Education for responsibility*

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IT is my privilege and responsibility to give the sixth annual William Pickles Lecture to honour the memory of a typical British country general practitioner. He was a man who, from a humble station in the medical hierarchy of this country, achieved international fame as an epidemiologist, and who became the first President of this College.

Will was appointed president on 14 November, 1953, a few months before the inaugural ceremony, in Vancouver, of the College of General Practice of Canada, as it was then called. Though he was unable to be present at the ceremony, he sent a recorded message, which I believe it is appropriate to recall at this joint meeting of the College of Family Physicians of Canada and the Royal College of General Practitioners.

"It is my firm hope and belief that the inauguration of our Colleges will be a turning point in the history of general practice, and that the patient endeavour of each will inevitably raise its standard and perpetuate the high ideals which we associate with this great branch of our profession" (Pickles, 1954).

If he could have been with us today he would have rejoiced in the progress that has been achieved in the past 19 years, and to see that his hope and belief was vindicated.

Early background

A man's character and faith must, to some extent, reflect his early background and environment. Will was the son of a general practitioner who practised in a "dreary, shabby, genteel neighbourhood in the centre of Leeds. Today it is a slum undergoing demolition" (Pemberton, 1970). Here he must have learnt something of the sickness, poverty and sadness of the less privileged members of Victorian industrial England. The summer holidays would have made a welcome contrast to Leeds, and we know that he and his brothers on some occasions went camping in Wensleydale, where eventually he was to practise for over half a century.

As a schoolboy and student Will was not particularly outstanding. He became a member of the second fifteen and passed his matriculation reasonably well at school, and then entered the medical school at Leeds. The main entrance of the Leeds General Infirmary where he did his clinical work remains much as it was when Pickles was a student. Though he won the anatomy prize, he later failed the London M.B., and, lowering his sights to the Licence of the Society of Apothecaries, failed that too. Subsequently he became L.M.S.S.A., in 1909, and M.B. London in 1910.

After a spell doing locums, as resident obstetric officer at Leeds, and as a ship's surgeon, Will settled in Wensleydale in March 1913 as a principal in partnership with his friend and fellow student Dean Dunbar.

There was no vocational training in those days. Both were relatively inexperienced doctors, but they made up for this by conscientiousness and energy. They had to take full responsibility for all patients in their part of the dale, and the appointment of

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part-time Medical Officer of Health was held by the practice. Communications were poor, and the nearest hospitals at Leeds or Darlington were 50 and 60 miles away.

Personality

How was it that this doctor, isolated in a Yorkshire dale, and with no more than average talents, achieved fame and produced that classic of medical literature, *Epidemiology in Country Practice*. Primarily I think it was because he cared greatly for all who lived in his practice, and for them provided total medical care. To improve this care, he observed closely, recorded meticulously, and persevered with that organised curiosity which has been described as the essence of general-practitioner research.

A message deriving from Pickle's life and work should be addressed to all young doctors, whatever their natural ability, entering a career in general practice. It is that those who follow Will's simple precepts will live a full and rewarding life, and will always have a chance to discover some new facts that will be important to the practice of medicine.

I first met Will at a council meeting of the College on the morning of the day that he was to be installed as President. The immediate, and indeed lasting, impression that I had was of his immense warmth of character, and how, when I was introduced, he shook hands as if this was the very purpose of his journey from Yorkshire to London. By chance I sat next to him, and we were probably the oldest and youngest people in the room. He sat forward in his chair, nodding his head as each point was made, but saying nothing. At one point I thought the proceedings had become dull and irrelevant, so I sat back in my chair—as the psychologists tell us, the classic way of rejecting the discussion. As I did so I whispered "They are talking nonsense", and he whispered back "Go on boy. If you think so you must say so." I took his advice and made my point. The point was taken and I was encouraged—so much so that I have been talking at college meetings ever since. Thus the advice that Will whispered to me in 1953 has resulted in my standing before you today to speak in memory of him on an educational subject.

Wensleydale

In searching for a theme I naturally read the previous Pickles lectures, and I remembered that in 1943 I too had known the "eight train", mentioned in the title of Professor Byrne's 1968 lecture, and watched it creep up the valley. For me it was the train that took me on leave and brought me back to a regiment of north country territorial soldiers armed with tanks with whom I served as Regimental Medical Officer.

We were stationed further down the dale than Will's practice, but on the moors where he would shoot grouse, we would fire our guns, and look down on his beautiful dale with its villages, guarded by its castle—still part of the estate of the descendants of its mediaeval owners—and its river, alternately peaceful and forceful.

Before I was posted to this regiment, which I soon looked upon as ' mine ', I had had the usual experience of my generation as a doctor—one house job, and then service with field medical units and general hospitals in the army. I thought that I had carried out my responsibilities pretty well. I tended the sick, read Army Council Instructions, and knew and kept my place within a strict hierarchy.

Suddenly all that was changed. True, there was an army hospital and army administrators at a suitable distance, but my civilian soldiers didn't want me to turn to them. I was the doctor, the buck was to stop with me, except in grave emergency, and an important part of my duty was to see a way round regulations. Thus, I was expected not to notice that a man had a short leg; I was asked to drain a large hydrocoele with a ten ml syringe however long it would take me. Proper military medical procedure would have

been to downgrade both men, and would have resulted in their being posted away from their military family.

I learned to treat phosphorus burns in young officers whose exuberance had led them to carry out highly unofficial experiments with smoke bombs. The treatment was first to immerse them in a bath of water, later, when it got dark, to pick off the pieces of phosphorus as they glowed, and finally to cover the whole with a liberal application of gentian violet. Irresponsible doctoring you may say, but it worked, and treatment in hospital would have led to courts of enquiry and possible court martial.

As might be expected, there was not much clinical work to do in my unit, but we did have one classic outbreak of influenza in late October 1943 in a sub-unit near Bedale. Shortly before this date, there had been an edict that only medical specialists were entitled to make the diagnosis of influenza, more lowly officers were to be content with euphemisms such as ' coryza' and ' upper respiratory tract infection '. Affronted by this attack on my clinical acumen I boldly wrote ' flu ', ' flu ', ' flu ' on my sick reports, and was immediately involved in a wordy battle with my administrative superiors. To my delight resistance ceased after a few days, and I was allowed to write the word ' flu ' as often as I wished.

For 27 years, until I read Professor Pemberton's book *Will Pickles of Wensleydale*, I thought it was my perspicacity that had softened the hearts of the colonels. What had happened was that my outbreak had moved up the dale to the grammar school at Askrigg, where Will had been consulted, and it was he, the local Medical Officer of Health and distinguished epidemiologist, who had alerted authority to the arrival of influenza.

I have spoken at some length of my experience in Wensleydale because it was here that Will seized responsibility as a general practitioner in 1913, and here that I began to understand the responsibilities of a personal doctor as opposed to a doctor working in a hierarchical team. I had no vocational training, but I did learn a great deal from the squadron commanders and the venerable stretcher-bearer sergeant, who knew their men in the same way that Will knew every man, woman and child in the dale.

The responsibility of a general practitioner

I propose now to attempt to consider the nature of the responsibility of a general practitioner. It is so fundamental to general practice that if we cannot at least guide young doctors to understand it, our ideas about vocational training for general practice may not be valid at all.

In 1913 or even in 1943 the role of a general practitioner was relatively clear cut. He would be a respected and learned member of his community, and, except in cases of major surgery, he would provide total and continuing medical care day and night for the whole year, except for the fortnight when he took his family to the sea. Emotionally many of us still see ourselves in this image, but it is no longer tenable. Particularly for those of us who have accepted responsibilities for guiding the next generation of doctors it is important to understand how the general practitioner's role has changed.

Of the factors that have brought about this change I put the following as the most important. First, the increased sophistication of medicine has resulted in the general practitioner being increasingly dependent on experts in his own profession. Secondly, the tendency to work in groups, to have duty rotas, and to delegate to supporting ancillary workers, has made a myth of the 168-hour working week. Thirdly, the rising standard of living and increased demand for leisure has changed the pattern of life in all sections of the population. Fourthly, we no longer form an outstandingly learned element in society. It is in this context that we should examine our role, and not that which held when we qualified; nevertheless there is no doubt that we have a special responsibility, and one that our patients expect us to accept.

I believe that the arrival of the so-called Welfare State in the United Kingdom is only incidental to the changed situation in which we find ourselves, and which we share with all western countries.

Opinions of friends

To help me to clarify my ideas about a general practitioner's responsibility I wrote to a number of friends of different ages, but all with considerable experience of general practice, and canvassed their views. I am grateful to them, for they all replied at length. On first reading their replies I was amazed at their disparity; they varied from the dogmatic to the cold and practical, and on to the emotional and philosophical. The only thing the letters seemed to have in common was that the writer had in each case drawn a pen picture of himself that was so clear that he could be identified if his name and address had been removed.

On reading these letters a second time I realised that in fact my friends were all in close agreement about their responsibility. In the same way that each of them no doubt expresses his own personality in his individual approach to patients and their problems, so they expressed their common understanding of a doctor's responsibility in differing ways.

All my correspondents would certainly be accepted as teachers by the College's criteria, but, as their characters are so different, would they all be able to guide and teach any trainee? A gross incompatibility between a teacher and his trainee is not common, but a young doctor should have the opportunity to develop his own personality by working with various doctors, particularly the partners of his official teacher.

Young doctors

It is possible to tabulate the responsibilities of a doctor under various headings—to his patients, his immediate colleagues, his profession locally, his profession nationally, his state, his family, and finally, to himself. None of these factors can be considered in isolation, for they are all interrelated, and it is not their sum but their interwoven pattern that produces the character and ethics of the whole man. The need for the young doctor is to establish his own priorities and arrive at a balanced judgment, a process that may take many years.

The decision must be his alone, but I am sure that he can be guided to the answer that best suits him by discussions with his contemporaries on courses, and his teacher and his partners in their consulting rooms. In whatever branch of medicine a young graduate aspires to practise, he will have to accept heavy responsibilities, and his judgments, if wrong, will lead to suffering or even death. The nature of his judgment will vary from a highly technical decision based on knowledge, skill, and experience by, for example, a haematologist, to that broader judgment of the general practitioner which, though also based on knowledge, skill and experience, must include attitudes.

The hospital specialist, whether working in a scientific or a clinical field, will develop his power of judgment, and thus his ability to accept responsibility, by progressing slowly, some would say too slowly, through the various stages of training in a hierarchy, working in the relatively cloistered atmosphere of a hospital.

The shock of entering practice

The future general practitioner will have worked as a lowly member of various hospital teams, during which time he will have developed appropriate knowledge and skills, but he will not have been called on to take ultimate responsibility for his patients. Traditionally he is then taken out of the hospital and becomes overnight an independent medical contractor, responsible for his decisions only to himself. He will no doubt

have considered his future role as a general practitioner, but the reality may come as a rude shock.

It is this sudden transition that distinguishes the problems a general practitioner has in assuming responsibility from most other doctors. A main purpose of the trainee year is to provide a young doctor with an opportunity to pass easily through this stage, and to consider his future role in a situation where he can practise good medicine without being under undue pressure of work. If this traineeship is to be successful it is vital that his teachers have a clear idea of the major problems that he will have to face in adapting to his new environment.

Abortions

I am reminded of a young doctor who recently completed one of our courses of training in Wessex. He told me that when he was working as a junior member of an obstetric and gynaecology unit, he willingly accepted the duty of assisting at terminations of pregnancy, which he regarded as nothing more than a technical procedure.

When he became a trainee he was confronted by the same problem, and found that he was no longer a technician, but a doctor who had to advise in the light of complicated emotional situations which affected a number of people. As a junior member of a hospital team he had acquired knowledge and technical skills relevant to termination, but he had learnt nothing about the total situation for which his chief, and not he, was accepting responsibility. Thus it was in general rather than hospital practice that he had to develop those attitudes that would enable him to make a responsible judgment in the light of the total situation.

This story illustrates that though much can be written and said about the doctor-patient relationship, and about the responsibility of the doctor, personal attidudes can only be developed by taking responsibility. What is important is that the trainee should be allowed to work slowly, to think about the various situations in which he finds himself, and have the opportunity to discuss his problems with some more experienced person.

Total responsibility

Several of the friends to whom I wrote said uncompromisingly that a doctor's responsibility to his patient is total. In the sense that total means that responsibility for the overall and continuing guidance of the patient must be accepted I am sure they are right. The young doctor has to learn the art of guiding the patient and how to avoid various pitfalls. He must learn to use his knowledge to the best advantage, and personally to carry care as far, but no further, than those skills allow him.

He must be willing to take advice when specialist knowledge is called for, and at the same time avoid unnecessary referral. He must learn how to speak firmly and critically if need be without losing the patient's confidence, and how to break down delicately the often flimsy barriers that patients will erect, and enter the private part of ill health, and discuss the worries of marriage breakdown, bereavement and impending death.

While he learns to do this he must avoid the danger of becoming too emotionally involved in his patients' problems. He must learn not to take the easy way and become unduly subservient to his patients' requests; to do this leads to perpetual work, and to a dissatisfied, unhappy and less effective doctor. Though the establishment of a good doctor-patient relationship is vital to success I shall say no more about it now. The subject has been discussed better than I could ever do it in *The Future General Practitioner —Learning and Teaching* which should be read by all who wish to teach about or become general practitioners (Royal College of General Practitioners, 1972). The essence of the problem lies in the college motto, *Cum Scientia Caritas*, and is a matter of striking a true balance between knowledge and skills and tender loving care.

Responsibility via the general-practice team

Few general practitioners in the United Kingdom now enter single-handed practice, the great majority become members of a partnership. Usually the partners will be supported by a team, of which they themselves will be a part. This team will, in contradistinction to the hierarchical hospital team, be divided horizontally into doctors, nurses, and administrative staff.

The young doctor will have to learn his responsibilities within this team, which is likely to be his professional home for the rest of his career. Though his primary professional duty will be to his own patients, he should have a secondary duty to the patients of his partners, for whom he should have to care when his colleagues are off duty or on holiday.

I use the word 'should' advisedly, because I am alarmed to hear that in many areas this responsibility is being delegated to anonymous doctors working in deputising services. Despite enthusiasm and knowledge he must learn not to disturb delicate doctor-patient relationships that have been built up by trial and error over the years; relationships based on art rather than science, which allow the patient to accept with equanimity the real or imaginary problems of life.

Once accepted into a group there is no room for the man who opts out and does his own thing; he is a loner, and would be best working single handed. The essence of success is in democratic discussion, in continuing self criticism, and in auditing the work of the practice. It is important to understand that the nurses, secretaries and receptionists should take part in this process, as they are all involved in the care of patients and from their differing viewpoints will have important suggestions to make about the policy of the practice.

Responsibility outside the general practice

As he has a duty towards his own team, so the young doctor must have a duty to use properly the supporting services that are available in the community and the local hospital. The community nursing services will be members of his own team, but the social services will probably not be. He must know what all these services are able to do, for he must mobilise them for the benefit of his patients, and at the same time ensure that he does not waste his own professional time in carrying out tasks that others are better trained to undertake.

The hospital service is there to help him care for his patients—but only for those who require hospital care. Hospitals are remarkably expensive institutions, and patients as a whole are frightened of them. His duty is first to keep his patients out of hospital by investigating and treating them himself, and secondly, carefully to select those who must have specialised attention.

Too many able practitioners do not see their professional responsibility extending beyond the care of their patients and loyalty to their own practice. Some even hold colleagues with wider professional interests in mild contempt. Medicine is never static, and all of us have a duty to see that it develops in the best way. It is the practising doctor who is best able to judge how this development should take place, whether in the field of clinical medicine or in the organisation of delivery of medical care.

Each doctor must judge for himself what his own contribution should be to his profession as a whole. It can be in advising the administrators and trying to ensure that limited medical resources are deployed for the best benefit of the patient, a proper activity often contemptuously referred to as medical politics. It can be in the field of organised curiosity in the hope of making a contribution to total knowledge, or it can be in finding time to hand on knowledge and experience to others—teaching in general practice.

No one is likely to find time to work in all these areas and still care efficiently for

his patients, but all trainees should be encouraged to be aware of these problems, and take an interest in at least one of them, and thus broaden their outlook. Without people of wide interest this College would never have been founded.

The doctor as an individual

We must also consider the doctor as an individual and a citizen. If he devotes himself too much to his patients, his team and his profession, he is in danger of becoming narrow in outlook, introverted, and dull, and in the long run his ability to care for patients may suffer.

He should therefore maintain some interests or hobbies outside medicine where he can relax and recharge his battery. Whether these leisure activities are carried out privately, for example gardening or photography, or more publicly, for example running the local flower show or Christmas pantomime, does not matter. What does matter is that he remains a whole man and not an introverted expert.

The general practitioner is no longer an unusually learned member of the community in which he works, but he will be expected to be informed about appropriate national problems of which his increasingly educated patients will be aware. For example, if the national press is reporting some aspect of pollution he should be able to express a balanced view that will give rise neither to hysteria nor complacency, if his patients ask for his opinion.

Financial responsibility

It is easy for the young doctor to forget that he has a responsibility to the national purse. The cost of the National Health Service is about £2,500 million a year, but this expense is initiated by the 20,000 general practitioners, an average of £125,000 each a year. In the national interest he has a duty to consider and justify that part that is controllable, for instance in over-prescribing, over-investigating and over-hospitalising. Before 1948 he would have learnt this from his patients, who would soon have let him know—and perhaps changed to another physician– if his advice resulted in too heavy expenditure.

A considerable part of the cost of the health service is generated by highly sophisticated techniques such as neonatal and transplant surgery—the marvels of modern medicine. When they should be used, or whether they should be used at all, depends not only on resources but on difficult ethical considerations. The specialist will hesitate to withold his skills, the relatives of the patient will hesitate to call a halt. In individual cases the general practitioner can do much to mediate and reconcile the demands of scarce resources, and the future prospects of the patient and his family. We shall achieve little if we make a hardly viable baby into a human cabbage, but much if we can give that baby a chance of a useful happy life.

Family responsibility

Because a doctor's professional responsibilities and his potential work load are heavy, many of us have tended to neglect our responsibilities to our families. Some would say that with longer holidays, weekend and night rotas, we are swinging too far the other way. We should remember, however, that Pickles and Dunbar shared their patients, and took turns to visit their various parishes. On the other hand, there will always be instances when very worried or very sick people must be seen by their own doctor regardless of rotas and off duty. We older doctors must understand the problems of our younger colleagues and their families, who will work in a society where the 35-hour, four-day week will be the norm.

I am reminded of a doctor I knew, who is now dead, who gave too little to his family and too much to his patients, and of how he left an important family dinner party abruptly

to attend a sudden death. Later he rejoined us after consoling the bereaved and arranging for the undertaker to measure the corpse for a coffin. You might say that this was an example of true devoted doctoring, but you might change your mind when I tell you that the deceased was a pet dog.

Accepting responsibility

I have tried to show that the general practitioner has many responsibilities, but they all come together in his responsibility to himself. Success or failure, happiness or unhappiness will depend on his conscience, his ethics and his ability to criticise and understand himself. He must learn to maintain the standards that he will have set himself as a young man, and through continuing study keep his knowledge and skill up to date. He must learn to maintain a proper balance between his triple roles of citizen, family man and physician. He must learn to use his talents as best he can, and the greater his talents the greater his responsibilities.

Is the doctor's ability to accept responsibility a talent that he is born with, does it depend on his environment, can it only be understood through experience, or can it be taught? I believe that all four factors are relevant, but that we can do much as teachers to encourage its quicker development.

Student selection

Many doctors are suspicious and even resentful of the methods used nowadays in selecting medical students which lay some emphasis on success in A level examinations. They say that it leads to selection of the academically able, and excludes those born into and nurtured in medical families.

At the medical school at Nottingham 40 students selected on grounds of academic ability, personality, motivation and general interests, were studied. Though they were found to have a high degree of literacy it was not possible to correlate their selection with the benefits of an upper social class upbringing, medical parentage, or a classical education (Olson *et al.*, 1973).

I know of no evidence that supports the view that doctor's sons because of their ecology necessarily make the best doctors of the next generation Though some of our children will choose to follow in their father's footsteps, others, equally able, are just as likely to make a positive decision to do anything but medicine, and become, for example, railwaymen.

Only the academically able can survive the rigours of the medical curriculum, but in the modern profession there is plenty of room for the technically minded medical scientist, and also for the more humane person who will choose general practice. Among those who have been selected and who eventually qualify both will be found.

Southampton University

In the medical school of Southampton University, with which I am associated, general practitioners will make a considerable contribution to the teaching of undergraduates. The course lasts five years, and in the first, students are taken to see patients in their homes, accompanied by a general practitioner.

The purpose is not to 'teach medicine', but to allow the student to begin to learn how to communicate with people, and to see the social and economic impact of illness on an individual and his family. In the third year, students will study in turn the major clinical disciplines, but once each week will visit a general practitioner. Not to 'learn general practice', but to see that the roles of the hospital service and the community service are complementary. To see, for example, that the treatment of severe depression is not just a matter of giving ECT and administering drugs, but a problem of long-term support for the patient and his family by a team of doctors, nurses and social workers.

During the fourth year each student will make a study in depth of a chosen subject, and this could involve work in a selected practice to find epidemiological information. He will learn not 'research in general practice', but that the morbidity seen in hospital is only a part of the iceberg of disease. In the fifth and final year the student will spend possibly two weeks in a practice; this period will be comparable to the clinical clerkship that he will carry out in the various departments of district hospitals.

Because we propose to make use of these teaching opportunities in general practice, we are already being talked of as a 'medical school to train general practitioners.' We are attempting no more than the General Medical Council (1967) asked us to do, "The object of this basic medical education should therefore be to provide doctors with all that is appropriate to the understanding of medicine as an evolving science and art. and to provide a basis for future vocational training."

Without experience of general practice you cannot claim to have provided "all that is appropriate." It is right that all students should have an opportunity to see the potential of a career in general practice, and all doctors should know something of the work of the community medical services. As a result, some will be attracted to general practice as a career, but it is equally important that others should be warned off at an early stage.

Undergraduate teaching has little to do with learning how to take responsibility, the student is in many ways only looking at medicine through a window. He observes, but has little responsibility, and as a result may underestimate its importance. The interest of the undergraduate tends to be in making an accurate diagnosis in contra-distinction to the young doctor who wants to know how to manage the situation.

In a recent report one of our trainees in Wessex pointed out that her undergraduate experience in psychiatry had been of a "showcase of diseases", but that in her post-graduate training she had learnt how people react to situations, of the relationship within families, and of the countless ways in which psychological disturbances present and of the need for her to know how to manage them. If responsibility can be taught it can be done best through example and by experience in the early postgraduate years.

Postgraduate experience of general practice

I have said that experience of general practice is necessary to broaden the understanding of all doctors. Similarly I believe that some postgraduate experience of general practice will help future consultants understand their patients and their needs, and avoid the situation that Laurence Weed (1969) refers to "There is nothing more tragic than the 'brilliant' specialist, over-confident of his knowledge and techniques, who, failing to comprehend the nature of his responsibility, fails also to treat the trusting patient in the light of his total needs." I am comforted to learn that, at least in some circles, the senior registrar with general-practice experience is looked upon with favour when he applies for a consultant post.

Vocational training can be broadly divided into one part that takes place in practice, and another that takes place elsewhere—for instance, in hospital. Of the latter I have little to say. It is a period when certain essential skills and knowledge are learnt, but I would warn against the danger of becoming obsessed with 'correct' hospital rotations. For some these rotations are excellent, but different doctors will mature in different ways, and it is maturity that is the vital factor in developing a sense of responsibility.

We must therefore always be willing to accept into general practice and into this College, people who have tried other careers in medicine, and those who, with a spirit of adventure, have worked overseas, or even journeyed to the poles. Perhaps these will have less need for apprenticeship in general practice than those who have chosen a more conventional training.

It is the apprentice or trainee year which is central to the idea of vocational training. This is the time when the young doctor is thrown into the sea of reality of practice, albeit supported by a life-line held by his trainer. No longer is he observing practice through a window, but dealing himself with the varied problems of patients, and forced to make responsible decisions.

The two main elements in the training year are firstly the teacher to whom the young doctor is attached, and secondly the opportunities for group education. The ways in which teacher and teaching practice should be selected have been described by a working party of the Council for Postgraduate Medical Education in England and Wales (1970). There are still many problems to resolve, but whatever is decided, it will be the quality of the teacher that will matter most, even though his ability to demonstrate what is best in general practice may be affected by the circumstances of his practice and the abilities of those with whom he works. We must not therefore discard the single-handed practitioner, or the good man who, for no fault of his own, works in poor premises.

Obviously we must select teachers who are good doctors by commonly accepted criteria, but above that they must have a desire to teach, patience, and an understanding of the problems and difficulties that beset the new entrant to practice. It is not always easy to allow someone else to practise medicine on one's own patients, but unless the trainee is given an opportunity to accept responsibility he will never understand it.

The most important teaching method is to allow time, each day, for discussion. In this time the timid must be given encouragement, and the over-confident must be curbed. If teacher and taught can develop mutual respect they will, from time to time, reverse their role.

Group education includes consideration of problems of the doctor's responsibility to his team, to the future development of the health services, and to the needs of society. Though some parts of formal courses may be dealt with in a didactic way, these should be relatively undertaught. In these situations we are dealing with concepts rather than facts, and though people with appropriate expertise may present their case, the success of the learning situation will depend on interchange of opinion between members of the class.

Perhaps the greatest value of a course is that it brings young doctors embarking on a new experience together, and it is when they are unguided that they begin to discover the nature of their new responsibilities. Their own peers working in different situations lead them to examine their own values—perhaps for the first time.

Multiple responsibilities

I have tried to show that the responsibility of a general practitioner is complicated, and is compounded of duties to patients, profession, society, family, and self. Some assume the mantle of responsibility naturally and instinctively, for others it is more difficult. No one can teach someone what is more concept than fact, but we can provide an opportunity where the nature of responsibility can be understood. The main ingredients required are a good example to follow, time to think, time to discuss, and a chance to practise.

Let us go back to Will with his wife Gertie in his Yorkshire dale where he assumed responsibility and developed his talents. He accepted his duty to care for and know his patients, and accepted responsibility for the public health of his area. Like John Snow, he stopped an outbreak of typhoid by locking up the village pump. He was a pioneer of continuing education, with his doctors' parties at which distinguished doctors spoke in the sitting room at Town Ends. He served his local profession on the executive council, and, according to Dr Eddison of Bedale was "very good—persuasive and tactful". He learnt from his experience, recorded faithfully what he saw, and was thus able

to make contributions of international importance to medicine. He was truly a great and responsible general practitioner.

Would he have made a good trainer? I am sure he would, through his knowledge of and sympathy for his patients and his high standards. He would have been firm with his pupil. It is recorded that even his customary urbanity disappeared when a locum complained of the patients exaggerating, malingering, or not carrying out treatment. "You can't" he said, "treat these people like that. I've known them for a lifetime—they're good people" (Pemberton, 1970).

Will's responsibility was to himself and his patients, and I don't suppose he would wish a better epitaph than was said to me by an old lady outside whose house I stood and looked over the Yure to the moors beyond. "He was our doctor and he cared for us for over 50 years. You must go down to the green and see the plaque the doctors set up about him".

WILL PICKLES *C.B.E.*, M.D.
1885–1969
Family Doctor, Epidemiologist
and first President of the
Royal College of General Practitioners
Lived and worked in this dale
Cum Scientia Caritas

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To the many friends I have made through my interest in postgraduate education and to whom I have given insufficient credit.

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