Young ambition's ladder

Jacky Hayden

That lowliness is young ambition's ladder,
Whereto the climber upwards turns his face;
And when he once attains the upmost round,
He then unto the ladder turns his back,
Looks in the clouds, scorning the base degrees
By which he did ascend

Julius Caesar Act II Scene I, by William Shakespeare

I AM honoured, if somewhat daunted, to have been invited to give the William Pickles lecture in our 50th anniversary year. The medical profession has been the subject of much recent criticism and I hope that in our 50th year we can begin to celebrate those things that we do well, learning from our predecessors, and modifying their practices to suit current patient expectations.

During the past 50 years the role of the general practitioner (GP) has changed enormously; we have moved from personal doctoring to care delivered by health care teams, and from care delivered mainly in the home to care delivered in purpose-built premises. Our range of drugs has increased exponentially and improved technology has expanded our potential for diagnosis and treatment. With increased specialisation in secondary care we have established our strengths as clinical generalists.[1] However, one thing that has not changed is the importance of the interaction between doctor and patient. The definition of the consultation that we used in our College's infancy is still used today. What has changed is the potential for general practice to be the main focus for teaching those skills to all doctors.

In 1968, in the first William Pickles lecture, Pat Byrne set out his vision for all medical students to learn in general practice;[2] his dream has become reality. As we move into our second 50 years I hope that we can contemplate how all doctors could and should benefit from time spent in general practice during their early postgraduate training.

The past few years have not been easy for our profession — our patients are better informed than ever, and the publicity associated with Bristol, Alder Hey, and Shipman has encouraged patients to question their health care more closely and take a more active interest in the quality of their practitioner. The NHS Plan[3] has encouraged patient involvement further with its vision of patient partnerships and patient-centred doctors. To achieve this vision we need role models who practice patient-centred care and environments in which young doctors can learn the necessary competencies.

In preparing for this lecture, I visited Aysgarth and listened to some of the local people who remembered their doctor. One woman recounted the time that Dr Pickles had diagnosed her chicken pox — she spoke affectionately about the doctor wagering with her regarding the timing of her sister developing the spots. Another woman, who had since entered nursing, told me enthusiastically about Dr Pickles' lectures in Leeds.

The countryside around Aysgarth was sparsely populated when Will Pickles entered general practice, and working as he did with the local population Pickles became respected in the community and by the local medical population, where he encouraged young doctors to take an interest in epidemiology. He was noted for his kindness and knowledge of his patients; Pemberton described him, along with Sir James Spence and Professor John Ryle as 'humanists who were interested in and sincerely liked their fellow men'.[4] Although experts in their individual fields, all three shared their values and learned from each other.

I had always had the impression that, in the early days of the NHS, it was acceptable for doctors to be paternalistic, and many adopted that approach because it was expected of them. I wanted to argue that being patient-centred was about responding to patients' expectations. However, as I read and learned more about Will Pickles I realised that he was far ahead of his time, both in the autonomy that he gave to patients and his skills in sharing options for treatment. He was what we would describe today as a patient-centred doctor. His friend and comrade in education, James Spence, went further and questioned how the profession might teach these skills, and postulated that special outpatient sessions should be created in which young doctors might learn the art of the consultation.

'If it be the purpose of medicine to give explanation and

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Submitted: 12 September 2002; Editor's response: 1 October 2002; final acceptance: 14 November 2002.

A patient-centred doctor:
- Explores the disease and the effects and expectations of the illness on the patient;
- Understands the whole person, their social context and the impact that the illness will have on them;
- Finds common ground in managing the problem and agrees goals for treatment and the roles of the doctor and the patient;
- Incorporates health promotion, health enhancement and disease prevention in their management plans;
- Maintains and enhances their relationships through sharing power, openness and honesty;
- Is realistic in the time needed for healing and the resources available.

Box 1. Characteristics of a patient-centred doctor.

advice in consultation, how are we to train our students? How are we to maintain in doctors the sympathetic understanding of so many individuals, without which their work becomes a weariness of spirit and flesh?'[5]

Patient-centred doctors

Patient-centred doctors work in partnership with their patients, exploring the disease, its effects on the individual and their family, and the patients' expectations of the disease and its management. They listen to and observe their patients, summarising to clarify and checking on the meanings of words. They understand the whole person, their social context, and the impact that the illness will have on them. Patient-centred doctors find common ground in managing the problem, agreeing goals for treatment and negotiating the roles of the doctor and patient. They are able to explain risk in ways that the patient understands.[6] They incorporate health promotion, health enhancement, and disease prevention in their management plans. They maintain and enhance their relationships through sharing power, openness, and honesty. Patient-centred doctors are realistic in the time needed for healing and the resources available. Patient-centred doctors focus their care on the patient rather than the disease (Box 1).

The skills necessary to be patient-centred come naturally to some, such as Will Pickles; others need to learn them. These skills parallel the competencies that are described by Goleman in individuals who have high emotional intelligence.[7] He groups these qualities into personal competence and social competence.

Goleman describes individuals who have high levels of self-awareness and self-motivation, who are conscientious, adaptable, trustworthy, and possessed with high levels of self-control. These individuals are effective communicators, both listening and speaking. They are empathic and are able to resolve conflict with skills in negotiation and teamworking. They are effective leaders (Boxes 2 and 3).

As with all competencies, those relating to patient-centredness can be taught and can be assessed. The skills of effective listening, sharing diagnoses, and negotiating management plans are already included in the general practice curriculum and can be assessed through observation of the young doctor with the patient. The skills can be taught through the usual sequence of demonstration, observation, practice, and adjustment. It is also possible to encourage the development of competencies, such as self-awareness, self-motivation, and flexibility, through modelling and effective specific feedback on performance. Equally, a doctor working in an environment that actively discourages self-awareness, sensitivity, and trustworthiness is less likely to recognise the importance of these characteristics and may fail to develop them.

- Self-awareness
  - Emotional awareness
  - Accurate self-assessment
  - Self-confidence
- Self-regulation
  - Self-control
  - Trustworthiness
  - Conscientiousness
  - Adaptability
  - Innovation
- Motivation
  - Achievement drive
  - Commitment
  - Initiative
  - Optimism

Box 2. Personal competence.

- Empathy
  - Understanding others
  - Developing others
  - Service orientation
  - Working with and encouraging diversity
  - Political awareness
- Social skills
  - Influence
  - Communication
  - Conflict management
  - Leadership
  - Change catalyst
  - Relationship building
  - Collaboration and co-operation
  - Teamworking

Box 3. Social competence.

Patient-centredness is not the sole province of GPs. Patients and the NHS need doctors throughout primary, secondary, and tertiary care who are able to understand the patients' perspective and share management plans. All doctors need skills in putting their message across clearly, they also need to learn the skills of listening attentively and checking when something is unclear, rather than make assumptions. They need technical skills to access information. What perhaps is less easy to achieve is the value held by Pickles and Spence on being patient-centred. It takes longer, initially, to consult in a patient-centred way and when

under stress there is a tendency to revert to the traditional method of history taking. Young doctors will find it much harder to practice their patient-centred skills if their immediate supervisor prefers a didactic disease-oriented approach. Trainees will find it difficult to develop skills in teamworking and valuing others when they are exposed to an environment in which the doctor is seen as the only team leader. Medical students, encouraged to be autonomous through problem-based learning, may become very stressed when asked to work in a doctor-dominated disease-centred environment. We therefore need to encourage patient-centred environments and support an ethos in which admission of ignorance is acceptable.

Creating an environment that encourages patient-centred doctors

Pickles entered partnership in Aysgarth with his medical school friend, Dean Dunbar. In the early years of their partnership, they lived together in the doctor's house. Each day they would discuss their patients and share their problems. They alternated the parts of the practice that they visited so that they learned from each other and shared their thoughts and diagnoses. Later in his career, Will Pickles expanded the concept of learning through his patients and met regularly with a group of like-minded colleagues in his house.

One of the problems that many GPs face is finding time in the working day to share problems with their partners and practice team. In hospital practice the traditional consultant ward round followed by coffee seems to be a thing of the past too, with the consequential loss of opportunity for young doctors to listen to and learn from senior colleagues. Gone too are the informal discussions after work. Most trainees are not resident and those that are working are frequently pressured to address outstanding clinical problems rather than spend time in reflection with their peers. Working practices may have changed, but if we are to ensure that tomorrow's doctors are able to work in partnership with patients then there is need to replace those learning opportunities with new ones that complement new ways of working. Each of us needs time when we discuss our thoughts and feelings about our patients with trusted colleagues. Significant event audit is one way in which teams come together to discuss patient care or other issues; Balint-style groups are another. Alternatively, trainees may be able to discuss their thoughts and feelings about patients in time set aside specifically for teaching and learning. If trainees are to develop the attitudes and skills of patient-centredness then these sessions will need to be confidential and safe, without judgements being made, and some of the sessions will need to be with other health care professionals so that all perspectives of patient care can be considered. This is not easy to achieve in the current climate of shift-working and clinical governance.

An environment that encourages learning has effective leadership with good communication and sharing of ideas. There is usually a culture of rewarding success and a willingness to admit and learn from mistakes. There are documented developmental programmes and appropriate management of resources. The effective learning environment is one in which there is flexibility and learning from each other and external resources.[8]

The learning practice or clinical team:
- Values learning;
- Meets together;
- Sees jobs as development opportunities;
- Sees mistakes as opportunities to learn;
- Discusses problems openly;
- Has a range of learning resources;
- Uses action learning;
- Discusses problems with patients.

Box 4. Characteristics of the learning practice or clinical team.

These concepts can be extended into the characteristics of a clinical team that encourages learning. These teams will value learning and meet together to discuss their work and learn from it. The team sees all jobs and activities as learning opportunities and they view mistakes as opportunities to learn. Teams that value learning use a range of resources to encourage learning, they frequently use action learning, and they have an open style with patients, discussing problems with them (Box 4).

In the North West of England we have attempted to measure the learning environment and have developed a robust model of visiting senior house officer (SHO) posts, which is based loosely on training practice visiting.[9] We are trying to evaluate six different parameters, using criteria developed through a consensual approach: the clinical care, the culture of the hospital, the role models of the consultants and other health care professionals, how well the education and clinical care are supervised, the local educational programmes, and the nature of appraisal and assessment. We have not yet implemented the training practice culture of observing the clinical teaching or the consultants interacting with patients. Each team receives structured feedback on our findings. And at the end of the visit, agreed highlights and areas for attention are presented to senior managers. Most clinicians and managers have welcomed this approach and have enthusiastically met the agreed standards by the next visit. Unfortunately there have also been a few who, for whatever reason, have resisted change.

Medical teachers and role models

> *'There should be in every school of medicine one or more teachers who have been in general practice for 10 to 20 years. He would have had the opportunity for knowing how to assess the value of symptoms.'*[10]

Effective medical education does not take place in a contained environment at a specified time of the week; it is continuous and often not noticed when done well. Marshall Marinker[11] described the 'hidden curriculum' over a quarter of a century ago, and yet we have done little to quantify its effect or use it positively or negatively. The environment in which trainees work, the culture of the hospital or practice, and the value placed on reaching a diagnosis, no matter how severe the discomfort for the patient, will all impact on

the professional values that the trainee adopts. Marinker describes vividly a medical student who was unable to discuss a patient's illness with her for fear of his own emotions. That student is likely now to be a consultant or principal and may well have responsibility for supervising doctors in training. If his lack of competence in working with patients' emotions has not been addressed he may well have established mechanisms in his clinical practice to minimise the likelihood of patients asking him emotionally taxing questions. What kind of learning environment will he have created?

In developing skills in our educational community in the North West of England we ask course participants what makes effective medical teachers; perhaps not surprisingly, many of the qualities that they identified are features of people with high emotional intelligence. The attributes that they have identified are that the individual is an effective clinician, they are learner and patient-centred, they have high-level teamworking skills and are able to solve problems; they are enthusiastic, communicate effectively, and exhibit leadership.

As well as our identified teachers, throughout our careers we all have role models who have influenced our thinking and our values. Young doctors who are continually exposed to clinicians who respect patients are more likely to develop those values. Trainees who work with consultants or principals who themselves regularly seek patients' views and share management plans will develop their own repertoire for being patient-centred. One of my most memorable experiences as a junior doctor was observing the professor of paediatrics on a ward round. No matter how young the child he always gave control to the patient, seeking permission before examining and explaining what he was doing. There have been those, too, that I have tried hard not to emulate, such as the senior registrar who referred to patients by their interesting physical signs and persisted with painful ineffective treatments.

Effective clinical role models are frequently generalists with greater than average teaching responsibilities, spending time with the house officers. They have usually received formal training for their role as a teacher and enjoy teaching; they value doctor–patient relationships and they are more often satisfied with their career. Interestingly, doctors who spent much of their time engaged in research were rated negatively as effective role models.[12]

During Deanery visits to monitor training in hospitals, it has been striking how frequently the SHOs resemble the consultants that they work with. In one emergency department all the SHOs assembled for our visit, the consultants covered their work so that they were free to meet us without interruption. They were bright, enthusiastic, and responded as a team. When we met the consultants later that day, they too had made a space in their working day to meet us and openly demonstrated their support for one another and their trainees. It was a stark contrast to some of our visits, where both groups seem reluctant to turn up at all and the main topics of conversation are about pressure of work and reticence to meet what are viewed as impossible standards.

One of Pickles' role models was James Mackenzie. Perhaps it was Mackenzie's determination that scientific medicine could and should be practised in the community that encouraged Pickles to observe and record illnesses in his patients.

The learner-centred teacher:
- Listens carefully to problems, checks, and summarises;
- Uses questions, metaphors and stories to help the learner solve a problem;
- Is skilled in giving both positive and negative feedback;
- Builds the self esteem of the learner;
- Responds positively to criticism;
- Works with peers to improve their own teaching skills.

Box 5. Characteristics of the learner-centred teacher.

Learner-centred teachers

There is evidence, again from America, that teachers who give autonomy to their students develop learners who are more likely to encourage others to be responsible for their own behaviour.[13] These teachers do not abrogate their responsibility; they encourage choice in the learner and provide the necessary information to make a rational and wise decision. They acknowledge their students' feelings and work positively with them.

Learner-centred medical teachers tend to be more humanistic in their approach to patients, and develop this perspective in their trainees. They listen to problems, carefully checking and summarising; they use questions, metaphors, and stories to help the learner solve a problem; they are skilled in giving both positive and negative feedback and they build the self esteem of the learner. Learner-centred teachers respond positively to criticism and work constructively with peers to improve their own teaching skills[14] (Box 5).

We have found in both generalist and specialist teachers that there are those who want to work with their peers to improve their teaching skills, responding positively to criticism, and those who are reluctant to expose any weaknesses. General practice teachers are now familiar with work on the tutorial, and most engage positively in critiquing their own performance. Few hospital consultants have had the same opportunities.

The early years

Medical training is long; a partnership in practice or a post as a hospital consultant used to be the ultimate goal, with the early years as a house officer being a necessary rite of passage to move into higher training. The need to meet the European Working Time Directive has quite correctly reduced the number of hours each doctor in training works in a week, but the result is often shift working and loss of the 'firm' structure, with consequent loss of learning opportunities. General practice is an environment that lends itself to developing patient-centred doctors. Some believe that tertiary centres are no longer appropriate sites for young doctors to learn about relationships and communication with patients. Patients are either being admitted for day procedures or are so sick that they are barely able to converse

with their doctor.[14] General practice is an environment that is currently underused, particularly for doctors who are undecided about their career, although at the moment we are limited by our training capacity.

In the North West of England we have been able to give a small group of doctors, who have been undecided about their career goals the opportunity to develop a generalist approach to patient care. There have been four main strands to our activity: pre-registration house officers working in general practice supported by a day-release course; house officers working in emergency medicine; 12-month SHO training programmes combining paediatrics and general practice; and a two-year general professional training programme. We were able to hand-pick our training sites and ensure that the teachers, both generalist and specialist, had training for their role; most had completed both basic and advanced teacher preparation courses. We also appointed an associate GP director to oversee the programmes.

The house officer programme in emergency medicine has been extremely popular and from it we have been able to derive some guidelines for other sites considering pre-registration house officer (PRHO) emergency medicine programmes.

Like all deaneries, pre-registration training in general practice has had a mixed reception. Most of the doctors who experience a placement in general practice really enjoy it and learn extensively from it, particularly about doctor–patient interactions.[15] In the North West of England we have overcome some of the isolation that has been expressed in initial studies, through a day-release programme. All the house officers in the GP placement meet together with an experienced course organiser on alternate weeks. They have all spoken in the highest regard for their day release. Unfortunately, pre-registration training in general practice is still spoken of as the 'soft option' and described by some medical school teachers as a 'career-limiting step'. This has resulted in placements lying vacant and our altruistic practices — which pioneered the scheme — withdrawing from it. We have also experienced 'burn-out' in our trainers for general practice PRHOs. Supervising a new trainee every four months is much harder work than was anticipated and we are considering ways in which the responsibility might be shared within the practice team or by building in regular vacancies. Improved funding may not be the prime motivational factor for these practices but it would signal very clearly how much we value them and how important it is for all doctors to spend time in a generalist environment.

We started our two new SHO programmes in 2000; evaluation is therefore at a very early stage. Four SHOs each year spend 12 months in 'stem cell' paediatric posts. During the week each doctor spends time in both general practice and paediatrics, but for six months they work mainly in paediatrics and for the other six months they work mainly in general practice.

The other new scheme is based on a concept shared between the Royal College of General Practitioners and the Royal College of Physicians. The programme is for two years, each SHO spending six months each in emergency medicine and general practice and a year in general medicine. A third year is optional and can be spent in any of the three specialities. Both programmes have day release where the trainees meet as a peer group, discussing patients and problems.

This small pioneering group has identified a number of aspects that have contributed to their development, including personal support from their trainer; less pressure from clinical work, support from the day-release course, learning from case discussion, learning communication and consultation skills, and working in a holistic way (Craven A, 2002; personal communication).

Like all good ideas in medicine it was not new: Sir James Mackenzie had postulated that all physicians should learn in general practice:[10]

> *'To obtain this knowledge it is necessary to see the patient through the various stages of disease, and only this can be done by the individual who has the opportunity.'*

The future

The tension between service and training will always be present; one way of coping with the limits that it places on general practice training is to move the main locus of training to general practice with release into specialist medicine to learn specific aspects. The other model — and perhaps the two are not incompatible — is for all doctors to spend two or three years after graduation in a preliminary training programme, during which they will spend some time, probably four or six months, in general practice.

During the past two years, medical school intake has risen and there will need to be new training placements to accommodate training programmes for these doctors. If we really do want to develop patient partnerships, then postgraduate deans and workforce development confederations will urgently need to consider how they will ensure that any new training placements will encourage patient-centredness. There is need for more work — particularly in postgraduate education — to consider the effect of positive role modelling and the nature of our clinical teachers. Postgraduate deaneries also need to consider how effective teaching skills can best be taught and assessed in primary and secondary care.

Postgraduate medical education, particularly that for SHOs, is at a crucial phase, with the consultation report[16] on basic training recently released and the future of the regulatory bodies — our Joint Committee and the Specialist Training Authority — under active discussion, through the proposals for a Postgraduate Medical Education and Training Board. Primary care, too, is at a watershed, with Primary Care Trusts recently established and still finding their feet. We don't know yet what impact they and the shift of resources will have on training. We also have little concept of the potential for GPs with a special clinical interest to contribute to the development of doctors in training; these new roles offer opportunities to bring a generalist approach to secondary care teams.[17]

Conclusion

My title comes from Shakespeare's *Julius Caesar*. How true that passage could hold for medical education, if we let it.

The reference to a ladder is particularly poignant for all of

us working in general practice. Many of us smart at the thought that we were described as a group who 'fell off the ladder of specialist training'.[18]

Will Pickles demonstrated that there was great merit in providing generalist care. He also demonstrated considerable expertise in describing and managing illnesses that are now frequently the province of specialist practitioners. Could anyone describe him as falling off a ladder?

However, if we as a profession value the importance of patient-centredness then we need to create an environment in which it can flourish. Today's doctors in training need strong role models, perhaps more than ever before. As the world or the junior doctor moves further towards shift work and with the ever present pressure of service delivery, there is a much greater need for caring, empathic, yet strong-minded teachers who are prepared to support their teams while challenging and stretching knowledge skills and values. As medicine becomes more complex with new and invasive treatments, young doctors need to remind themselves of why most of us are here; to provide care, support and comfort to our patients, often while nature heals them. No matter what the specialty, our patients need doctors who are able to listen to them and understand the impact of their illness on them and their families. They need doctors who are able to put the latest evidence into context and explain the options and risks for each patient. We are more likely to achieve this through effective clinical teachers who base their teaching on the needs of the learner and who provide strong role models.

Pickles contributed extensively to our College and our discipline as a GP and teacher. Maybe all of us should ask ourselves, what could I do differently for doctors of the future and their patients? I hope that from today we can all wholeheartedly embrace the concept of house officer and SHO training in general practice and open our doors to contribute to the training of both generalists and specialists.

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Acknowledgements

This lecture would not have been possible without the commitment and enthusiasm of the many general practice trainers, hospital teachers and educational leaders in the North West. I am particularly grateful to my family for their encouragement and to Dr David McKinlay for his wise counsel, support and instruction on the history of medicine.