Outer Signs of Inner Qualities

Sir,

Throughout history man has sought for outer signs of inner qualities. Although some 'good men' exhibit such signs, the reverse is not necessarily true. Moreover, once signs have been accepted by an authority as a hallmark of inner qualities, they tend to lead men not to goodness but to orthodoxy, not to the administration of the spirit but to the letter of the consequent guidelines that are built upon such signs.

I write through you, Sir, to those who are today seeking the signs by which a 'good' trainer can be identified. Whether they choose the visible practice library, preventive activities or the number of trainee nights on call (July *Journal*, p. 395) the dangers in the process remain.

Is it too late to urge those concerned to look for a more reliable way of detecting those inner qualities that made each of us label some of our own teachers 'good'? It was my experience that these teachers were distinguished less by uniform outer characteristics than by a questioning and tolerant mind, the ability to inspire and enthuse others, a zest for the task in hand and empathy for those in their care.

It would be a sad day for general practice training if some of those who possessed these qualities were overlooked because they did not have the inclination to produce a set of outward signs, which alone would satisfy their selectors.

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In Defence of the College Examination

Sir,

The recent report of trainees' attitudes towards the MRCGP examination (July *Journal*, p. 457) in part merely reflects the age-old antipathy of students to examinations.

As a medical student, I remember the professor of anatomy voicing concern at the introduction of multiple choice questions and continuouus assessment. How could anyone become a clinical student without going through the ordeal of second MB? Students, of course welcomed the march of progress.

At graduation a number of colleagues expressed the view that they no longer wished to be part of the rat race and sit any more examinations—they would enter general practice. How many junior hospital doctors would sit the MRCP or FRCS examinations unless the possession of the appropriate certificate was necessary for a steady progression along the path to consultantship?

It is encouraging that in the recent study 20 per cent of trainees expressed a wish to be tested by examination at the end of vocational training; most individuals would be expected to express the opposite view. How many trainees/candidates who recently sat the examination found it a worthwhile experience? Despite the interest in alternative methods of assessment,[1,2] 76 per cent of trainees considered that examination should form at least part of the means by which membership of the College is obtained.

Dr Griffiths has stated previously[3] that nearly all of those who intended to sit the examination were doing so for the wrong reasons. Surely sitting as a stimulus to study, for self assessment or for personal reasons is not wrong. These would accord with the aims of the College and it would be interesting to know the total number of those who described themselves in these categories.

If, as has been suggested, to take the examination serves little purpose, then there is the possibility that some may argue more forcefully for the introduction of objective and subjective assessment before vocational training. That the association of membership with the examination, which clouds the function of the College to some, can be overcome has been well answered before.[3,4] The breakdown of the College into faculties, which does not exist in other Colleges, confers both unique opportunities and responsibilities on those involved in running the College at the local level.

A further criticism of the examination was that it detracts from the trainee year. (April *Journal*, p. 249). Is it then acceptable to take the examination at the end of vocational training if the trainee year occupies the middle year? There are three years spent in vocational training and yet it seems that the emphasis is often placed on only one year. If more stimulus were given to trainees during the hospital years, the examination would not present the hurdle that it does at present.

Study for the examination does not necessarily detract from the trainee year nor result in wasted opportunities. Few would argue with Dr Griffiths that appreciation of the individual is very necessary in general practice. Such an attitude needs to be introduced and developed in the trainee year if it has not already been done. However, as Professor David Metcalfe has pointed out, attitudes are only one aspect of the teaching and training to be carried out by the trainer.[5] Teaching about skills and knowledge is also necessary. That the acquisition of knowledge in the trainee year is very important has been demonstrated clearly in the survey of trainers and trainees in Manchester.[6]

Our senior house officer colleagues in hospital often have to burn the midnight oil to gain their postgraduate diplomas. It sometimes seems as though trainees in general practice expect to never have to follow suit.

By all means let us explore other avenues but remember that the examination is an acceptable means of assessment to large numbers of trainees. Everything in the garden is not rosy but there are more flowers in bloom than are sometimes seen at present.

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References

1. Bond A *et al.* The MRCGP Examination. *J Roy Coll Gen Pract* 1982; **32:** 642.
2. Obtaining and maintaining membership: a Council discussion paper. *J Roy Coll Gen Pract* 1981; **31:** 521-524.
3. Griffiths TN. Membership. *J Roy Coll Gen Pract* 1981; **31:** 697.
4. Visit of trainees to the College. *J Roy Coll Gen Pract* 1983; **33:** 180.
5. Metcalfe D. *Medicassette* 1983; **17:** no. 4.
6. *The influence of trainers on trainees in general practice.* Royal College of General Practitioners. *Occasional Paper No 21,* 1982.

Family Medicine—at a Loss for Words

Sir,

Dr Anthony S. Dixon's paper (June *Journal*, p. 358) is one of the most exciting and relevant I have ever seen published. He expresses (with a penetrating knowledge of the uses and limitations of language) our current dilemma: our inability to describe the new landscape which those in the forefront of thinking about general practice are trying to chart.

In 'Awakenings'[1] Oliver Sacks makes a similar point which engages the same challenges: the complete physician must often move out of the mechanical, and into the metaphysical. The fear that general practice, or family medicine, is often seen as either hum-

drum or in some way inferior in its thinking to that of the 'hard science' of hospital-based medicine, often seems to lead to attempts to erect an alternative edifice of research emphasizing, say, epidemiology or statistics. This talks the same language and carries some academic respectability. There is, of course, need for such work, and indeed for continuing expansion in the other discernible directions of modern general practice, training and postgraduate education. But we now have glimpses of a new sort of medicine, and if we have the vision to begin weaving together those threads that are appearing, they will provide the material for a new tapestry of medicine which will illuminate our practice in ways that we can, at present, only dimly, but with mounting optimism, anticipate.

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Reference

1. Sacks O. *Awakening*. London: Pan Books, 1982.

Sir,

Having been slightly dismayed by Dr A. S. Dixon's recent article (June *Journal*, p.358) I feel I must make the following four points in reply:

1. Dr Dixon describes as a 'moot point' the degree of acceptance among linguists of Edward Sapir's hypothesis concerning the influence exerted on a society or culture by its language. I think he would find, in fact, that the vast majority of linguists are rather less favourably inclined towards this view than he suggests.
2. The main argument against Sapir's theory of language providing a grid through which its speakers see the world is that while it is indeed the case that different cultures make different distinctions in their languages, according to what is considered important in their respective societies, such differences in categorization do not prevent the implicit recognition of distinctions which are *not* made. The fact that some languages do not distinguish between blue and green in their colour terminology does not mean that their speakers see the sky and grass as being the same colour. The influence of society on language, however—the converse relationship—is much more widely accepted; it is surely as a result of his environment, rather than his state of mind, that the well-quoted Eskimo has so many words for snow.
3. I would also dispute rather strongly Dr Dixon's description of language as 'conservative'. There are innumerable examples of language changing quite readily to fit the changing needs of its speakers: the kinship terminology of Russian, for instance, changed quite drastically after the revolution to reflect the development of a different kind of family unit, and certain terms quite quickly became obsolete as new ones were found to be necessary.
4. Dr Dixon's view, then, that it is language which 'encourages the depersonalization of illness and the placing of disease beyond the patient's control' is surely rather a cop-out. He does, however, admit that it might be necessary, when trying to improve the current situation, to break through 'social and ideological rather than (the) linguistic or conceptual barriers'. Would it not therefore be more beneficial to that society to spend time trying to change its views of control of illness and shared responsibility between doctor and patient, rather than attempting to provide the medical profession with a language which will undoubtedly develop anyway in response to the changing needs of its speakers?

JUDITH HALLIWELL
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Sir,

'Is the underlying grammatical construction of our language the reason . . . why we seem to have trouble with apparently vague processes and influences as represented by the psychological and social factors in our lives?'

The question certainly needed to be asked. We are surely indebted to Dr A. S. Dixon for tackling the subject with such erudition and scholarship (June *Journal*, p. 358).

Even the answer is provided. 'In natural languages . . . vocabulary, inflection and modes of sentence structure . . . do not make it impossible to express certain things, they (may) merely make it more difficult to express them.' Why then does Dr Dixon in his conclusion state three difficulties indicating that his answer to the initial question is an unqualified yes? His article itself contains two pointers to why this may be.

We in the medical profession do not use words fundamental to the philosophy of medicine with thought and consistency. For example in the first enumerated difficulty in his conclusion Dr Dixon implies that we might be more successful if we did not automatically consider diseases as 'its'. But surely the whole advantage of inventing (not discovering) any disease is that we then have a hard mental tool to use in healing people who are ill. Diseases are similar to Newton's Laws of Motion. As such they are as concrete as any abstract notions can be. It would appear diseases are invented specifically to be 'its'. I believe it would be clearer to argue that we should not consider all illnesses to be 'its'.

Let me return to a phrase from the article's fundamental question, namely 'apparently vague processes and influences'. Consider Dr Dixon's example of 'it rains'. This phrase did not prevent meteorologists from making great strides in the understanding of weather systems. Apparently vague meteorological processes and influences of 10 years ago are now elegant hypothesis shaped by Occam's razor.

In short, that our patients' illnesses seem vague is not due to any inherent defect in the English language but to our lack of knowledge. We in primary care would wait futilely for a grammatical revolution. What we need are our equivalents of the weathermen's sputniks and Kray II computers.

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Treatment of Heroin Addiction

Sir,

I read with interest the account of clonidine withdrawal in general practice by Joliffe and Melville (June *Journal*, p. 368). I agree that the prevalence of the problem, the inadequacy of the present clinic system and the imperative to encourage a sense of self achievement and responsibility by the patient, all lend support to a community primary care approach to the problem.

I have been treating heroin addicts with clonidine withdrawal for the past nine months. My treatment practice differs from that of Joliffe and Melville in that I do not insist on a fixed dose of clonidine. I explain the action of clonidine in as technically complete terms as is possible and allow the patient to titrate symptoms of withdrawal against over-sedation and drowsiness. Ideally, I ask the patient to keep a record of all