create a theory for the education of those preparing for general practice. Theory in the sense that I use it is not play therapy. Like diagnosis, it has one purpose only—a prescription for action.

Home visits to 12 patients at a weekend

Before I return to the abstract world to develop theory I would like to invite you to accompany me on a clinical excursion. My reason for doing so is first to reduce any dissonance between us as to what we understand by general practice; the second is to illustrate a point I wish to make later. What I would like you to do now, in your mind's eye, is to come and spend a weekend with me in my practice and I will describe 12 patients who then asked me to help them. My account is from the correspondence

columns of *The Lancet* a few years ago when I exchanged letters with another doctor. My letter was in answer to a doctor who felt that the great obstruction to modernising general practice in this country was the retention of the traditional visiting list. Part of my thesis was the opposite view.

There is nothing exceptional in the cases themselves. Every one of you will have had similar experiences. I will quote part of my letter and then give a brief commentary to establish a simple base for defining our function and deducing educational objectives.

"I list below some of the patients I saw and cared for in their homes from midday on Saturday, 26 January to 09.00 on Monday, 28 January. It was a busy winter week-end in a rural general practice. No doubt exists in my mind that I saw my patients in the proper place. They could not have been cared for so well in office or hospital, or as well by any one except their own personal physician."

Patient One

A panic call during lunch to find an hysterical teenager in the lavatory—a 26-week fetus drowned in the bowl; joined by its umbilical cord to its mother. Who but the family doctor should cut the cord, put the patient to bed, and thereafter spend much care and time to keep an angry and frightened teenager from goading her guilt-ridden parents into punishing her, and themselves?

Patient Two

An immobile 80-year-old man went suddenly deaf in his remaining ear. To restore hearing with simple syringing was a duty to be delegated to no one else.

Patient Three

A 70-year-old women, recently widowed and now living alone, had a sudden unexplained attack of dyspnoea. An electrocardiogram which I took a few hours later confirmed a recent posterior infarct. I found someone to live with her for the next couple of months and explained things to distant relatives on the telephone. I felt that she was being treated in the right place by the right person. To send her to hospital would have been cruel and also second-rate medicine.

Patient Four

Four visits to a three-year-old child with headache, vomiting, and fever. The parents thought she might have meningitis. Frequent visiting in her own surroundings convinced me that she had not. She lives in a caravan four miles away. Had she been my child, I most certainly would not have wished her to be rushed to and from an office by car, or to be admitted needlessly to a hospital.

Patient Five

A twice-daily visit to a small infant with a nasty upper respiratory tract infection. She should not have been moved from her own warm, steamy bedroom.

Patient Six

A young woman with rheumatoid arthritis on steroids in our cottage hospital suddenly became paranoid. A visit to her husband in his own home was made, to explain gently and quietly why it was necessary to admit her to a mental hospital. This meeting in the man's own parlour was kinder and more effective than summoning him unexpectedly to an office or hospital.

Patient Seven

Three visits were made to an old diabetic dying in his own bed. He had no next-of-kin, but his fat and happy house-keeper looked after him devotedly. He had a right to die where he was, and not in a lonely hospital ward.

Patient Eight

A frightened 60-year-old man sent for me because he had thought that the sudden severe sciatic pain in his leg was "a clot of blood about to travel to my heart". An explanation, and some pethidine by mouth, restored calm and alleviated pain.

Patient Nine

An hour's family conference with a lawyer who discharged himself from hospital so that he could talk over the advisability of a major abdominal operation "without," he said, "all the pressure that one gets in hospital". He admires and respects his surgeon, as I do; but that man's dignity and courage demand that life and death be discussed in his drawing room and not in an office by appointment.

Patient Ten

A 60-year-old woman rigid with rheumatoid arthritis and disabled by a pathological fracture, who has had all the specialist care possible and now lying well cared for by her nieces, develops her first bed sore. I am called first, then both nurse and I will care for her.

Patient Eleven

At 02.30 hours on Sunday, a healthy woman was delivered by the district nurse, her husband, and me of her third child in conditions of peace and normality.

Patient Twelve

On Sunday afternoon a 25-year-old mother of two developed pneumonia. After daily penicillin she rapidly recovered. Had she been my wife, I would have considered ambulance rides and admission unwise, unnecessary, unkind, and poor medicine.

What I have told you is a true account of one-and-a-half days in general practice. I feel that you will agree with me about two important facts. The first, that to be able to handle these various problems we must possess a reasonable competence in all fields of traditional medicine: obstetrics, paediatrics, surgical diagnosis and judgment, internal medicine, psychological and geriatric medicine. The second factor must be even more glaringly obvious—that we are going to be totally unfitted to carry out our task properly, unless we are able to handle with reasonable competence and confidence, the social and behavioural dimensions implicit in almost all the situations I have described.

Note I beg of you, the use of the word reasonable. Not for a moment do I wish to suggest that we are paragons at work. I wish merely to state the range of work that we do and thus the knowledge, skills and attitudes needed as tools for handling human distress —the major pathology of our work. None of us—generalists all, working in an open system of human interaction can afford the luxury of certainty, or even near certainty.

Three time-scales

I will return to some of my patients and take a three-dimensional time-scale view of my approach to them. The first time-scale is the present—the here and now situation. The time for decision and action, or lack of action, rather than an academic diagnosis. The time that my patient has asked for help. How I fulfil the role that my patient is asking me to fulfil, and how I fulfil the role that my profession and society are demanding.

The second scale is the past. The effect on my patient, his family, and on me, of previous contact and knowledge of each other. That is, the use of the doctor-patient relationship, my knowledge of previous physical ills, my cognisance of his past reactions to stress, and my patient's confidence and trust in me (or the reverse) based on past experience.

The third scale is my goals for the future—the practice of allowing a permissiveness of approach between ourselves and our patient which is the least obtrusive that we can

possibly devise. The use of the present for the prophylaxis of future mental and physical health is possible at almost every consultation, no matter now apparently simple. And with it the consciousness always, of the long shadow falling before every action and move that we make. We are in *loco parentis* to our patients—the good parent—whether we like it or not, and the appropriateness or otherwise of one's problem-solving devices may well be the pattern that they and their children will use in the future.

Bearing these scales in mind could I now consider some of the problems in shorthand for in each of these cases is an hour's story.

Patient one—miscarriage

The first problem was the need for technical competence to deal with a potentially dangerous situation where a valuable young life on the threshold of adulthood may be psychologically maimed by poor initial handling. And concurrently there was the problem of presenting to two desperately distressed and wounded parents an appropriate pattern of behaviour that they will accept, because of past trust in the doctor's professional judgment. There was the problem of trying to create once again the shattered affection between child and parents, so that their grandchildren will not bear the brunt of their child's guilt and anger. There is a need unobtrusively to work through the problem in the future and to keep watch on the vulnerability of the child's future marriage.

Patient three—myocardial infarction

This illustrates similar themes. The present need for an accurate diagnosis and a competence in modern aids to that diagnosis; and the appropriate treatment of a dangerous condition. The needs of the future in both physical and mental rehabilitation. The need to allow an immediate dependence on one in a crisis, and the judgment necessary gently to disengage, and allow one's patient to live again a life of unafraid independent dignity when better.

Patients four and five—sick infants

Again there was overriding need to watch over potentially-dangerous ills in a situation of great anxiety for young parents with sick children. To give them confidence in themselves in a crisis situation, which will in the future, influence to some extent the way that they will engender behaviour patterns in their children.

Patient six—rheumatoid arthritis and madness

This illustrated the need for urgent action and the need to stand by a father made incompetent by disaster and to give him courage to withstand the real shock and shame of a wife being admitted to a mental hospital. It was also necessary to help him arrange the care of himself and his two children remaining at home.

Patients seven and ten—the care of the dying and the care of the bereaved

I believe that the skill and subtlety required in handling these patients and the service one gives to a community in doing so would be reason enough for the existence of a family physician were that his only task. It requires a wide informed sympathy based on a past knowledge of all parties. To tell, or not to tell the dying; and permit them their right if they wish it, to speak of their fear or relief at the brink of death. To allow the living to express the ambivalence within them, to express both anger and love, and by things said and unsaid to show empathy in sharing suffering, and to encourage grieving in a positive fashion.

Patient nine—the impending major operation

Again it is implicit and easy to see how one would act in all three scales, past, present and future to help one's patient.

Patient eleven—childbirth

The rapport built up over many months of careful antenatal care reaps dividends. There is a need to allow the pregnant mother to express her fears and fantasies while watching for organic and psychological difficulties, to share with a wife and husband an event of tremendous import, and be careful not to appear to upstage either, for they are both of greater moment than the attending physician. There is the need to allow one's midwife to practise her difficult and hard-learned art, and to allow a young mother to care for her child, a task she will, with minimal guidance, do better than anyone else.

I have described something of our function, and some of the tools we all use to carry it out. In a world of uncertainty we are happier if we can define the limits of our role, and our relationship with those with whom we come in contact. To try to see the wood for the mass of untidy and unruly trees we construct concepts of our function, the better for ourselves, and others, to see what we are doing. I have tried to construct one by giving you a glimpse of a typical general practitioner at work for 36 hours.

Four aspects of work

The conceptualisation of our work is based on the recognition of four constants which run through that work and which make our task different from doctors who work in other branches of medicine.

Primary physician

Firstly, one is a primary physician. One is prepared to take a decision on any form of problem or illness which presents, and is prepared to accept that one is usually the first person to be asked for help on most problems. A basic skill must be in handling the initial presentation of unorganised illness—physical, emotional or social. We must analyse unorganised symptoms, said and unsaid fears and angers, and watch for an recognise the covert content in any consultation.

There is a need to realise the overwhelming importance of this initial brief encounter for it is in the physician's hands whether a patient is allowed to develop a neurotic dependance and fear, or conduct himself in his trials with dignity, independence, and insight—and to be allowed to help himself.

Personal physician

Secondly, one is a personal physician. In a difficult world it is professionally important (in the sense of being able to help one's patient to the maximum) that one's relationship is intimate and personal, and that the responsibility for one's patient remains undiluted in spite of siren calls to share such responsibility. There should be an awareness of the psycho-dynamics of the doctor-patient relationship, and those involved in family, community, and work. We should try and use these relationships, not to make us feel secure and superior, but to our patient's better ends. It is implicit that a patient is of infinitely more importance than his disease. These things we all try to do—and we fail too often.

Comprehensive practice

Thirdly, our practice of medicine is comprehensive—across the whole broad face of medicine. No hierarchy of disease should be recognised. We should not recognise the term trivial illness. The concept ideal, often not reached, and in cold blood sounding a little trite, is one of holism—the absolute indivisibility of matters physical, psychic, and social.

Continuity of care

Fourthly, and finally it is continuous. Not narrow, episodic, recognisable clinical entities such as fracture, childbirth, depression, pneumonia, diabetic coma or anxiety state

which a hospital doctor sees and quite rightly tends, by the enormous constraints placed upon him, to treat in isolation; but all that happens to a patient and his family and his community day in, day out, night in, night out, year in, year out. Not so much, as has been said, to attach a diagnostic label—but to explore a whole situation in physical, behavioural and social terms.

Our function then as I see it is to provide care for those who are sick in body or mind, or think that they are sick; and try to keep them as near healthy, independent and active as can be. To act as their medical broker, to help them canvass all the options, to give them, or get them, help when and where they need it.

The traditions of our art go back many centuries. They have changed hardly at all. They are I believe a service that cannot be given as well or as efficiently by anyone else, or by fashionable combinations of so-called health professionals. They are the primary, personal, comprehensive and continuous cares of anyone who says, "Doctor, I would like you to care for me and my family".

What I have done so far is to attempt two things. Firstly, to ground our discussion firmly in the real world of clinical medicine. And secondly, to suggest that theoretical models of the consultation are necessary—not as tools for experienced journeymen—but to analyse and make more effective our attempts to teach.

Observing doctors

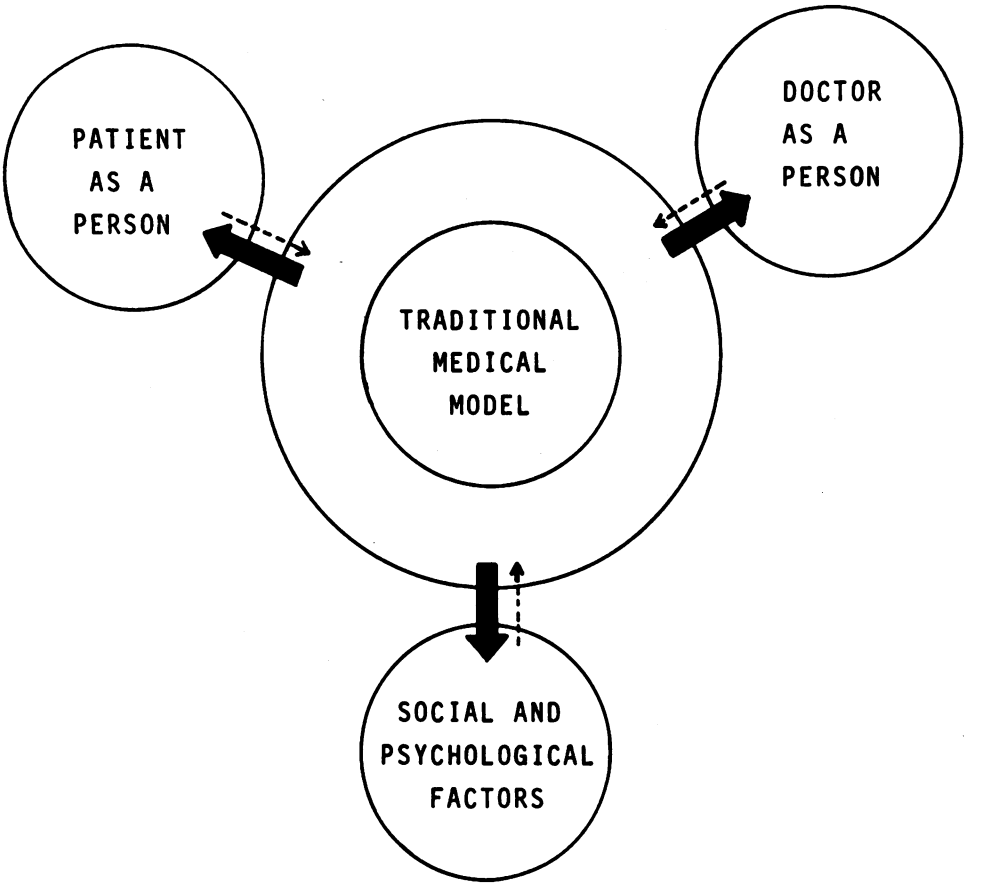
Next I want to describe some of my simple findings from watching doctors. And from them, and other experiences, to construct models of the consultation which are pertinent to teaching. These are making a diagnosis in a closed system as in specialty practice, and problem-solving in open systems as in general practice. Neither is better than the other—in fact they are not comparable. Each has evolved for a particular purpose. They are complementary and symbiotic. We use them both.

Four years ago while on a Nuffield travelling fellowship I had the great privilege of working for nearly three months in Professor Ian McWhinney's unit in Ontario. He challenged me to produce some method of assessment of the consultation. My first task was to attempt an analysis of the consultation—to try in primitive and amateur fashion to see what was happening in that rapidly changing and complex kaleidoscope. In doing so I adapted methods used by Miller and Flanagan—the critical incident survey. All that this simple device means is that one collects incidents which are clearly good practice, or clearly bad practice, and omits the grey middle ground of the ordinary.

Max Weber was one of the first to employ this method, which he called 'ideal typing', as a device for illuminating social structures. In many people's hands it has proved a powerful analytical tool. For example, the explanatory value of polar ideal typing has been shown by the examination of the two extremes of general practice: Stephen Taylor's *Good General Practice* (1954) and the Collings' report in 1950; zenith and nadir. By examining both white and black one can evolve clear pictures of what constitutes excellence.

I spent week after week behind a one-way mirror collecting about 500 critical incidents in general practice. Most of these were from trainees. To test the reliability and validity of my findings I checked them by watching four highly experienced principals, and later had the principals simultaneously analysing consultations with me. I found a high level of agreement among us. Finally I experimented by getting the trainees to assess themselves at the same time as I assessed them. My research was incomplete, for I returned to my practice, and have not since had access to a viewing box. I need hardly add that all this was done with every single patient's explicit permission.

What became much clearer to me during this exercise were the common patterns used by general practitioners in their strategies and tactics of solving both their patients,



PARADIGM ONE

AN ALGORITHMIC DIAGNOSTIC PROCESS IN A CLOSED SYSTEM

Figure 1

IDEAL TYPE CHARACTERISTICS

MENTAL SET TOWARDS SEARCH STRATEGIES INVOLVING

Disease or organ-centred medicine
Maximum use of technology—'Male instrumentality'
Convergent thinking
Hypothesis testing by simple binary sorting
Intolerance of ambiguity
Known end point, e.g. game of draughts: an algorithm
Organised illness—previously sifted problems
Single, fixed search-strategy
Affect neutrality by doctor and patient
Verbal communication—"of what do you complain"? Closed questions
Adult–child relationship—authoritarian
Sympathy
Relatively non-probabilistic aura of certainty
Criterion based—i.e. non-unique
Mystification—power—judgemental
Ritualistic
"Safe for doctor"
No arena for patient negotiation—warm sympathetic dependency
The team syndrome—dilution of personal responsibility in both patient and physician
Learning is teacher directed
THE SYSTEM IN THE CONSULTATION IS CLOSED

and equally, their own problems. Over the months I could see and feel the great pain and struggles of trainees as they shifted from the enormous and valuable skills that they had learned in eight years of closed-system diagnosis to a threatening open system of problem-solving. The crux of teaching in general practice is the enabling of this shift of paradigms.

The closed system

I do not intend here to describe the details of my findings—but just to outline the general flow of the consultation. Consider first the closed system we all learned in medical school and during our hospital residency persiod. Remember that I am "ideal typing". One of the dangers in doing so is to produce an unduly static model: it can distort, as well as clarify. To save time and by using a shorthand of the unit ideas and key concepts involved, we can share a meaning, albeit a caricatured one.

We learned as students: (1) History, (2) Examination, (3) Investigations, (4) Diagnosis, (5) Treatment.

We can call this the traditional medical model. It is a method of great use and scientific aesthetic beauty. It produces enormous difficulties when used alone in general practice. When used in combination with the other variables in an open system it increases our usefulness to our patients in general practice.

Consider the first paradigm in figure 1. Here we are using the traditional medical model. This minimises, but does not entirely exclude, the doctor as a person, and the personal, psychological, and social factors of the patient. The "ideal-type" characteristics and the mental set towards search strategies in a closed system are listed in figure 1.

The open consultation

Consider now if you will my second paradigm in figure 2. Here the traditional medical model is in the centre of the picture. Without its use as clinicians we are nothing. Used alone we are not doctors but medical scientists. I cannot do better than quote Dr G. I. Watson (1967): "Neither the patient alone, nor the doctor alone, but the patient consulting his doctor is the central point in medicine. This is the supreme learning and teaching moment towards which our young doctor's training leads . . . at this moment, behind and around him, visibly or invisibly, stand his family and his habits, his genetic and personal past . . . around them both lies the community in which they live and work."

James Spence (1960) is often quoted, and I cannot resist him again. "The real work of a doctor is only faintly realised . . . it is not an affair of health centres, public clinics, operating theatres, laboratories, or hospital beds. These techniques have their place in medicine, but they are not medicine. The essential unit of medical practice is the occasion when, in the intimacy of the consulting room or sick room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it."

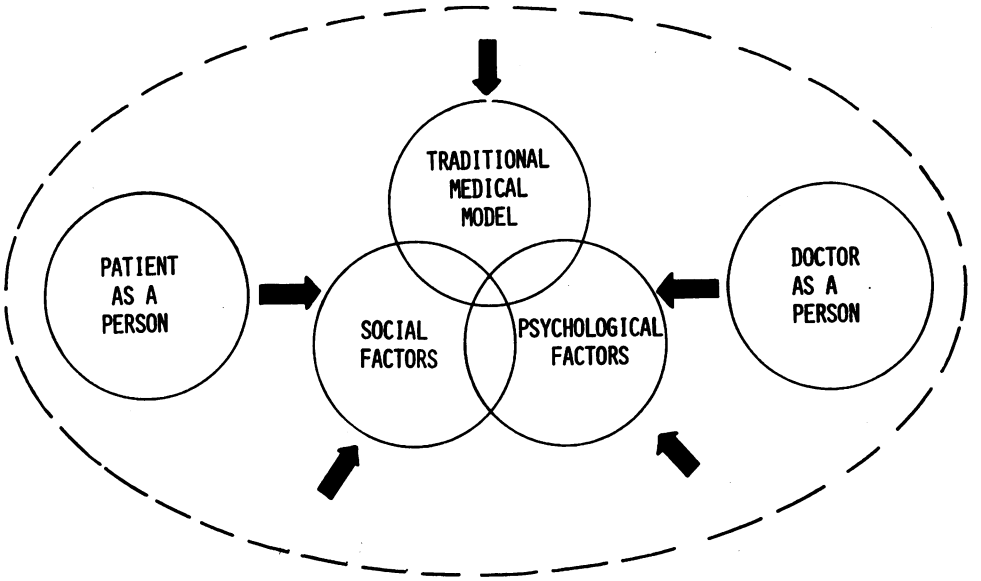
The doctor as a person, and the patient as a person, are very consciously included in our problem-solving set. The 'ideal type' characteristics, and mental set towards such strategies in an open system, are listed in the figure.

I would like to pause for a moment to acknowledge a debt. In 1962 Thomas Kuhn wrote *The Structure of Scientific Revolutions*. When I read it I had a curious feeling of *déjà vu*, that he was speaking of the major efforts of many general practitioners all over the world to find a common symbolic language to tell each other, and particularly students and young doctors, what it was that they did, and wished to do.

The essence of Kuhn's argument is that scientific revolutions do not occur by the concept of development-by-accumulation usually assigned to them. We do not become family doctors by learning fragments of all the specialities, and then welding them together. The birth of this College heralded a revolution. "Normal science" said Kuhn

"is predicated on the assumption that the scientific community knows what the world is like . . . it often suppresses fundamental novelties because they are necessarily subversive of its basic commitments . . . when the profession can no longer evade anomalies that subvert the existing tradition of scientific practice—then begin the extraordinary investigations that lead the profession at last to . . . a new basis for the practice of science . . . it shifts the network of theory through which it deals with the world. The study of paradigms is what mainly prepares the student for membership in a particular scientific community in which he will later practice."

The crux of teaching the science of consultation, which is the essence of general practice, is the enabling of the shift of paradigms, from working in a closed system, to



PARADIGM TWO

HEURISTIC PROBLEM SOLVING IN AN OPEN SYSTEM

Figure 2

IDEAL TYPE CHARACTERISTICS

MENTAL SET TOWARDS SEARCH STRATEGIES INVOLVING

Patient and person centred medicine
Behavioural 'technology'—'Female expressiveness'
Divergent thinking
Hypothesis testing by Bayes theorem
Tolerance of ambiguity
Doubtful end point, i.e. game of chess—heuristic
Unorganised, undifferentiated 'illness'—holistic
Alternating search strategies
Communication mode "How can I help you"? Open questions
Verbal, non-verbal, extra-verbal, vocal cues
Adult–adult relationship
Unique situation
Counselling: The Rogerian triad;
1. Affective involvement—but non-possessive warmth
2. Less sympathy—but accurate empathy
3. Congruence—genuineness, psychological 'honesty'
The trust syndrome: concentration of personal responsibility in physician and patient
Learner directed learning
THE SYSTEM IN THE CONSULTATION IS OPEN

working competently and confidently in an open system. It is done less by the accretion of facts, than by a revolution of insights and attitudes.

Vocational training

I will now finally turn to vocational training and the education of those preparing for general practice. To improve their competence in closed systems they must obviously work at postgraduate level in internal medicine, obstetrics, casualty, geriatrics and paediatrics—or some similar combination. Methods must be found for maintaining the trainee's interest in general practice during this time. Now is the time for him to learn to work in a group and to start his sensitivity training.

How should we begin the shift of paradigms to an open system? Clinical apprenticeship is vital. By far the most important learning situations for a trainee exist within his training practice. Here alone can he be socialised, by role modelling, into a family doctor. Here alone can he learn by doing, to achieve Oslerian *Aequanimitas*. Here alone by vocational training can he learn the here-and-now craft of the generalist. Here alone can he learn from his patients, and receive that training for the ultimate responsibility of which Dr George Swift (1973) reminded us in his splendid Pickles lecture. It is only here, forged on the anvil of clinical practice, that he can integrate theory, practice, and his own true feelings. Here he will be taught *caritas*, and feeling with the patient.

I cannot stress too strongly my feelings of the importance of vocational training in the teaching practice. Its extension to 18 months or more, with an equal diminution in the hospital component, is overdue. The great majority of general practitioners fall easily and competently into the role of teacher to a clinical apprentice.

Education

I will therefore not dwell on vocational training but concentrate on the conceptually quite different problem of the trainee's education. This is a field unfamiliar to most doctors, although an increasingly large number are becoming very competent educationalists indeed.

Education as I see it is different in many ways, but is in no way better than vocational training. Of course they interact, and are mutually dependent. I have lightly sketched what I think are the broad aims of vocational training. There is no satisfactory simple definition of education, so I will scramble A. N. Whitehead, Ian McWhinney, Winston Churchill, and Donald Crombie, to produce ideas that match my own as to its essential components.

Education concerns itself with the joy of discovery; the discovery of useful ideas, their use, testing and throwing them into fresh combination. Theoretical ideas are the only way of keeping knowledge alive. Education is concerned with the central problem of preventing intellectual pollution by inert ideas, with training the imagination, and teaching a learner to teach himself, now and throughout his life. It alone can prepare him for the serious and laborious business of scholarship ready for the long and hard discipline of doing good original work. It will teach him how to ask the right questions, and how best to attempt their answers.

"The division of medical labour," wrote Mackenzie, "darkens understanding". Being a man of his time he lacked the simplest symbolic tools to tell us what he really thought of the effect of emotions on patient, doctor and illness. There is a rare excursion into this field in his 1918 *Principles*. "When the patient and physician come first together, it often happens that there is an unconscious struggle as to who is to be dominant". To light understanding, and make conscious that struggle, our trainee, in the consultation, needs the three central perspectives of the generalist. These are: firstly, an understanding of the disease and the diagnostic process. This is superbly taught by medical schools of the British clinical tradition.

Secondly, he needs an understanding of the patient's illness, and his eco-system. Thirdly, he needs both understanding, and making conscious, that knowledge of himself which is clinically significant in personal relations.

There are elements of a new educational need in all these perspectives, especially the last two. Although all of us involved in training schemes are still experimenting, I believe that the essential process and task most suitable for a shift in paradigms is becoming clearer. What is the task of a teacher during the trainees' academic day release? You can cut the cake in many ways. My stated overall aims for the Ipswich scheme are:

(1) To assist the trainees to achieve their own objectives on their study day, and to bring teaching methods to their notice.

(2) To ensure that at the end of their trainee year all trainees will be confident and competent teachers. A considerable amount of the responsibility for organising the course purposely falls on its members. I see it as my responsibility to ensure, as far as is possible, that the following elements in learning-teaching situations are incorporated, and that all learning should:

1. Be relevant to the learner's motivation,
2. Actively involve the learner,
3. Be directed towards clearly-defined broad objectives,
4. Allow for individual differences,
5. Have feed-back,
6. Take place in appropriate and varied situations.

(3) That at the end of the course all trainees will be able to audit their own clinical performance in general practice, and thus have a sure basis for continuing education for the rest of their professional lives.

(4) To introduce the trainees to important aspects of both educational, and general-practice literature, and modern methods of information retrieval.

(5) To evaluate the study day, both continuously with the trainees' help, and the total educational exercise at the end of the year.

Objectives of the trainees

During their two hospital years our trainees thought a great deal about the objectives they wished to achieve during their final year in general practice. Here is a list of their main aims:

(1) *Adaptation of work.* In our practice to adapt our method of work to the time and space scales of general practice. This includes the change in diagnostic and therapeutic processes to take account of physical, psychological and sociological aspects; using ancillary agents when needed, and paying particular attention to the early signs of illness.

(2) *Topic symposia.* We wish to study the management of the major clinical problems of general practice. We intend to do this by sifting the experience and practice of our general-practitioner teachers. We also intend to search the data for two years back, from seven selected journals: *The Practitioner, The Journal of the Royal College of General Practitioners, The British Medical Journal, The Lancet, Update, Prescribers' Journal* and the *Drugs and Therapeutics Bulletin.* By major clinical problems we mean diabetes, hypertension, chronic chest disease, peptic ulceration, backache and otitis media and similar diseases.

At the end of each symposium a consensus of good practice will be printed out and fed back to the practices for audit.

(3) *Random case analysis.* By analysing random cases seen during surgery and home visits (including night visits); to gain insight into our performance in the consultation.

(4) *Project teaching and learning.* Taking the theme of the seven ages of man, to

study topics of mainly emotional and sociological significance which impinge largely on the general practitioner's work. Having studied the subject, we intend to present to the meeting a series of subject headings to serve as leads for group discussion. The added knowledge and the specialised reading of a topic leader, and as many teachers as possible from the training practices, will contribute to the subject under study.

(5) *Sensitivity training.* To continue sensitivity training in the Balint-type group which was held throughout the two hospital years.

(6) *Assessment.* To assess whether, and how, the educational objectives of the group are being maintained.

(7) *Educational theory.* To acquire a basic knowledge of educational theory and practice, so as to improve our potential for self-education, and to prepare us for the task of being teachers in the near future.

Vocational training will teach them *caritas*: vocational education-*scientia.*

Project work

I would like to consider briefly two methods of learning which are apposite. The first is project work in small groups. This is a method whereby learners are first purposely exposed to the work they are being trained for, i.e. clinical general practice. During this work they can learn to identify the knowledge, skills, and attitudes, lacking in their previous hospital experience. This gap can be filled by extensive study. The learner's new ideas and full references are typed on a simple position paper. Resource people may be used if he wishes. These should include one or more principals from his practice. A period of two hours is allowed in which to present his project. His new knowledge can then be effectively integrated, reinforced, and internalised by teaching to his peers.

I am now working with my third group of trainees, and the power and effectiveness of the project method is a never-failing astonishment to me. It is as near an ideal educational instrument as can be devised. It tolerates an analysis by all the major principles of adult learning previously listed. To show its enormous range it is worth listing some of the projects completed by recent trainees. Because they are training to be family physicians, the family life cycle is imposed on the projects.

1. Normal patterns of child rearing
2. Developmental paediatrics
3. Problems of mentally and physically handicapped children and their parents
4. Battered babies
5. Intervention in family patterns of illness
6. Preventive and promotive health
7. Socio-economic factors in children's education
8. Behavioural problems in school children
9. The family doctor's role in educational problems. School refusal
10. Broken homes and one-parent families
11. The non medical use of drugs
12. The school leaver
13. Sexual problems—Sex without marriage
    Abortion
    Sterilisation
    The unmarried mother
14. The age of consent
15. The value of revolt
16. Communication with patients.
17. How to make patients—anxious, angry, helpless and hopeless
18. Screening for symptomless disease
19. Late calls
20. Religion and medicine
21. The working wife
22. Redundancy and unemployment
23. Medicine and the law

24. Medicine and politics. Principles of management
25. Record systems
26. Occupational medicine
27. Health education
28. Sickness absence
29. Rehabilitation
30. The sociology of fertility
31. Alcoholism
32. The sociology of marriage
33. Audit in medicine
34. Old and alone
35. Social services for the elderly
36. Geriatric screening
37. Visiting the elderly
38. Terminal care
39. Death and bereavement

Our greatest error as teachers is to underestimate the very considerable divergent capacities of our trainees. It will be extremely difficult, due to our own past imprinting, not to palisade their growth by teacher-directed learning. Instead it is absolutely necessary to encourage non-directive, shared leadership, discovery learning. The teacher must be a challengeable equal.

The single most important thing that I have learned in the educational field was taught me by W. L. Corlis who is a quiet, shy, Australian general practitioner whose interest in non-directive work dates back to the 1930s. He is I believe, the foremost medical educationalist in the world today. It has been my good fortune to work closely with him on my three visits to New South Wales.

The teacher's responsibility for process

What he taught me, I now understand to be the central keystone of education. A teacher's function is essentially to be responsible for process. If a satisfactory process is achieved, it is certain that learners will complete the task content better than he, or all the resource experts in the world.

A teacher does not have to teach a single fact: without his cognitive intervention, the learner will learn, not only more, but more effectively. He will learn not only the hard facts of clinical medicine, but also those skills and attitudes which will enable him to shift paradigms by his own efforts. He will learn the science of consultation in general practice.

Sensitivity training

The second method of learning I would like to discuss is sensitivity training. What most of us teachers feel pretty sure of, is that some method must be found for teaching counselling skills. Lack of these skills is the devil in the machine of traditional medicine. We must learn to handle and gain insight into feelings—feelings of dependency, anxiety, aggression, sexuality and collusion—in ourselves, and in our patients. None of us is sure how most effectively and economically to teach this aspect. Balint methods, role-play, case building, and their variants are being tried in many parts of the world. Can we teach it, or do we need specially skilled resource people? We very much need to experiment and share our experiences in this particularly difficult field.

Let me briefly summarise what I have said because I think it is of overwhelming importance. If we as teachers introduce shared leadership small-group methods of interactive learning to our trainees, they will be better than we can ever be at achieving learning themselves. They themselves can employ the most sophisticated and effective methods of education that can be devised. With minimal guidance they can themselves create meaningful personal objectives from their own experience and motivation—not second-hand from someone else's, or from a book.

It is perfectly feasible for trainees to construct their own curriculum, devise their own learning-teaching situations and syllabus, and learn to assess themselves and audit their own clinical performance in practice. In that process they will become good doctors —and good teachers. In all this, as in any important learning, especially that involving a shifting paradigm, there will be much pain, many doubts, and numerous morale-shattering mistakes.

Examinations

In the long run, contrary to current educational credo, subjective and peer evaluation is of infinitely greater value than any so-called objective assessment. I believe it to be wholly wrong over to prepare a trainee for an examination. I have never mentioned that word to any of the 40-odd trainees to whom I have acted as tutor. To do so is an admission of educational failure.

It may be a perfectly reasonable procedure to examine a trainee who is preparing to work in an algorithmic closed system. By definition there is, in such a system a procedure that guarantees a solution to the problem. As he works in such a system it is reasonable to examine, for example, an airline pilot, an anaesthetist, a shipmaster or an orthopaedic surgeon.

No logic exists for the institution of an examination for a generalist working in an open system using heuristic procedures to solve problems. To do so in authoritarian fashion, will in the long term, be counterproductive and inhibiting to the true learning process.

Membership examination of the College

I can well understand and sympathise with the historical reasons that persuaded Council to institute an examination for membership of this College. Those reasons no longer obtain. I am horrified when I think of the rigidifying influence and sheer waste of resources in erecting an examination industry to process well over 1,000 candidates each year. At best, such a procedure can only be a bizarre *rite de passage*; at worst, for hundreds of good men and women, an unnecessary degradation ceremony.

A profession is not an occupation: it is a method of controlling an occupation. In 1815 our forebears the apothecaries were the first profession in this Kingdom to introduce a written examination system. They did so, for political, status and fiscal reasons. We are, above all else, plain men and women. I hope such reasons will never influence us. I hope that Council will one day have the courage to reverse one of its very few mistaken policies.

Risk of failure

I have so far concentrated on various factors in learning and teaching the science of consultation for the future general practitioner. I will now turn in the last few minutes to certain fallacies which I believe will prevent or inhibit such learning in the future. Remember if you will, the caveats I entered at the beginning of this talk. I almost called this lecture 'Unintended Consequences' to stress my point that good sincere men were doing things, for short-term gains, which I believe will incur not less than catastrophic losses in the future. At the beginning I put forward the gloomy opinion that there is a good chance, that in the next 20 years, we may lose more than we have ever gained. We may lose ourselves, our patients, and become lost strangers in our own house.

If you and I do not share a fundamental ethos, which the Oxford English Dictionary defines as the prevalent tone of sentiment or genius of an institution or system, then I have failed altogether to communicate with you today. But I do very strongly feel that all members of this College, indeed, all experienced general practitioners, do share a common ethos.

The wants of society

In 1830, over 140 years ago, and only ten years after the first use of the term general

practitioner, the Metropolitan Society of General Practitioners issued their memorandum. With an astonishing shaft of sociological insight they said "We are a body of men who exist because the wants of society have raised us up".

We would do well to remind ourselves of that, and that every single principle that we hold as vital was forged by the much denigrated single-handed family doctor in private general practice. It was he alone who taught us the essential need for an intimate personal medical adviser. He listened to the voice of society demanding primary care from a comprehensive generalist. He, and his patients, laid down the essential principles of accessibility and availability—without which continuous tenured care becomes a mockery.

At the outset I declared my bias. It is the belief that to have easy access to a humane and professionally well-educated personal physician is one of the most valuable blessings that western civilisation has to offer its citizens. Unless we family physicians defend this right, which is both our patients', and our own, it may well go by default.

We stand at the high point of a watershed in what the social engineers call so unattractively 'the delivery of medical care'. The tide may fall one way, or the other: towards the Hippocratic ideal of the "calm, faithful, effective servant of the sick", or towards a more impersonal form of population—maintenance, or community medicine. I believe it is a clear duty of this College to nourish the former, and oppose the latter.

Fears about health centres

I fear the adulation of the team, and the whole concept of large health-centre practice. They have given us no single concept of value. As Harry Lime unkindly said of the Swiss, "Five hundred years of democracy, and what have they produced?—the cuckoo clock!" The health centre as Spence reminded us, is not medicine; it is a technique for the delivery of a certain kind of population medicine. Its resemblance to personal family doctoring has as much in common as red ink to good red blood. There may be superficial resemblances—but the functions and ethos are almost wholly dissimilar.

What I am trying to point to, is the one great fatal flaw in current thinking and the implementation of ideas about the 'new general practice'. Good men will make any system work—temporarily. Forward planners of the new ideas have forgotten the most important variable of all; that is, the superb training in person-centred medicine and personal responsibility that the present incumbents had in their small practices.

The destructive fallacy lies in the assumption that the future general practitioner can learn these things in large state-owned health centres. Should these places continue to proliferate it is difficult to avoid the conclusion that in the future, training and education for a life's work in an open system will not be available. It will be a tragedy for future general practice if we continue to ossify such dogma in concrete; and for the next century to have standing such memorials to yesterday's problems, and expecting them to solve those of the morrow.

It is sociologically and architecturally inevitable that these large organisations, no matter how virtuous every member of the staff, will develop in time all the characteristics of a rational-legal bureaucracy. They will in time, develop more and more of the stigmata of a closed system resembling in all detail a secondary caring hierarchy, as in hospital. It is wholly predictable that doctors will then spend their time, in the phrase so often used by closed system devotees "Doing those things for which they were properly trained". When that happens, as it will, general practice as you and I understand it will perish from this Kingdom.

I told you earlier of 12 ordinary home visits. In the brave new system, here and abroad, this absolutely invaluable source of information-gathering is rapidly on the wane. We can never be family doctors until we know the inside of every single patient's home.

It will take years to discover this fabric of practice. But no longer than it takes a general surgeon intimately to know the fabric of his domain—the human body. The doctor in the new system will ever more closely resemble his hospital counterpart, operating what my friend Bruce Arthur has called the "great protection racket"—deputising services—(Does a young doctor really know what general practice is until he has done a hundred night calls?), reception and telephone barriers, primary and secondary assessment by nursing and social work feldshers, and that most tedious and unnecessary of barriers, the total appointment system.

On this subject I would commend to you two works of remarkably sensitive scholarship. Donald Crombie's 1969 Gale Memorial Lecture, and Ruth Cammock's superb study on health centres. To me, these are two of the most important works of the last decade.

Today we are gathered to do homage to the memory of one of the greatest practitioners of all time—James Mackenzie of Burnley in the county of Lancashire. I have chosen, rather than to look back on his life and times to look forward in a direction he favoured. In the preface to his *Future of Medicine* he wrote: "From a description of personal experiences, certain inferences can be drawn, which form a basis on which a constructive policy can be developed . . . until it is superseded by another conception." I have attempted to emulate the master by examining and drawing educational inferences from that 'brief encounter'—the consultation in general practice.

I would like to end with a quotation from a great open-system consulting physician, John Paulley, " In the compromises that must inevitably follow the reorganisation of the Health Service, we must for ever be on our guard not to lose the one thing we have that is five gold—our prior responsibility and allegiance to the individual patient".

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