

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 'The first stage is one of confusion, the trainees unresponsive, silent, withdrawn' — 'They did not really understand what it was all about...it was an unpleasant task?'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

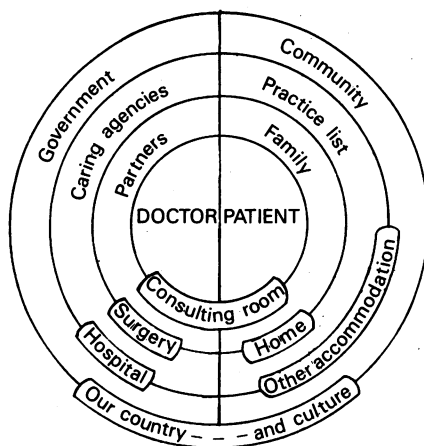


Figure 1. The general practitioner paradigm.

work and relationships of a general practitioner.

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 year of age, pre-school 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 sub-sample 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 (Manson'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.