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What every doctor knows

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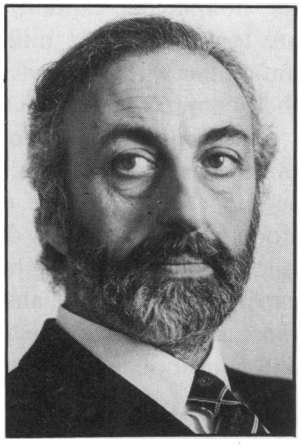

THE William Pickles lectures are concerned with educational themes, and I want to attempt something which does not appear to have been done before. I propose to take a hard look at the way education strategies overall are being used to influence the practice of family medicine. In the course of this appraisal I shall be noting some of the shortcomings, as I see them, in what is taught and how it is being done. Because I regard general practice as essentially a postgraduate subject, I shall not be dealing with aspects of undergraduate teaching. There will be nothing new or particularly revealing in what I have to say. The title of my lecture means just what it says: What every doctor knows. And, incidentally, by 'doctor' I am naturally referring to proper doctors; that is to say, general practitioners.

This will be largely a personal testimony, one individual's view of things; with no references, no attributions, and no statistics. This hardly confers any scientific merit on my lecture, and one can imagine the disdain of our academic colleagues. But I am afraid there is worse to come. This is to be a completely anecdotal account, with no report of studies or surveys. It is one doctor's journey; an individual's experiences and his reflections on general practice education.

Disciplined scepticism

However, I should hate it to be thought totally devoid of science. Words such as 'science' and 'research' can sound intimidating, but become less so when, for example, research is understood as organized curiosity. In the same way, I felt encouraged when I heard science described as disciplined scepticism; because this is just what I want to bring to bear on the subject of general practice education.

I shall obviously do my best to keep my fire as accurate as possible, but I must apologize in advance to those who might feel wounded as a result of any ricochets. My principal targets are certain concepts and practices, not people. Least of all, people I have been privileged to work with as colleagues, and proud to know as friends. My criticisms are directed primarily at what I consider to be muddled thinking and false priorities.

Learning about education

When I first entered general practice in the Fifties, I rapidly became aware of the defeatism among coughs and colds doctors and among those others who resented having to run a complaints department 24 hours a day, 365 days a year. Their broken spirits resembled those of Tennyson's lotus-eaters, who wailed:

> 'Why are we weighed upon with heaviness
> And utterly consumed with sharp distress,
> While all things else have rest from weariness?
> All things have rest: why should we toil alone,
> We only toil?'

However, I survived this unpromising baptism, attended lots of courses, joined a Balint seminar, and exchanged experiences with other doctors. You used to have to be in general practice at least 10 years before you could even begin to be considered as a trainer, but I applied as soon as I could and underwent some further education, 'resourced' by nearly 20 trainees who passed through my hands. Or did I pass through theirs?

Attending workshops, organizing trainers' courses, and running sessions for trainees on their half-day release were further learning elements. Eventually, with the Joint Committee, I became involved in assessing trainers, and in the inspection of training schemes nationwide. I had become conversant with postgraduate education at all levels; but the best thing about it was that I had succeeded in remaining a practising doctor, a practising trainer, organizer and assessor.

Part of my education about medical education was obtained in travels to Third World countries while I was the College's Dean of Studies. Doctors in private practice in those countries felt under some threat both from government health agencies and from the native physicians, and they sought advice from us on how to protect their status. The West had done its usual job of exporting its medical tower blocks, and the general practitioners now felt in need of academic respectability. They already had a College, but they wanted a College examination—for future members; and, of course, a university department of general practice. They had heard about such developments in Britain. How it had come about that general practice, a craft-based discipline with a particular approach to patients' problems, should one day find itself regarded as a suitable subject for university teaching. And in the United States, McDonalds, the fast-food chain, had founded the Hamburger University and was now issuing diplomas in french fries. It was understandable, therefore, that doctors in the Third World should look on these acquisitions as conferring the seal of academic approval.

Where are we heading?

As a result of such experiences, and many others accumulated over a period of 25 years, I gradually formed a view about where we were with education for general practice, and where we seemed to be heading. I cannot claim any profound thoughts, but I have thought hard and long. And what I think, is this.

The promise has simply not been fulfilled. For the most part, continuing education remains inappropriate and is undertaken desultorily, if at all. As for postgraduate training, the early enthusiasms and ideals have in large measure led to disillusionment. The pioneering architects can only look on with dismay at the way their original exciting plans have been employed to erect the present jerry-built edifice we call vocational training. What should have developed into a process of continuous experiment in adult education, rooted in practical experience, has turned into a system of student training whose most notable feature to many observers is that it satisfies the requirements of the academic and bureaucratic juggernauts which now so strongly influence it.

In the remainder of this lecture I shall try to show how, in my opinion, this state of affairs has arisen; and what, if anything, can now be done about it. The factors I shall be discussing are not all educational; many have to do with medical practice. Indeed, a point I shall be making is the increasing tendency to separate teaching from the ordinary activities of family medicine; the widening gap between preaching and practice.

The rapidity of changes in social attitudes and medical practice may take us by surprise. Who, 20 years ago, would have guessed the present extent of our medicalization of people's ordinary troubles; or the professionalization of the merest human gesture of help?

Education should reflect changes in the way we practise. But in claiming for education the role of pacesetter, some academicians go further and would direct general practice along certain paths. We are continually being offered visions of the future, by enthusiasts for one particular approach or another, and assured that this is the way family medicine must move.

Yesterday it was the community care unit, a veritable hypermarket of health facilities which would rid us once and for all of the despised designation, 'cottage industry'. Today, the expanded primary health care team is the answer, with the general practitioner very often as the nonplaying captain. Tomorrow, microcomputers are to usher in the millennium. We doctors are not unfamiliar with panaceas. In therapeutics, we have seen their counterparts come and go.

The suggested reforms are not necessarily bad in themselves, but they are promoted in such a way as to suggest that, instead of evolving along broadly understood lines—what every doctor knows—general practice is to proceed according to the lights of a select few: the experts, the theoreticians, the academicians; including those from outside medicine, such as social scientists and educationalists.

Outside experts

The latter group already influence the content and process of vocational training and, to a lesser extent, continuing education. These fields were entered by experts who came, let it be said, by invitation, and who found virgin territory in which to practise their talents. They were brought in during the Seventies, at a time when formal teaching in family medicine was in its infancy. The unsureness of trainers, tutors, and organizers perhaps explains their avidity for the new doctrines, and why most of them proceed to lap up the gobbledygook.

Nowhere did this influence express itself more starkly than in the application of educational theory to the practical task of training future general practitioners. The euphoria it induced in many of our own people was truly remarkable. To say that they were infatuated with educational theory would be an understatement. They behaved as if they were besotted: in love with love itself. It was pitiful to behold first-class, able, natural teachers fumbling awkwardly as they strove to conform to the current ideology and to master the appalling jargon.

In regretting the uncritical acceptance of certain doctrines emanating from the fields of sociology, education and psychology, I am not suggesting that there have not been valuable contributions from these disciplines. As generalists, we can never be self-sufficient: our discipline overlaps with too many others for that. But we can be more self-reliant, and place greater value on what we already know collectively. Until we do so, we shall not properly advance our own discipline.

I can best illustrate what I mean by reference to an analogous problem experienced by the distinguished

American physician Alvan Feinstein. He was having trouble, not with the new sciences of sociology and psychology, but with basic clinical science itself. In his book, *Clinical judgement,* he wrote:

> 'The clinician has been taught to believe that basic clinical science includes all of biology except the clinical treatment of patients; that basic clinical science comes from manipulating a dog, fish, pigeon or cell, but not from talking to a person; and that basic clinical science is a birthright granted in the laboratory and lost at the bedside or in the community.'

He concluded:

> 'The clinician has an ancient and honourable heritage, a tradition of enlightened thought and achievement, and a domain whose humanistic and scientific complexity can challenge the most demanding intellect or spirit, at levels of fundamental enquiry. He need not look for basic science elsewhere. He can make his own.'

Just so. And we general practitioners need not look for the new sciences elsewhere. We can make our own sociology, our own educational psychology; if only we were prepared to tap our rich heritage—what every doctor knows.

Priorities in continuing education

From time to time we see a spate of earnest activity inspired by the College and designed to assist doctors, whether Members or not, along certain paths. What this reveals about our priorities is very interesting. We combine trying to teach grandmothers to suck eggs, with portentous statements on a more majestic scale, in keeping with the very proper ambition to make an impact on the national and international stage. Thus: fluoride is good for you; nuclear war, on the other hand, is bad for you; as for experimentation on live human embryos, that does not bear thinking about; to take just three issues on which we, as a College, have felt constrained to pronounce.

At the level of everyday work in the surgery, instead of finding ever new things for us to do, one could wish for help with the problematical areas we already have. Prescribing, for example, is something many of us are doing dozens of times each working day. Opinion varies on whether it is generally good, bad, or indifferent; but there is growing concern about some aspects of it. On any objective view we would have to admit, not in public of course, and never by our medicopolitical leaders, that some general practice prescribing is a nonsense; often an expensive nonsense, occasionally a dangerous nonsense. We try to obey the injunction, firstly do no harm; but we cannot deny that prescribing is not always accompanied by the gravitas it deserves. The very term, prescribing habit, suggests a certain programming of behaviour, if not a completely automatic pilot. Pressures on us to prescribe show no sign of letting up. Some are subtle, some not so subtle. We imagine that brash and gaudy drug advertising does not influence us. But can we be sure? An awful lot of money is devoted to it by the manufacturers. Do they know something we do not? Our College is now talking in a friendly fashion to the pharmaceutical industry, but we do not hear of plans for joint research into the effects of advertising; or of other studies which could prove of great educational value to us.

I have singled out prescribing because improvements in this area could lead directly and promptly to tangible benefits for our patients. We clearly need appropriate and continuing educational input to discharge this particular onerous responsibility. Responsible prescribing will inevitably mean less prescribing; but there is more to Medicine than medicines, as every doctor knows.

A great deal is said and written about standards in general practice and the quality of service. There has been an almost illiterate use of these terms, which are badly overworked. The feeling is growing that it is perhaps time to come off the gold standard and leave the pursuit of excellence—which threatens to be the enemy of the merely good in general practice—to the occupants of ivory towers; while the rest of us get on with those slight, undramatic shifts which promise the greatest good for the greatest number.

The potential territory of general practice is enormous, and we shall always remain vulnerable to incursions by those who can do particular bits of it better than we can ourselves; whether they be from hospital-based services, community health clinics, or even self-help groups. We cannot hope to protect all our frontiers, and it may be wiser to give up trying to define our territory in terms of particular clinical activities or the depth to which we ordinarily take them. Our work is still very largely determined, perhaps defined, by whatever our patients choose to bring us.

Education or training?

What bearing does this have on our educational programmes? Just this. Since we cannot hope to ensure that our trainees will be totally adequate in every possible situation they may encounter in the course of their professional lives, their teaching should equip them with the ability and the drive to seek out the skills and information they will find themselves needing when they are on their own. In other words, the emphasis should remain on education rather than on training.

Vocational training is of course one of the College's success stories, somewhat soured by reflection on the means which had to be adopted to make it universal. There is little point in now going into the background to the haste with which the regulations were finally introduced, but it had the effect of virtually fossilizing training in the form it happened to have reached at that moment. Training schemes are now look-alike, and opportunities for comparative studies are becoming fewer. Moreover, the crucial question, whether vocational training really does confer substantial and long-lasting advantages, remains unanswered.

To be sure, there have been studies which purport to

show that trainees benefit from their training; and that superior trainers produce trainees who benefit most. But was the assessment of benefit and superiority based on the way patients were managed or practices run? Not at all. In an incredibly circular argument, MRCGP examination techniques were used to provide the criteria. Better trainers, that is those with higher MCQ and MEQ scores, produced the greatest improvement pre-course to post-course in their trainees; judged, naturally, by *their* MCQ and MEQ scores.

The begged questions and self-fulfilling prophecies in this type of study take one's breath away; but these things can happen when a myopic view of particulars is not balanced by a wider commonsense perspective. It is the old story of carefully thought out means towards carelessly thought out ends. At all events, I remain unimpressed by the so-called evidence of the effectiveness of vocational training; and I believe that those who are impressed are scarcely showing any more perspicacity than the young man who was convinced that his dandruff was brought on by wearing a blue serge jacket.

I find it faintly ominous that there should be so little eagerness, among those at the top, to conduct a proper study which would enable us to discover whether we were on the right track with our present methods of vocational training. Impressed with the example of one of our sister Colleges, I once tried, unsuccessfully, to persuade our own College to do a limited survey of all recently established principals within certain FPC areas, to find out how those doctors now regarded their vocational training in the light of their experience as full principals. A modest-enough exercise, and admittedly subjective, it would have been a start in evaluating vocational training, not by pattern recognition or in terms of marks obtained in a classroom, but by being matched against the demands of real-life general practice.

Looking more closely at vocational training, the term itself calls for comment. We speak of undergraduate education, and of the continuing education of established practitioners. But why should the intervening phase be referred to as 'training'? The usual explanation is that training has to do with inculcating the knowledge, skills and attitudes necessary for carrying out already identified tasks. Is there anything more to this than semantics? For an answer, I look at some of the other contexts in which the term training is used. For example: soldiers are trained to withstand the heat of battle; certain plants are trained to climb along walls in a particular way; circus dogs are trained to jump through blazing hoops; some babies are potty-trained. The common feature appears to be that at the conclusion of training, the individual concerned can be relied upon to perform without thinking.

Is there a hint here of what seems to be the desired outcome of vocational training today; with its emphasis on the behavioural aspects, on performing? As with trainees, so with trainers. Educators today are meant to be doers, and to display an interventionist style of teaching, something demonstrably active; for there is a horror of the atmosphere of *laissez-faire* which characterized the early days of general practice training.

The system of apprenticeship has acquired a bad name—unjustifiably, in my opinion. There is much to be said for the pastoral approach in general practice; with trainees as well as with patients. This does not mean the good shepherd squatting on the hillside, gazing into the distance. It entails watchfulness, preparing, checking, but in a low-profile way and with minimal interference.

Instruction and experience

This approach would not, of course, satisfy the activists among us, who feel we cannot justify our existence as doctors or as teachers unless we are seen to be busy doing something. But training in our field should be solidly based on experience, not instruction. Supervised experience. It is the supervision which is the hard work and which justifies our existence as trainers. Experience with patients is crucial, and there can never be too much of it; because the only true teachers our trainees ever possess are the patients they see. Trainees do not merely learn *about* patients, they learn *from* them—as every doctor knows. Professional educators seem slow to realize this and have inflated ideas about the importance of formal teaching in our field.

The separation of teaching from experience is a worrying trend in current vocational training, and there is uncertainty about the right balance between seeing patients in the surgery and going off to attend courses. Part-time trainees in particular are faced with this problem. One academic department of general practice actually proposed to run special courses to compensate for the reduced experience, and sought to have this recognized as an adequate substitute. This is a disturbing indication of the kind of thinking all too prevalent in academic circles. Classroom instruction and other types of courses can supplement experience with patients, can catalyse, can enormously increase the benefit to be derived from experience, but it can never be a substitute for it, as every doctor knows.

But every academic knows something; which is, that in certain circumstances instruction can indeed appear an adequate substitute for experience in the field. Those circumstances are rather special. They have to do with performance in the MRCGP examination.

The point may be illustrated by looking at how trainees in the Armed Forces get on. The Services have put a considerable amount of effort into their vocational training, and on our later inspections we found them generally giving training of a standard comparable to their civilian counterparts. However, through no fault of theirs, some of the trainees were being deprived of adequate—or even any—experience in certain areas: home visiting, for example; or working with health visitors; or treating elderly patients. And sometimes

patients with so-called minor disorders were first filtered off by nursing orderlies or others, so that there was not always the same degree of contact with undifferentiated presentations that trainees in civilian life are accustomed to.

Now, these particular features would simply not be acceptable in training schemes run by regional health authorities; and would certainly attract adverse comment from the Joint Committee. Nevertheless, trainees from the Armed Forces do well in the MRCGP examination; a tribute to the extra reading they do and to the special instruction they receive in those deficient areas. Thus, by the criterion of examination performance, classroom teaching is as good as general practice experience; while commonsense tells us it is not.

So there we have it. Satisfying the examiners? Or obtaining a statement of satisfactory completion? If passing the MRCGP examination is the true arbiter of successful vocational training, then some of the Joint Committee's criteria must either be superfluous or redundant. If, on the other hand, those criteria are perfectly valid, then what precisely is the examination a test of? What does passing it mean?

I propose to leave this intriguing discrepancy unresolved for the moment, and turn to another area where professional educators and practising doctors find themselves in conflict: learning about the consultation. Some current methods of teaching trainees and more experienced doctors how to conduct a consultation and what should go on during it, rely on breaking it down into component parts and analysing these. Each element is looked at separately, the doctor's performance being awarded a plus or minus accordingly.

However, this process does not do justice to what we know about the consultation as an organic entity. We may achieve exactitude about individual elements in the consultation, but at the possible cost of losing sight of greater truths. For example, what was that consultation all about? What on earth did the patient take away? There cannot be many doctors who have not sometimes pondered that mystery. Yet where does this figure in the calculations of those classifiers, those partitionists, those atomists? They do not seem to realize that the essence of the general practice consultation is not a total, all-embracing, omniscient approach; but selective attention. Nor have they grasped the obvious but painful corollary: selective neglect. To say nothing of the many patients with whom we have repeatedly tried, but failed; and where only a state of peaceful co-existence is now possible.

The vital factor often missing from these meticulous analyses is what was going on in the doctor's mind during the consultation. Without this knowledge, videotaped consultations can be observed but not properly understood. They remain little more than examples of voyeurism; entertaining, amusing, shocking even, but not particularly educative to lookers-on.

If trainers were encouraged to formulate their own aims for training, working from first principles rather than relying on the ready-made variety, they would feel more committed towards them. My own approach leans towards seeing the process of training as something biological, involving growth, development, flowering; rather than something technological requiring programming and the slotting-in of information (Figure 1a,b,c). The ultimate message is the familiar one: To cure sometimes, relieve often, comfort always. Or in practical terms, and more aptly for us in general practice: To prescribe sometimes, explain often, befriend always.

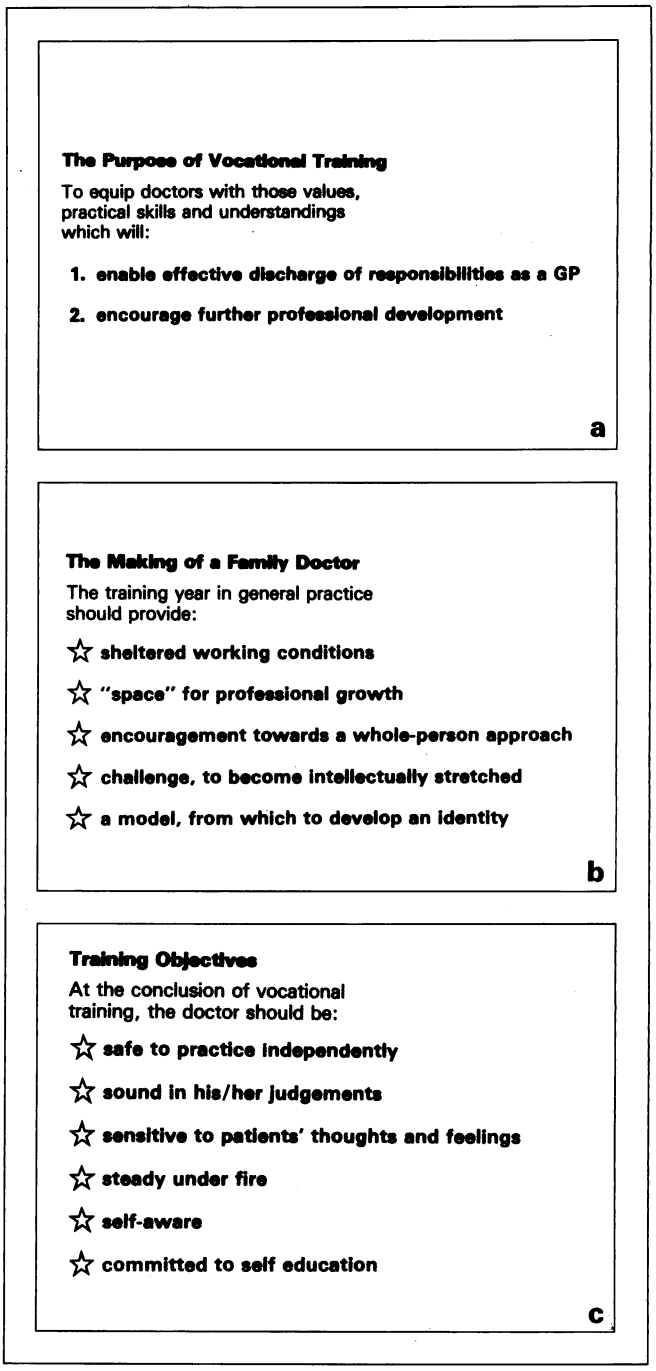

Figure 1a, b, c. *Aims for training.*

Of the many heavy responsibilities we bear as general practitioners (Figure 2), few can be more important

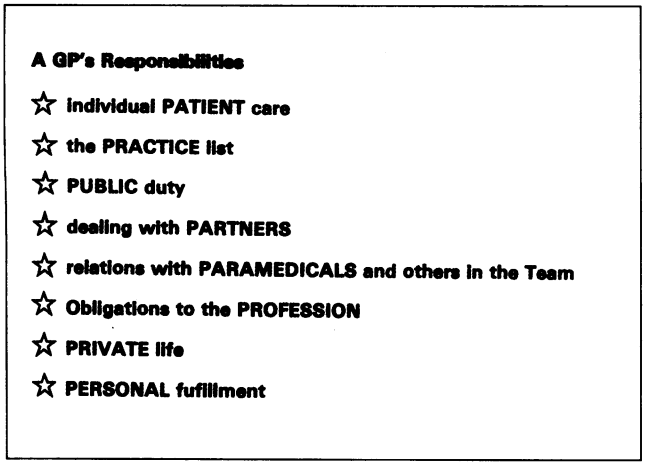

Figure 2. *Responsibilities of the general practitioner.*

than service to our own profession: the responsibility to support, to communicate, to advance understanding, to take part in mutual education, and, especially, serving those who are to come after. Here, we have to be tactful, for there has been a tendency to underrate the contribution which can very often be made by ordinary experienced practitioners, who, addressing their junior colleagues, might well say, with Thomas Hardy:

'And ye, red-lipped and smooth-browed; list,
Much is there waits you we have missed;
Much lore we leave you worth the knowing;
Much, much has lain outside our ken;
Nay, rush not; time serves; we are going.'

Clever young doctors

The College itself was largely responsible for promoting what can only be described as the cult of the clever young doctor. It had its heyday in the late Seventies, and is still alive and well in one or two of our faculties. Rejoicing in the rising intellectual calibre of its recent recruits, the College deliberately made the MRCGP examination more difficult to pass, and heaped adulation on the highest scorers. As the examination was then being loudly proclaimed a test of competence in general practice, it therefore followed that getting higher marks meant being a more competent doctor—you might say, the very model of a modern, major, general practitioner.

We know better now, but that does not stop extravagant claims still being made for the examination. It is deservedly regarded as the College's pride and joy; and, as the late Lord Butler might have said, it is the best general practice examination we have. But there are things about it which prevent us from unreservedly acclaiming it as a totally relevant test of general practice. For instance, the comparatively poor performance of experienced practitioners; and the many able trainees who fail it. The record of the MRCGP examination is impressive enough; thousands of successful candidates testify to that. Against this, an individual critic can set only his anecdote; or in my case, three anecdotes. But my admittedly limited experience of the examination does span a period of 10 years.

I sat it the first time in order to become a member of the College, and found it invigorating and a fair test. Six years later I took it again, to see how I—and the exam—were getting on. My marks were again nothing to write home about, but the exam was now almost unrecognizable, and blatantly geared towards the trainee. What was worse, the hard-won experience of the established practitioner went for nothing; only the right answers counted. And how were these right answers ascertained? Was it by reference to what every doctor knows? Hardly. In some cases at least, it was by the simple expedient of looking up the relevant specialist textbook. I recall well the moment of truth when this was disclosed.

Through the courtesy of the then Board of Examiners, I had, as Dean of Studies, sat in on the oral examination of some candidates, and noted how hesitantly the experienced doctors behaved—because they could see more than one side to the problem—compared to the eager trainee who was bursting to give the right answer. Examiners change the subject once they are reasonably sure whether or not the candidate knows the answer. This may be a test of sorts, but it is no way to get the measure of a colleague.

It was clear by now, though not necessarily to the examiners, that the exam had ceased to be a test of competence in general practice. It was nothing more nor less than a measure of whether the candidate had paid attention during his course of vocational training. Three years later, I sat it again, out of a grim sense of duty. The results were worse than mediocre, and confirmed that the exam was indeed not for the likes of me. By now, it was being officially recognized as a test of vocational training.

Today's examination leaves untouched whole areas of important experience. It is not just the absence of a clinical component which flaws it as a relevant test of the practice of family medicine. The examination invites candidates to indicate what they might or might not do in certain hypothetical circumstances with patients they have never seen, let alone related to. But in general practice, many of our ordinary dealings are with people we already know well; some are greeted like old friends. They are not cases to us. Where does this enter into the examination protocol?

Membership of the College

Quite apart from its inherent shortcomings, the examination has had a number of unfortunate consequences; most serious being the effect on the College's membership structure. As the sole mode of entry to membership, and given its present philosophy, the exam has become an obstacle to some of the aims of the College. It is divisive. As we know, there was vigorous debate at the time about whether to make entry to the College

depend on passing the exam. Those who took the final decision did what they felt right and they should not be criticized for it. They thought it would be for the best.

No such charitable dispensation can be offered to those who today still claim, in the absence of even meagre evidence, that retaining this monopoly somehow enhances the work of the College and promotes good general practice. It is patently not so; and only those blinkered by the narrow specialism of the examination apparatus could think that it was.

It is all very well to say that doctors who fail the exam, or who will not sit it, are welcome to become Associate Members. But what sort of welcome is it to a long-established and highly experienced practitioner, with much to contribute, to be permanently designated a mere associate of a College which is the embodiment of his life's work, and which has no counterpart? I remain unhappy at the exclusion of such colleagues, for I do not see that they differ from us all that much.

It is true they have not sat and passed the examination; but then, neither have some Members, including some of our most distinguished leaders who very wisely have not the slightest intention of doing so. Non-Members do not attend our faculty meetings and other College gatherings. No; but ask any distracted honorary secretary or tutor how many Members turn up. As for taking part in peer review, some non-Members do and some do not, just like Members. Non-Members are far less likely to be appointed as trainers. That is true. That is very true. And who would like to venture an opinion on the quality of care available to patients of Members and non-Members respectively? What would the criteria be?

Where are these significant differences then? If non-Members are pricked, do they not bleed? If tickled, do they not laugh? If poisoned, do they not die? And if scorned, held to be inferior, and constantly denigrated, shall they not lash out with wild and unjustified charges of elitism, arrogance, pomposity, and overweening ambition?

For how long more are we to tolerate two nations within general practice? Those who like to play the numbers game and find consolation in the fact that 10,000 Members already represents one third of the country's practitioners, might care to reflect on a less attractive, patient-orientated statistic. Only one patient in five in this country has a doctor who is a Member of our College. If our College represents all that is good and progressive in general practice, as I firmly believe it does, and if it genuinely wants to be inclusive, then eventually our colleagues must be encouraged to come in out of the cold. At the very least, they should not be hindered from doing so. Nearly five years have gone by since a formal faculty resolution made a similar point.

It would be presumptuous and well beyond the scope of this lecture to suggest how those who presently have the stewardship of our affairs should respond. They are in the acutely awkward position, familiar to leaders throughout history, where those behind are crying 'Forward!' while those in front cry 'Back!' But unless something more than lip-service is paid to the idea of an inclusive College—one in which members strive to stay in, not just to get in—then charges of elitism and hypocrisy are bound to be levelled against us, and may get more difficult to refute.

Figure 3. *Scientia and Caritas.*

I happen to believe that the educational aims of our College would be far better served if all practitioners became Members; not, as at present, by jumping a formidable once-and-for-all hurdle and then forgetting about it; but on the undertaking to conform to basic principles of education and practice. The College now possesses, in its 'What sort of doctor?' protocol, the means to achieve this honourable aim. We are gradually becoming clearer about what sort of doctors we want to be. It is that which should determine what sort of College, rather than the other way around. Let it not be forgotten that ours is a college of general practitioners. We are not yet an academy of general practice, far less an institute of primary care.

Sacred cows

It is time to draw the threads together. In this critique, I have complained that postgraduate education is becoming increasingly remote from the ordinary practice of family medicine. I have:

- questioned our priorities in continuing education;
- challenged the relevance of the MRCGP examination;
- criticized the College for not undertaking a proper evaluation of vocational training;
- taken it to task for its reliance on outside experts;
- chided it for its academic pretensions and political posturings;
- argued against its current policy on entry to the College;
- and raised doubts about its stand on standards.

Could there possibly be any sacred cows I have overlooked? Actually, there is one I have not mentioned. I hesitate to put it forward for slaughter, partly because of its sheer sacredness (Figure 3) but also because I am

genuinely undecided about it. Let me share my uncertainty with you.

Some years ago, a friend of mine challenged me with the following proposition: If the Scientia of general practice were sufficiently well developed, there would be no need for the Caritas. I promptly replied that Caritas was an indispensable pillar of general practice's ethos; and that we had virtually invented this unique doctor–patient relationship. Whatever techniques other branches of medicine might rely on, and irrespective of further advances in our discipline, it was unthinkable that Caritas would ever become redundant. I thus readily disposed of his suggestion. Perhaps too readily. For in succeeding years I have found myself often wondering about it. Why should kindly compassion be regarded as worthy of separate mention, as if it were some icing on the cake? Should it not be so thoroughly integrated in the way we deal with patients that it ceases to be recognizable as a distinct quality? Was it perhaps our former comparative ineffectiveness as doctors that led to the emphasis on Caritas? Yet, we would all have to agree that, in general practice at least, a doctor who was not good *with* people was unlikely to be much good *for* them.

The thinking doctor

I should want to combine Scientia and Caritas in the one word: Thoughtfulness. Because in its double meaning, thoughtfulness connotes considerateness, as well as proper professional concern. It is the thoughtful doctor by whom the patient will ultimately be best served. He may or may not display his feelings or brandish his compassion; his manner may be correct rather than cordial, showing respect rather than warmth. But these are matters of style, not of substance or of standards. Only let him, or her, be thoughtful; let him think, reflect, ponder; and there is hope for the patient.

This, it seems to me, is what education should try to achieve. Not telling one another what to do, or what to think. Nor even, as is now fashionable, how to think. But encouraging us all *to* think. The thinking has to be translated into practice. It must also be communicated so that everyone has an opportunity to compare, to weigh up, and to decide about such matters as quality in general practice.

An unexpected lead into the vexed question of judging quality comes from the arts. Jakob Rosenberg's dissertation, *On quality in art,* contains two particularly interesting quotations.
First:

> 'Value cannot be demonstrated except through the communication of what is valuable.'

Second:

> 'The artistically sensitive and trained observer will be able to recognize and appraise it with great assurance when he is in its presence.'

I came across these statements only after our original work on 'What sort of doctor?'; but there is a striking parallel with the thinking behind our proposals. Demonstrating to one another the way we deal with patients and how we run our practices; sharing ideas and experience: those things come first. By these means, we communicate what is valuable. It then calls for trained observers to recognize and to appraise true worth. This sequence is the natural and logical way forward for our continuing education. It also provides a basis for reformed and more relevant vocational training; one which never strays too far from its roots in medical practice.

Finally, perhaps I should comment about the style of my presentation, which I deliberately chose to render in personal terms, partly to make the point that opinions based on individual experience ought to count for something. And we general practitioners are notorious individualists. I have criticized pretty freely and, I hope, not unfairly. The strong element of implied self-criticism in what I have been saying is because, of course, I have been an accessory before as well as after many of the aforementioned facts. It is unlikely that the arguments I have been putting forward will attract general agreement. That is not important as long as there is agreement that these are the issues that matter in general practice education, and that all doctors should have a view about them.

It is possible that some of my remarks might find an echo. Some may prompt a different train of thought; some, only confirm the repugnance of such ideas. No matter. The value of an occasion such as this—the whole educational point of it—is to enable colleagues, each one of us, to identify more clearly what we think, to know what we stand for, what sort of doctors we want to be. After all, this is—is it not?—precisely what every doctor should know.

The estimation of blood pressure by hypertensive patients

A study was undertaken to see if a group of patients could estimate their blood pressure (BP). One hundred and thirteen hypertensive patients were asked whether they could tell when their BP was high, and if so, how. Patients were also asked to give a categorical and a numerical estimate of their current BP. It was found that patients did not appear to be able to predict their BP any more accurately than they could be expected to by chance. Patients who predicted correctly, and those who were incorrect, used the same symptoms to predict elevated BP. These were headache, a feeling of warmth, nervousness, dizziness, and pounding heart.

Source: Béique C, Lindsay TF, Flegel KM, *et al.* Can hyptertensive patients tell when their blood pressure is elevated? A cross-sectional study of 104 patients. *Can Fam Physician* 1984; **30:** 323-324.