acceptable standards for the community as a whole.

The 'collaboration' document[1] devoted paragraph 24 to the potential role of the community physician. Like the new breed of general practitioners, the community physicians, many of whom were general practitioners, undergo intensive training to acquire expertise in epidemiology, statistics, management, health service planning and appraisal. It would seem eminently reasonable for them to act as the linchpin between family practitioner committees and district health authorities; even more radical would be the stationing of them at family practitioner committees allowing these skills to be utilized by the whole service. Advice and help could be offered to individual practices or practitioners as required.

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Medical education: where is it going?

Sir,

Our present system of medical health care produces two completely different types of doctor. On the one hand we have the highly technical or expert consultant, based in a hospital and whose knowledge is considerable within a section of the medical spectrum; on the other hand we have the general practitioner who undertakes the health care of the family unit and must have a less specialized but broader knowledge of the disciplines involved in the art of medicine.

There are various factors in today's society which further polarize the profession. The relentless onward drive of technology gives the general public the subliminal impression that doctors are omnipotent and that soon all disease will be curable. There is consequently a major psychological force playing on the profession to increase its success both in frequency and scope.

To have doctors trained to cope with or recognize this new-found expectation of the public we have to think about the patient's real motivation for consulting the doctor. Particularly in general practice, doctors must be continuously aware of the possible reasons for consultation. In hospitals, they must be aware that the patient asks for more than scientific excellence in diagnosis and examination of his body.

Obviously there is not always time or necessity for protracted explanations but a high level of awareness of the patient's fears is essential to any doctor. Practising medicine inevitably involves making difficult and life-changing decisions. There is frequently no correct answer to the problems facing doctors and the solution is almost always a balance of opposing problems.

The area which I feel the profession recognizes least in its educative structure is how the personality of the individual doctor, as well as that of the patient affects the outcome of the decision.

Do we, as doctors, consider our motives in our attitude to the patient? Are we trained to recognize our own emotions and the way they colour our judgement? Frankly, I doubt we are aware of these problems. I am not suggesting that every doctor with every decision should examine his psyche first but he should be aware of the problems he might generate by his own personality. The earlier this understanding is imprinted on the young medical mind the easier it is to accept. We cannot pursue a purely technical approach to medicine.

For the aspiring general practitioner the going gets hard. With luck he will have a good general practitioner trainer whose example and skill will begin to show the young doctor the art of medicine.

Unfortunately the most difficult discipline to teach in the 'art of medicine' is that of human relationships. Doctors going into general practice must be made more aware of their own involvement during a consultation. They must understand that psychological interaction is happening on both sides. The patient may be behaving in a certain way because of the attitude of the doctor.

All general practitioners have difficulty with some patients which may be because the patient sees the doctor as a figure of authority, too paternalistic or maybe insensitive. These feelings may cause the patient to relate to earlier experiences of family life as the patient may identify the doctor with a disliked relative. However hard the doctor may then try, the relationship becomes difficult because the doctor unwittingly represents an emotionally powerful person who stirs up many early negative feelings. Obviously this cannot be avoided, but better insight into such a difficulty will help the doctor to understand the problem and, therefore, cope with the situation more easily even if the patient remains unable to gain insight into the doctor/patient relationship.

Sympathy and kindness are important as is the ability to empathize with the patient. Michael Balint has said that the doctor himself is the most potent of his medicines, a point that must be remembered at all times. This can be made to work in the doctor's favour but it can also lead the patient and doctor into increasingly difficult situations.

The young doctor must receive warnings and education on the problems of 'burnout', a real syndrome in the caring individual. As a profession we are expected to cope with very stressful situations and we will often be told by our patients that we are trained to cope with any stressful situation. Frankly, I am not trained to cope with the stress that a cot death may cause in the family of long-standing patients. I know how to deal with the situation, but the very effect of professionally dealing with such a situation while remaining in control of one's own emotions requires great reserves of inner strength.

More discussion between doctors about the emotions involved in these situations is the only way to allow the profession to feel less isolated. If a general practitioner is to be any good at the 'art' of medicine he has to care. The more he cares about his patients the more vulnerable he will be when the going gets difficult. The more he cares and the more difficult the going, the more pain he will feel. The quantity of pain he can endure will depend on his own personality. Some doctors solve the problem by keeping emotions at arms length and functioning on a purely technical basis. Others suffer the pain in varying degrees and some suffer the consequences of the toll this takes; suicide, alcoholism and drug dependence are all too common among members of the medical profession.

To conclude, I would like to make a point provoked by a friend who is a financial company trouble-shooter. When he joins an ailing company to try to sort it out, he asks the question 'What business are we in?' Very often companies fail because they think they are in one business when, in fact, they should be functioning as another. This view changes the emphasis from the dull mechanics of a business to one of human appeal.

The same question must be put to medicine. What business are we in? We are not in the business of producing medically functioning bodies, we should be in the business of healing and comforting

people. If we can achieve this then the public image of medicine will be less cynical and the greater faith will work to our advantage in the healing process. To create this healing process the profession might have to recognize and learn from the more structured branches of complementary medicine.

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Affected learning?

Sir,

Your leading article 'Affective learning: a new approach to medicine' (January *Journal,* p.4) made wonderful reading. It is heartening to think that general practice is soon to be overtaken by a flood of born-again young doctors, their immature minds scientifically disassembled, jumbled around, and re-educated. It reminds me of all the best science fiction stories, our hero, staunch upholder of all that he has believed in, unshakeably cynical of the new catechism, whisked off to the laboratory of psychological rehabilitation, from which he will emerge a 'new man'. 'The first stage is one of confusion, the trainees unresponsive, silent, withdrawn' — 'They did not really understand what it was all about...it was an unpleasant task'.

Ah yes, but of course the end result justified that. After all, everything that went before, the old way, had to be expunged from the mind; re-education had to be complete. Universal Balintism (to whom in his wisdom be all honour and praise) would have nothing less. And of course it behoves all general practitioners to fall down and worship the new approach to medicine — like the crowds applauding the emperor's new clothes for fear of being thought fools; after all, who wants to give the impression he's got stuck at the stage of denial, or anger?

Or is it possible, just possible, that this is all a load of baloney! 'Affected learning', perhaps?

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General practitioner paradigm

Sir,

A model (see Figure 1) based on a series of concentric circles is introduced, in which the circles are used to define the work and relationships of a general practitioner.

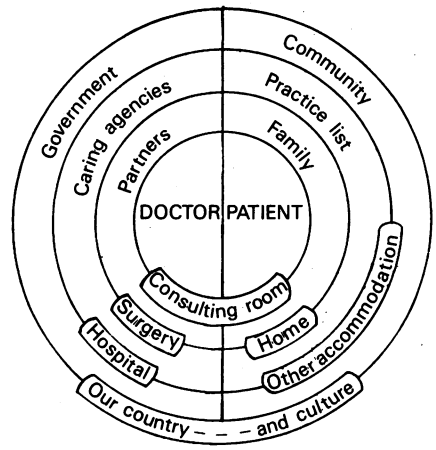

Figure 1. *The general practitioner paradigm.*

The model serves two purposes. First, it can help in tutorials to explain in an easily understandable form the work of a general practitioner. Secondly, it can help to structure the thinking of those concerned with curriculum design for vocational training.

A curriculum can be built up by examining the individual components and the relationships demonstrated in the model. The relationships are suggested by looking at the model, for example: doctor–patient; doctor–partners; patient–partners; doctor–community and so on. The obligations and duties which arise from each of these relationships can then be taught and discussed.

The individual components can be examined by taking each in turn and asking questions about them. For example, Doctor: What are a doctor's obligations by way of continuing education or quality review? Patient: What needs to be known about a patient? How is the information recorded? How do patients arrange visits, or repeat prescriptions? Consulting room: What should it contain? How should it be organized? Partners: How do partners communicate with each other? What should be in their contract? How do you appoint a new partner? Family: What is its role? What are the different family units?

Alternatively the word patient could be replaced by one of the following terms: fetus, infant up to one years of age, preschool child, prepuberty child, adolescent, young adult and parent, mature adult, adult in old age. If one of these terms is substituted in the model and the model is thought of in relationship to this age group, then a different series of age related topics is suggested. For example, if the word fetus is substituted in the model then the following topics suggest themselves: obstetrics, genetics, preconceptive care, infertility, appropriate screening procedures, adoption.

These are not all the questions that can be asked but we have shown how it can be done. It can be seen that topics are generated by examining the different relationships and components. In this way the model can aid the creative and systematic development of a curriculum.

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Ventricular ectopy in healthy subjects

From 1973 to 1983 73 asymptomatic healthy subjects who were discovered to have frequent and complex ventricular ectopy were followed up. Ventricular ectopy in these subjects was measured by 24-hour ambulatory electrocardiography, which showed a mean frequency of 566 ventricular ectopic beats per hour (range, 78 to 1994), with multiform ventricular ectopic beats in 63 per cent, ventricular couplets in 60 per cent, and ventricular tachycardia in 26 per cent. Asymptomatic healthy status was confirmed by extensive noninvasive cardiologic examination, although cardiac catheterization of a subsample of subjects disclosed serious coronary artery disease in 19 per cent. Follow-up for 3.0 to 9.5 years (mean, 6.5) was accomplished in 70 subjects (96 per cent) and documented one sudden death and one death from cancer. Calculation of a standardized mortality ratio (Monson's US data, 8th revision) for 448 person-years of follow-up indicated that 7.4 deaths were expected, whereas two occurred (standardized mortality ratio, 27; $P<0.05$). A comparison of survival of the study cohort with that of persons without coronary artery disease or with mild disease, patients with moderate disease, and men with unrecognized myocardial infarction showed a favourable prognosis for the study cohort over 10 years. We conclude that the long-term prognosis in asymptomatic healthy subjects with frequent and complex ventricular ectopy is similar to that of the healthy US population and suggests no increased risk of death.

Source: Kennedy HL, Whitlock JA, Sprague MK, *et al.* Long-term follow-up of asymptomatic healthy subject with frequent and complex ectopy. *N Engl J Med* 1985; **312:** 193-197.