

Debate & Analysis

William Pickles Lecture 2013:

For they are born for another time



The poet George Seferis wrote:

*'As pines keep the shape of the wind ... so words guard the shape of man.'*¹

I want to dedicate this lecture to the memory of Helen Lester. Helen was wonderful in shaping her words. She will live on in our hearts for what she achieved, just as William Pickles has left a lasting legacy. From his country practice in Wensleydale and his interest in epidemiology he brought the values of primary care to an academic world where secondary care dominated. Half a century later, the secondary ethos still tends to rule in the university arena. I am the only GP on a Council of 34 medical school deans. I will argue that a readjusted balance, away from the dominant secondary care context of medical education, is needed to produce doctors fit for future health care.

The honour of presenting this lecture led me to reflect on a mantra I have frequently used:

'Do not confine children to your own learning for they were born in another time.' (Hebrew proverb).

A fundamental fact, often overlooked by educators, is that the world as viewed through the eyes of the young is inevitably different from ours. There is a strong and natural tendency to look back to the old, perhaps unsustainable, values of our own education. We struggle to look forward. Yet the different values of the new generations may equip them better for the challenges they will inevitably face.

There is potential for GPs to engage much more overtly with undergraduate education,

bringing our community-based generalist expertise to the fore and strengthening our presence and leadership. I have chosen to centre my reasoning on the definition of generalist practice framed by Joanne Reeve and colleagues:

*'Generalist practice is decision making which is person-focused, not disease-focused, which is continuous and not episodic, which integrates the biographical and the biotechnical knowledge ... all with a view to supporting health as a resource for living and not an end in itself.'*²

This captures the generalist approach, important both to secondary and primary care. It provides an excellent platform from which to review the generation gap and the skills those 'born for another time' will need for an uncertain future.

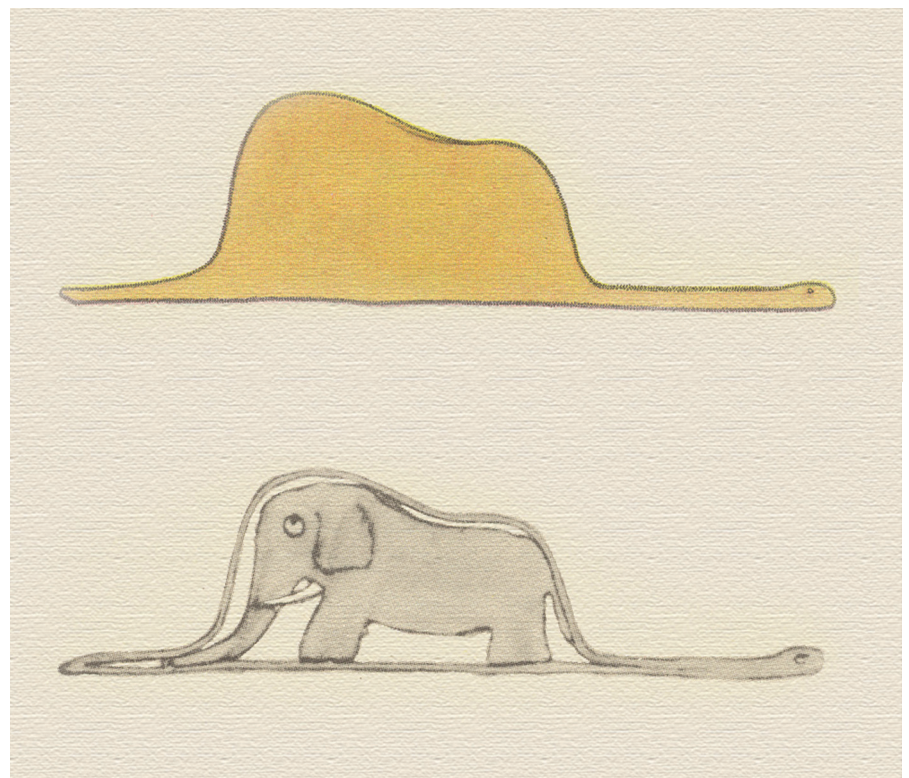
THE GENERATION GAP

Two illustrations demonstrate the significance of the gap. First, from the learner's perspective. In *Le Petit Prince*,³ a

treasured story from my youth, the author, Antoine de Saint-Exupéry, narrates his encounter when stranded in the Sahara desert with the Little Prince who is visiting earth from his tiny asteroid B-612 (where the sun sets 47 times a day). A drawing by *Le Petit Prince* is interpreted by adults as 'a hat' but, in actuality, is 'a boa constrictor digesting an elephant', a vivid reminder that as educators we must acknowledge and make sense of the learner's different perspective. Adults made no attempt to understand his interpretation. He, the Little Prince, was advised to abandon drawing and concentrate on geography, history, mathematics, and grammar! Second, from the educator's perspective, we hold an awesome responsibility in forecasting the healthcare environment our students will encounter.

'We live in a world where change is exponential and we are helping to prepare students for jobs that don't yet exist, using technologies that have not yet been invented, in order to solve problems that we don't

The 'hat' and the 'boa constrictor digesting an elephant' from *Le Petit Prince*. Kindly authorised by Antoine de Saint Exupéry Estate.



"It seems inevitable to me that we are preparing our young for work in a world where the West no longer dominates."

know are problems yet. In short, we have a responsibility to prepare our students for a lifetime of uncertainty, change, challenge and emergent or self-created opportunity.⁴

I would like to highlight three reasons why the generation gap may be widening.

Transformation of knowledge

We face a sea change in the technologies used for holding, processing, and transmitting knowledge. For generations doctors have held immense power through the possession of knowledge. This power is now being eroded by the internet and information technology. Inevitably this impacts on the doctor's position in society. As educators we need to acknowledge this.

Reversal of world dominance

It is easy to assume from the tradition of Western supremacy that our paradigms of healthcare education represent the gold standard. Yet we face a stark reality:

*'By 2020 India will be graduating four times as many college graduates as the US. By 2030, China will have 200 million college graduates — more than the entire US workforce.'*⁵

It seems inevitable to me that we are preparing our young for work in a world where the West no longer dominates.

Climate change

Perhaps in the West we are somewhat in denial. It seems imprudent not to prepare students for the seemingly inevitable challenges of climate change. This requires a sound understanding of public health and globalisation: we have so much to learn from

the developing world.⁶ *Le Petit Prince* cares deeply for asteroid B-612, looking after his planet by decoking the volcanoes, weeding, fighting the baobab trees, and cherishing his one tender rose. If we fail to nurture our own planet I fear for the impact on future clinical practice, but was reassured that the *Lancet* Commission's report *Health Professionals for a New Century* also encompasses these thoughts.⁷ We need to move beyond the confines of our current educational practice to prepare our trainees for a rapidly changing world. I offer three areas where current practice could usefully change.

GLOBAL AWARENESS

Fostering global awareness across the generation gap is fundamental, yet, as our young doctors highlight, it is barely acknowledged in our curricula.⁸ We must avoid the pitfall of reducing global awareness to knowledge-based disease-focused learning outcomes. Richard Horton once cogently paraphrased 'global health' as being about 'People, human rights, justice and knowledge' (personal communication). If we are to foster professional, holistic, global attitudes towards patient care, students must understand their own personal values and uncertainties. Global awareness needs to be locally responsive and globally connected. Indeed there is a whole minefield of cultural complexity within our student cohorts which may inhibit local responsiveness. In a cohort of second year medical students across two medical schools, we identified significant barriers to discussions about race and ethnicity within different ethnic groups.⁹ The recent work of Suzanne Vaughan¹⁰ supports findings elsewhere¹¹ of worryingly ethnically-segregated social networks within the student body. Segregation has already

been highlighted as an issue for primary and secondary education. This has potential importance for learning and achievement. As the *Lancet* commission concludes, future doctors must be 'competent to participate in patient and population-centred health systems as members of locally responsive and globally connected teams.'⁷ Where best to tackle these issues contextually than generalist practice which 'integrates biographical and biotechnical knowledge'?²

THE DOCTOR-PATIENT RELATIONSHIP

Patient centredness has had a profound impact on the doctor-patient interaction. I fear that an unintended consequence has arisen from the fixed frameworks we use to teach the consultation. These models risk distracting from the doctor's equally important role in the interchange. This is potentially damaging. I am haunted by a quote from Sarah Yardley's fascinating work on medical students' early contact with patients:

*'You will speak to people in a certain way and people will react to you in a certain way ... whenever you mention you're a medical student to anybody ... you're not a person anymore.'*¹²

This is far from our intention when preparing them for clinical practice. The fixed patient-centred approaches we use may fail to support an interaction which acknowledges and encompasses the student's own personality and self-awareness. Indeed the work we did in inner-city London demonstrated that GPs who communicated well used a totally flexible consultation style.¹³ Ian McWhinney stated very clearly in 1996:

*'We can only attend to a patient's feelings and emotions if we know our own but self-knowledge is neglected in medical education.'*¹⁴

These wise words have tended to fall on barren ground. Reeve and colleagues carefully refer to a 'person-centred interaction.'² Consultations in primary care offer an ideal opportunity to sensitively explore the doctor's perspective of the interaction.

THE INDIVIDUAL

This leads to my final point. Students need to understand their own individuality and cultural background to develop the resilience needed for the potentially exponential changes in clinical practice they may face.

"The fixed patient-centred approaches we use may fail to support an interaction which acknowledges and encompasses the student's own personality and self-awareness."

Qualitative medical education research is increasingly highlighting the challenges and difficulties students experience through the hidden curriculum which permeates the workplace. Unintended, sometimes undesirable, learning takes place in the clinical environment. Students tend to divorce their learning on the medical school campus from that they perceive is required for actual practice. Indeed having learnt certain ethical values they then find these challenged by clinicians 'confined to their time'.¹⁵ The Francis report¹⁶ highlights even more that students must develop the strength and resilience to challenge unsatisfactory health care. They need assertiveness, negotiation skills, and courage to do this. But faced with the future, resilience has to be deeper as encapsulated by Ogden:

*Those who learn to operate in a vastly changed ... global environment; those who can walk on quicksand and dance with electrons; those who amass an array of varied experiences; those who see connections where others see chaos — they will flourish and find opportunity in every experience.*¹⁷

So can we make a difference? Well, to return to my initial despondent reflection on the low profile of GP undergraduate deans, maybe. It appears that a greater proportion of graduates enter core training in general practice from some of the newer medical curricula where primary care is used more

contextually for learning. Here I rest my case and conclude with the words of Antoine de Saint-Exupéry:

*'A civilisation is a heritage of beliefs, customs, and knowledge slowly accumulated in the course of centuries, elements difficult at times to justify by logic, but justifying themselves as paths when they lead somewhere, since they open up for man his inner distance.'*¹⁸

The key words here are 'inner distance.' I have explored this, as we look to future civilisation, at three levels. The inevitable distance within the generation gap between ourselves and those we educate and the often made and rather bizarre assumption that what was good for 'us' is equally good for 'them.' Secondly the inner distance between the doctor and patient and the need for educators to address this and move away from a fixed mantra of patient-centredness. Finally, as Albert Einstein said:

*'The true value of a human being can be found in liberation from the self.'*¹⁹

Bridging the inner distance to understand and reach a sense of personal identity is essential. The educational context of primary care offers a relatively safe ambience to achieve this. If we can overcome these distances I believe medical education can truly support the generalist aim of 'health

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as a resource for living and not as an end in itself.² This will be critical for those doctors 'born for another time'.

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The original presentation with illustrations can be accessed at:
<http://medicine2.keele.ac.uk/val/presentation.pdf>

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