Editorials

CONSULTATION AND EDUCATION

CLINICAL medicine is concerned with defining and mitigating health problems. To achieve any degree of competence in this, the student—on either side of the watershed of graduation—must not only acquire an inbuilt corpus of factual knowledge, but must also develop his faculties of perception, his ability to handle information and concepts, his motor skills, and his attitudes to interpersonal relationships, to society, to illness, and to death.

Self evidently, this requires in turn not only a wide field of clinical experience, but also a critical observation by his teacher of what the student does, and how he does it. ' Self-evidently ' since, while the shortfall of which the student is himself aware is already on the way to correction, it is the shortfall of which he is *not* aware that matters more.

This holds, of course, not only for the childhood, but also for the adolescence and adult life of clinical practice, for the ' established ' practitioner as well as the vocational trainee and the student. Any clinician—be he consultant or general practitioner—who is unable to expose himself to the critical comment of his colleagues is a potential menace to his patients—it is perhaps one of the functions of the College Faculties—as yet, little exercised—to foster the development of small groups of practitioners who use the help of neighbouring colleagues as external assessors of their practice habits.

But here the rub lies—in the essential privacy of consultation for, as Sir James Spence (1960) remarked, the practice of medicine is not a matter of laboratories, of wards, or of health centres. Instead, " the essential unit of practice is the occasion when, in the intimacy of the consulting room, a person who is ill or believes himself to be ill seeks the advice of a doctor whom he trusts." This element of privacy, of person-to-person contact, is particularly evident in general practice. Indeed, the restoration of an holistic approach to patients' problems has come about, in no small measure, from the emphasis which general-practitioner teaching has laid on the personalised, private character of the consultation.

Consultation is seen rightly as an activity between *two* people. Education and training demand an activity involving *three* (or more). To some degree, therefore, the latter cannot be achieved without disturbing the former.

Various teaching techniques have been developed to circumvent this dilemma. Simulated situations are being widely used in individual and in group learning. The use of case histories to develop skill in ' extended diagnosis ' was powerfully stimulated by the work of Balint. Others are exploring the use of audiotapes, of videotapes, and of direct observation from outside the consultation room. Bounded though they are by ethical constraints, these are nevertheless useful adjunctive methods which remove the presence of a third party at consultation.

But they remain adjuncts. And the involvements of students and trainees in active consultation remains an essential component of both education and training.

The problems which this involvement poses for patients, for teachers, and for students have not yet been adequately explored. One may reasonably assume, for

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example, that the clinical behaviour of both teacher and student is different from what it would be if the other were not present. But in what ways? Are clinical histories taken differently?—examinations differently performed—or investigations differently used? More important, what are the constraints experienced by the patient? How do these affect both the process and the outcome of consultation? There is some evidence that the psychological and social components of discussion are the ones that are more likely to be affected; and that women patients are more sensitive in this than men (Wright, 1974). But how far the impact of a third person is influenced by the pre-existent relationship obtaining between patient and doctor, by the status of the observer, by practice traditions and circumstances and by a host of other factors, remains largely unknown.

Perhaps it is time that this was looked at more closely.

REFERENCES

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LONDON AT LAST

TWO leading London medical schools have at last created chairs of general practice. St. Thomas's have appointed their Reader in General Practice, Dr D. C. Morrell, and Guy's have appointed Dr P. M. Higgins, a Senior Lecturer on the Thamesmead project.

About a third of all the medical schools in the United Kingdom are in London and about half the medical graduates in England are trained in this one city. London ideas about medical education permeate throughout the English-speaking world.

It has therefore been surprising and regrettable that for so long London has lagged behind. Scotland took the lead and now with the new chair at Glasgow has a professor of general practice in all its four clinical medical schools. At a time when half the doctors in this country are likely to practise in the community, the need for a department of general practice in every medical school is clear.

We have commented before (October 1973 *Journal*) that general practice has special problems in big cities, an idea which has recently been echoed by the Lane report (1974). Providing a primary-care service that is both accessible and able to supply continuing care to a highly mobile population remains a challenge that has not yet generally been met. Clearly there is a need for new energy and academic departments with new ideas may help to solve some of these besetting problems.

It is too soon to know whether the solutions will emerge on traditional lines as at St. Thomas's or whether a more radical view should be taken as at Guy's, where Professor Higgins is developing some interesting new ideas.

It is a particular pleasure to see Dr Morrell's promotion. His concern with the day-to-day care of patients is well known. Despite the heavy burden of university administration, he works hard in his own practice with a heavily booked surgery every day.

University departments alone may not be able to solve the problems of general practice in London and the College and other interested bodies must also play their part. Nevertheless without strong professional departments neutralising the traditional domination of the London teaching hospitals, proper progress cannot be made.