A NEW SCIENTIFIC DISCIPLINE ACADEMICALLY TAUGHT

SIR FRANCIS WALSHE, O.B.E., M.D., F.R.C.P., F.R.S.
London

Dr Max Clyne's informative essay* on undergraduate teaching in comprehensive medicine must necessarily interest not only his fellow general practitioners, but also those " specialist physicians and surgeons " who find it difficult " to go beyond the field of the basic natural sciences ".

" Good general practice ", he maintains, " is unthinkable without the general practitioner's ability to understand human emotions and relationships . . . unless this understanding is made a scientific discipline, it can hardly be taught at an academic level ".

We may readily agree with the first part of this pronouncement, and yet demur strongly from the notion that this understanding can be made a scientific discipline to be taught at an academic level.

He says, also, that the study of the psychological component of illness has lately come much to the fore. It has certainly been the subject of more and bigger words than of yore, but that our predecessors did not understand it is open to question. " Psychosomatics " were first defined, perhaps, by Laurence Sterne (1760) when he reminded us in his picaresque novel, *Tristram Shandy*, that " a man's body and his mind are like a jerkin and a jerkin's lining, rumple the one you rumple the other ". And all this in words of one and two syllables. If it be the case, as Dr Clyne clearly implies, that the specialist physicians and surgeons who have hitherto monopolized the teaching of medicine and surgery to undergraduates have no competence outside the range of the basic sciences, it seems that his comprehensive medicine calls for a profoundly new kind of teacher.

His remedy, as far as it goes, is that we make a scientific discipline

*Undergraduate Teaching in Comprehensive Medicine. *J Coll. gen. Pract.* *1961.* 4, 228.

of the understanding of our fellow men and proceed to teach this science academically. How is this to be done, since, as he tells us, neither physician, surgeon nor psychiatrist do or can teach it? Who is to be the exponent of this new science, how and by whom is he to be trained?

With respect I suggest that the further we follow Dr Clyne's line of thought the more unrealistic it becomes.

Speaking, if I may, for the " specialist physician " who has had something to do with teaching undergraduates medicine, it seems reasonable to recall that even now the majority of us practise private as well as hospital medicine. How does Dr Clyne suppose that we can earn a living by private practice—as we had to do before 1948 —without an effective understanding of human emotions and relationships, as well as a working competence in some field of medical science and art?

Does he not know that a noteworthy proportion of the patients referred to us by his fellow practitioners are not sent for technical virtuosity in diagnosis, but that they are anxious and unhappy folk, seeking reassurance and understanding, a patient listener who will hear them out as they tell their follies, griefs, and fears? The notion that this role is the exclusive prerogative of the general practitioner could not survive five years experience in consulting practice.

There may be a dichotomy between specialists and general practitioners, but it is not the dichotomy Dr Clyne assumes.

It has been said that more nonsense is talked about education than about any other topic, much of it on the assumption that education is simply a pouring in and not also a drawing out, and with little consideration for the capacity of the vessel into which we have poured so much already, and which now appears to be threatened with a new scientific discipline.

Surely at the age when the undergraduate can really believe that a public students' rag is a feast of wit and humour which everyone can be expected to enjoy, it is scarcely reasonable to think that teaching at an academic level will hasten and complete his mental and emotional maturation, so that he will understand all the complexities of human nature, the difficulties of that vulnerable entity—the doctor-patient relationship, and all this without experience of life. One does not learn to ride a horse by reading books or listening to lectures on equitation, but only by throwing one's leg over the saddle and walking, trotting, and cantering it out, often with a very sore behind and a number of falls. There are, I believe, rapid modern methods for the seasoning of timber and of kippers,

but I can conceive of no process by which we can mature medical students before their time by word of mouth. We have never expected to find old heads on young shoulders, and no formal scheme of education will eradicate that natural and essential greenness of the young doctor when faced for the first time, on his own, with the complex problems of human relationships.

Could anything be more dangerous for him than to lead him to believe that by suitable academic treatment he can be sent out ripe from his medical school, a sort of emotional and intellectual "broiler", fit to meet all human emergencies? Is there nothing he is to be expected to learn in the hard school of experience, both in the human and in the technical sides of medical practice?

The limitations of hospital medicine on the human side are well known to us all, and they will probably remain when, the barriers cast down, the general practitioner enters the hospital wards as of right. He will still find there, as he may find in any busy industrial practice, that the pressure of work is too heavy, the hospital population too migratory, to allow him to do justice to all the human problems that will pass before him. How this problem is to be solved is not easy to see, but certainly not by making a pseudo-scientific discipline, academically taught, and imparting "prepacked" experience and all those elements of ethics and *caritas* which, unless we have encountered them in our earlier lives, we are scarcely going to absorb as part of a medical training.

I feel that unwittingly Dr Clyne is engaged in image building, seeing the medical profession as consisting of a medico-sacredotal element on the one hand, the general practitioner, and some clever exponents of technical skill, the specialists, on the other. I believe this to be a fantasy, and not the image of anything that exists, or can exist, amongst us. All of us who practise clinical medicine are in this together, and in an imperfect world it would be idle to think that any of us can ever be perfect, but our aims should be the same.

Furazolidone—A Clinical Trial in the Treatment of Diarrhoea. S. S. ROWELL, M.B., B.S., E. SKLAR, M.R.C.S., L.R.C.P. and L. J. STOLL, M.R.C.S., L.R.C.P. *The Practitioner* (March 1960) **184**, 364.

Furazolidone (furoxone) is related to nitrofurantoin which is often used for the treatment of urinary infections. A trial of its value for the treatment of diarrhoea was made in three London practices, and 56 patients were treated in all. Bacteriological control was used in most of the cases. The only noteworthy side-effect was the orange colour produced in the urine. The average time for clinical cure to occur was 3.6 days.