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THIS WEEK

It is hard to get the balance right between knowledge and practical action. Can you be an aspiring academic and still be a good clinician? Ruth Chambers and Kay Mohanna think so (s25). Being an academic clinician enables you to be "creative" and "more autonomous" but, more importantly, as you extend your knowledge and skill base, you will enhance your patients' care.

Graduate entry schemes in medicine are becoming more popular and Linda Hutchinson, Patricia Hughes, and Peter McCrorie (s28) discuss why their scheme at St George's in London accepts graduates from the humanities as well as the sciences. Studying the humanities correlates with better clinical performance, and why shouldn't medicine be open to art students who now want to change direction?

David Greaves will be delighted to hear this (s30). He admits that he never really wanted to be a doctor and it took him years of trying many different routes before eventually finding his niche in the medical humanities. In philosophy he discovered he could integrate the arts, social sciences, and natural sciences in relation to the whole of medical knowledge, education, and practice.

"Whether to get involved or not to get involved?" is a deep philosophical question doctors sometimes have to consider—usually in the space of split seconds. Some are reluctant to get involved in good Samaritan acts for fear that they might be sued. However, according to Anahita Kirkpatrick (s29), not helping could result in career suicide. Would you like to be referred to as "Dr Walk-on-by"?

In a real test of putting knowledge into practice, Clare Lindsey explains the benefits of being assertive and gives some tips on how to put this into practice (s27). Being assertive does not mean being selfish. Rather it means knowing and meeting your rights and needs, as opposed to your wants. Easy in theory, but many of us find it very difficult to say "no." Maybe it's time for you to put your knowledge into action.

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Academic research in primary care

Ruth Chambers and Kay Mohanna explain what is involved

If you are hankering to turn your side interest in research into a substantial career path there are many opportunities to do so in almost any academic field that interests you. Your current involvement in simple research projects as part of your everyday post can become your livelihood. Medical academics are highly sought after. Besides their conventional work in educational establishments, medical academics are commissioned by health and social care organisations, government agencies, and charitable bodies to undertake research and development, evaluations and needs assessments, and education and training.

The options

You might choose to work part time or full time in academia. Clinicians often combine academic and clinical work. Medical academics often combine education and training with research and development. Continuing to work as a clinician has the advantage of maintaining close contact with clinical colleagues and patients. This will keep you immersed in real life practice, so hopefully your research work will be as relevant and realistic as possible. It also keeps your options open for your future career.

There are numerous vacancies in academic medicine. This is partly to do with academics' lower pay and longer hours compared with full time clinicians. Senior primary care academics are not able to "earn" merit awards as are their consultant colleagues. This discrepancy has been a topic of much protest in primary care. Another rea-

son for posts remaining unfilled might be the misleading image of academics as living in "ivory towers," out of touch with everyday practice.

Working as an academic clinician enables you to be creative—or at least for enough of the time that the drudgery and disappointments are soon forgotten. The more autonomous you are, the more control you have over the direction of research projects and use of research funds.

Funding

In academia, money is power. Funding buys staff and resources—for extending projects, training, travel, and attending conferences. The more money you bring in from successful bids and the higher the profile you gain from publications, networking, and presentations at conferences, the more likely you are to attract further sponsorship and investment in your research. Sponsorship comes from prestigious sources such as research councils and national charitable bodies, from pharmaceutical or other commercial companies, and from local sources such as healthcare organisations, whose money may be targeted more at development than original research.

Academic career paths

Starting off

Your first academic post might be as a lecturer employed by a university, progressing to senior lecturer, reader, and then professor over 10 or more years. An alternative is as a research fellow, a relatively junior research

Starting on an academic career

AM graduated in 1990 and spent four years in various senior house officer posts before settling on general practice, with vague aspirations to be an academic. His general practitioner vocational scheme included a fourth year, when he learnt skills in research and epidemiology as well as working as a general practitioner registrar one day a week.

His first academic post was a junior research fellowship in a prestigious department of a well regarded university with a high research rating. Two years later he gained a similar post in another university, where he was granted some protected time to complete an MPhil thesis, write associated papers for publication, and prepare an application for a national research fellowship. Much of this work was done in his own time over many weekends and evenings. He continued to undertake one or two general practice surgeries a week.

Four years after starting on his first academic post, he obtained a national research fellowship, which covers his salary and fees for three years. The salary is far short of what he might earn as a full time general practitioner.

position in an academic department that often requires some prior research experience. You might progress to a senior research fellowship, probably after many years of research and a higher research degree. You might zigzag between research fellowships and being a lecturer or senior lecturer; it will depend on what jobs are on offer in different academic departments.

Alternatively, you might start your academic career as a research assistant on a particular project, probably with a temporary contract. This might be an employed post with a university or in a healthcare organisation such as a health authority. You might find that a post in a healthcare organisation is aligned with a local university and that you are an honorary member of the academic department. Sometimes a research or other academic post (such as one more focused on education) is jointly funded by a university and healthcare organisation, with one party holding the employer's contract for all the employed sessions; sometimes such a position is organised as a short or medium term secondment.

Making it to the top

Promotion to become a reader or professor is through others recognising your status. This is assessed by esteem factors such as a national and international reputation in your subject—as evidenced by being invited to talk at major conferences, obtaining substantial research grants from institutions such as research councils, and publishing

papers in peer reviewed journals. You can become a reader or professor by applying for an advertised post or by being promoted in-house in recognition of your achievements. Uniformity between UK universities is maintained by external validation by senior academics from other universities at professorial appointment panels.

Traditional versus newer universities

There is a certain hierarchy about UK universities. Universities with medical schools are traditionally regarded as more prestigious places to work than those without. The income and size of medical schools leads to a far bigger critical mass of medical academic staff. Staff in the newer universities with health schools rather than medical schools tend to include a range of health disciplines such as nurses, therapists, etc, rather than being focused on doctors.

You can move up your research career path in both traditional and newer universities. Most readers and professors will have worked in more than one university during their career.

Training and qualifications

General research training courses are run at a local level for established health professionals and managers by many universities and colleges. These might give you your first taste of the rigour of research and help you decide whether you are suited to it.

You will usually need to have a higher degree to gain any substantial research post. Various masters degrees are available with different proportions of taught modules and original research culminating in a dissertation or thesis. A relevant degree might be a masters in medical sciences (MmedSci) or MSc in primary care, health economics, or education. These will probably include modular work where research is an underpinning component but not necessarily the main focus. If you undertake a masters degree in education you might carry out research into the effectiveness of education or curriculum development, for example. You might work up to a masters degree in stages by first completing a certificate and then a diploma. Another type of masters degree is the MPhil. This might be taught but is likely to be supervised original research, progressing from a literature search that justifies the aims and design of your research project to an analysis of your findings. You would expect to publish at least one article in a peer reviewed journal from your MPhil work if you are going to progress in a medical academic career.

You will probably have a doctorate or be near completing one by the time you apply for a senior lectureship. The doctorate might be a PhD or, for medics, an MD. It is difficult to specify the exact differences between these two types of higher research degree as regulations and arrangements vary greatly between universities. A doctor undertaking an MD usually works in a semi-autonomous way with less supervision than that usually given for a PhD. University regulations specify the extent to which supervisors are trained and experi-

Further information

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- Royal College of General Practitioners. *Undertaking higher research degrees. Some practical guidance*. London: RCGP, 2000
- University annual reports
For example, the *Department of General Practice and Primary Care Annual Report 2000* of Barts and The London NHS Trust describes the backgrounds and experience and qualifications of departmental staff

enced in their role and are experts in a relevant field. Completing a higher degree usually takes longer than you anticipate—perhaps two or three years full time and six to eight years part time if you are continuing with full time clinical commitments. You may be able to register for a PhD at any university in the United Kingdom where the purpose and scope of your research coincides with that of the academic department to which you are applying and where they have the capacity to supervise your degree. You may only be able to register for an MD in a university from which you graduated or where you are a member of the academic staff, although a few universities allow doctors to register where neither of these apply.

One of the surest ways to progress in a medical academic career is to gain a research fellowship of some sort where fees are paid and you are supported financially and given protected time from your clinical commitments. A few such fellowships are available from bodies like the Royal College of General Practitioners, some NHS centres of research and development, the Medical Research Council, and various charities. Details of how to apply are provided in advertisements in *BMJ Careers* and *British Journal of General Practice* or in newspapers such as the *Times Higher Educational Supplement*. Contact your local university or research and development bodies for more details and ideas.

It is important that education, research, and development are integrated in primary care, to encourage the gathering of evidence about best practice and its systematic application. Being a medical academic is exciting and rewarding, as you make developments that extend the knowledge and skill base and ultimately enhance patients' care.

Ruth Chambers general practitioner and professor of primary care development, Staffordshire University

Kay Mohanna general practitioner and senior lecturer in medical education, Staffordshire University

Being assertive

Clare Lindsay *explains why being assertive can enhance your career and gives some tips on how to put assertiveness into practice*

Assertiveness has the potential to open more career doors than any other set of personal skills. It can boost self esteem, build confidence, reduce personal stress levels, and help people get as much from their working environment as possible. With the ability to treat colleagues positively and fairly, assertive people gain the respect and genuine liking of those they work with. They feel good about themselves and their abilities, respond well to difficult situations, and manage their time efficiently by saying "No" to unreasonable demands. Creating around them a relaxed environment in which problems can be openly discussed, assertive people give and receive criticism constructively, deal with negative emotions healthily, and handle conflict effectively. Communicating assertively can lead to happier working conditions, lower stress levels, and greater performances at work.

Learning to be assertive is probably of greater relevance to medical students and junior doctors than doctors already established in the profession, when stubborn attitudes and unspoken conflicts are common practice. It helps you survive the hierarchical system and arrogant behaviours that will sometimes do their best to undermine you, your abilities, and your needs.

What is assertiveness?

Based on principles of equality, assertiveness involves individuals treating themselves and others as equals and emphasises the importance of individuals taking care of personal rights, needs, and responsibilities. The aim of assertive behaviour is to ensure that the

rights and needs of the self are protected and satisfied while still equally considering those of others.

Tips to being more assertive

Recognise and value yourself as an equal
Accept that your rights, needs, feelings, and ideas deserve the same respect as everyone else's.

Identify and protect personal rights
You have the right to have your rights respected. These include to be treated with respect, to have your needs met, not to be taken for granted, and to be allowed to make mistakes. Protecting your rights is your responsibility.

Identify and satisfy personal needs
Having your needs met does not mean you're selfish. Having needs met is essential to wellbeing. This is different from wants. It is your responsibility to ensure that your needs are met.

Acknowledge and respect the equal rights and needs of others

Listen to what others have to say. Use empathy to let others know you've heard them and you appreciate their position. Use awareness of other people's rights and needs to ensure you treat them fairly.

Don't take responsibility for other people's feelings or behaviour

Accept that you can be responsible only for your own thoughts, feelings, and behaviours. It's not your responsibility to protect other people's feelings, nor is it fair to neglect your

Fundamentals of assertiveness

- Think of and value yourself as an equal to others
- Recognise and protect your rights
- Identify your needs and ask for them to be met
- Take responsibility for yourself and not other people
- Express negative thoughts and feelings healthily
- Stand up for yourself
- Confront awkward people
- Give and receive criticism
- Handle conflict
- Learn to say "No"

needs in order to keep others happy. If someone chooses to react angrily to something you say, assuming you have behaved fairly, the other person's anger is his or her responsibility. You have no right to feel responsible or guilty.

Express yourself honestly and clearly

Disclose feelings—You have the right to express both negative and positive feelings. Telling others how you feel helps them understand and appreciate your needs.

Learn how to say "No"—Draw on the above skills. Use initial gut responses to judge whether you wish to do something or not. Remember: you have the right to say "No." If you're not sure what you want to do, buy time and decide later. Go with what is right for you. Saying "Yes" can leave others feeling bad if they detect you feeling resentful. Remember, by saying "No," you are rejecting the request not the person. Own up to your feelings, share them with the other person, and let them go. Suggest an alternative to leave both parties feeling good.

Use stock phrases when confronting others—Choose a stock phrase that concisely encapsulates what the problem is and what you want to change or to happen. Use this to explain to other people what you wish to achieve. Listen to other people, consider their rights and needs. If your desired outcome remains unchanged, repeat the stock phrase until your key points have been heard and acknowledged. Empathise with other people but keep to your agenda—for example, say, "I appreciate your point about [repeat stock phrase]." Disclose your feelings and state your rights to strengthen your case. Feed back honest positive feelings to others—for example, say, "I really value your opinion, but [repeat stock phrase]." Persevere until you reach an outcome or compromise satisfactory to both parties.

Developing self esteem, confidence, and healthy coping behaviours is also essential for your patients, and you might want to pass these tips on to them.

Clare Lindsay *professional counsellor, Cambridge*



Graduate entry programmes in medicine

There are currently four graduate entry schemes into UK medical schools at Oxford, Cambridge, Leicester and Warwick, and St George's Hospital, London. Linda Hutchinson, Patricia Hughes, and Peter McCrorie—pioneers of the scheme at St George's, London—discuss their experience

Graduate entry to medicine is not new. Graduates, mostly with science degrees, make up 10-15% of recent intakes to five year and six year MBBS courses in Britain. Most come into the first year, but some universities accept students from biomedical or life sciences or dentistry into the third MBBS year.

The case for graduate entry

In North America medicine has been only graduate entry for several generations, and from 1997 four Australian medical schools changed from predominantly school leaver to exclusively graduate entry. Despite this change in practice, there is little research evidence on differences in subsequent performance between graduates and non-graduates.

Research on students' age and outcome is inconsistent; some researchers found older students do better, whereas others reported the same or worse performance and rate of dropout.¹⁻³ The strongest argument for admitting graduates and mature entrants is to increase flexibility, allowing people to make a career decision in their 20s and 30s, not just during their school years. In addition, graduates increase diversity in the student body, their motivation is less likely to be influenced by parents or school, and they have already shown that they can study successfully at university level.

In the middle to late 1990s, the Australian experience stimulated several UK schools to consider introducing a shorter MBBS course for graduates. This coincided with a new government, a new agenda for medical education, and encouragement to diversify entry. Within individual schools other factors, such as new leadership, were catalysts for change, and it was thought that more intensive and shorter courses would be more attractive to graduates. Shorter courses are feasible provided GMC requirements on core content, and EU regulations on hours of training (5500 in total) are met.

Students on a course that requires a degree at entry are eligible for the same financial benefits as those on a first degree course, removing one of the major drawbacks for graduates contemplating changing to medicine.

Eligibility and selection

Which graduates should we admit? Scientific knowledge is core to a medical degree, so science qualifications are usually demanded for entry to medicine. But what about those who chose arts and humanities at school and university but now want to change direction? Study of the humanities has been shown to correlate with better clinical performance,^{4,6} so ideally both scientific knowledge and ability in the humanities should contribute. The solution at St George's Hospital was to invite

applicants with any degree subject and to give them an exam that covers both science and the humanities. We adopted the graduate Australian medical school admission test (GAMSAT), a broad based exam that covers scientific knowledge and reasoning and reasoning in the humanities and includes two short essays to assess ability to argue logically and communicate in writing.

The prospect of an exam has not discouraged applicants: there have been 8-10 applicants per place in the two years to date. We invited the highest scoring applicants to interview, about two for each place. We identified desirable non-cognitive characteristics and developed and piloted a 40 minute structured interview. Members of the interview panels were blind to all but each applicant's name. In our experience interview ratings have not correlated with either GAMSAT scores or previ-

ous exam performance. All interviewees had scored well in the written exam, and so places were offered on the basis of interview ratings.

Other UK graduate entry programmes have developed different selection processes, considering only science graduates or those with science A levels or equivalent, and generally giving greater weight to previous examination performance.

Should we design a new course or tweak the existing five year one?

Tweaking the existing course is cheaper, takes less time to develop, and does not challenge the institution with major change. Students may prefer the integration with five year students, and a completely separate course could encourage isolation and rivalry. On the other hand, a new course is an opportunity to start afresh and to set up the ideal course we always wanted. Graduates would benefit from a course designed specifically for their needs, and a new course is clearly attractive. However, it is essential to have the support of the institution and backing from its leadership.

When Australian medical schools changed to graduate entry only, they stopped recruitment for two years to allow transition from a six year to a four year programme. This provided valuable development time, while maintaining the annual output of medical graduates for house officer posts. This has not been feasible in Britain, however, where the graduate entry programmes are additional to rather than replacements for existing courses.

We opted to set up an entirely new course to run in parallel with the standard five year one. Students on the two MBBS courses are taught separately but share social and sporting activities. The ring fencing of funds from the Higher Education Funding Council for England for the graduate entry programme was important in paying for new developments and initiatives for the programme, and these can now be made available to students on other courses.

Curriculum details

The core content in all graduate entry courses must be the same as that of other MBBS courses, but graduates may be more suited to specific learning styles, such as problem based learning. Experienced students are expected to manage self directed learning well, and we allocated substantial resources to developing web based materials to support this. The small numbers of students have allowed a strong emphasis on small group work for subjects such as ethics and the clinical and interpersonal skills needed for a good doctor-patient relationship. Contact with patients starts in the first week. These aspects are desirable in any MBBS, not necessarily just those for graduates.

Our experience so far

From the institution's perspective, the creation of the graduate entry programme has been an opportunity to develop a problem based learning course, with integration of basic and clinical sciences across all years and with early clinical and community experience.

Details of four year graduate entry courses

St George's Hospital, London

- Selection criteria
- Degree—Any subject, level 2.2 or above
- A levels—Any
- Written exam—Graduate Australian medical school admission test
- Interview—One of 40 minutes
- No of places—35 in 2001, 70 in 2002

Cambridge

- Selection criteria
- Degree—Any subject, level 2.1 or above
- A levels—Science or equivalent
- Shortlisting before written exam
- Written exam—Own exam
- Interview—Two 20 minute interviews
- No of places—20 in 2001, 20 in 2002

Oxford

- Selection criteria
- Biomedical or life sciences degree, level 2.1 or above
- A levels—As needed for non-graduate admission to medicine
- Shortlisting before interview
- Interview—Two 20 minute interviews
- No of places—20 in 2001, 30 in 2002

Leicester and Warwick

- Selection criteria
- Biological sciences degree (includes genetics, biochemistry, cell biology, molecular biology), level 2.1 or above
- A levels—As needed for non-graduate admission to medicine
- Shortlisting before interview
- Interview—One 20 minute interview
- No of places—64 in 2001, 128 in 2002

Questions for students considering graduate entry programmes

- Do I want a shorter course?
- Does the course accept my first degree?
- What A levels are required?
- What kind of degrees will the other students have?
- Is there any advantage in having a higher degree?
- Does the course have an upper age limit?
- Will I need to sit an entrance examination? How should I prepare for it?
- Is the course part of the curriculum for medical students on the standard MBBS course?
- What is missed out of the course if it lasts only four years?
- Do I need work experience?
- Will I be eligible for fees, bursaries, and loans?

The investment in new selection processes and web based resources can be capitalised on by extending them to other courses.

The graduate students are challenging, enthusiastic, and fun to teach. They start with a wide range of backgrounds; some students have PhDs in science subjects, whereas others have no formal science qualifications, but all contribute to the rich pool of experience and perspectives. In problem based learning tutorials tutors and students have benefited from dealing with differences and have developed teamworking skills. In lectures and seminars teachers needed to adjust their approaches to teaching to accommodate the range of prior knowledge. It has been especially rewarding to see those students who had not been eligible for conventional medical programmes, as they have overcome their and our concerns about their minimal science background and are now thriving.

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Patricia Hughes *subdean for admissions*

Peter McCrorie *director of graduate entry MBBS programme, St George's Hospital Medical School (University of London), London SW17 0RE*

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Good Samaritan acts

You might be tempted to walk on by when someone needs your medical help for fear that being a good Samaritan might wreck your career, but this is not the case, according to Anahita Kirkpatrick from the Medical Defence Union

You might not yet be battle hardened and confident enough to construct a thoracic drain using a mineral water bottle and a coat hanger, but the compelling weight of moral and professional opinion says that medics should help if they find themselves in an unexpected emergency situation. One of the most frequently offered excuses for walking on by is fear of litigation if something goes wrong or the fear of litigation even if everything goes right medically speaking but the patient dies anyway—always a possibility.

Apocryphal stories of good Samaritan medics being sued to within an inch of their lives for not saving the victim of a 100 mph car crash are just that. If you are trying to do the right thing by using your professional expertise to help a fellow human continue to live, then the chances of you facing legal action are so low they are almost non-existent.

I have carefully searched through many legal case notes and found that, even in a land as litigious as the United States, there has been only one case when a doctor was sued after a “good Samaritan” act. Many US states have passed legislation protecting doctors and nurses who carry out such acts. Your medical defence organisation should be able to offer you a policy covering good Samaritan acts anywhere in the world. If you happen to be holidaying in a remote part of the world your chances of coming on a situation that might require your professional skills are a lot higher than if you are in a big city close to modern medical facilities.

Some countries take such a proactive approach to encouraging altruistic acts that you could face prosecution for ignoring an emergency. In France there is a good Samaritan law which compels doctors to do whatever they can in an emergency. Failure to do so could result in a jail term.

The General Medical Council's booklet *Good Medical Practice* states that you should offer to anyone at risk “treatment you could reasonably provide.” So the fact that you are not a consultant in emergency medicine, have never been trained in advanced trauma life support (ALTS), and do not have a fully equipped crash trolley close by should not be a barrier to helping someone to the best of your ability. However, you should remember that whatever you do would be classed as a clinical intervention. You must therefore record the name of the patient, make a clinical record of what you are doing, and give your name and address to a suitable official such as a member of the aircraft cabin crew. Don't forget your duty of confidentiality to patients, which continues beyond death, especially if there is media interest in the case subsequently.



The original good Samaritan

Always remember to take appropriate personal precautions with infectious diseases. Many doctors take needles, syringes, gloves, and other medical equipment for their own personal use—some people even take a unit of their own blood. In view of the recent tightening of airport security, however, it is important to confirm permission for taking such items with the airline before the day of departure.

In the absence of specialist equipment and premises the assistance that you can practically give is limited, and it may be preferable to speed the patient's transfer to hospital rather than attempt to do more at the scene of the incident.

If you are on a holiday flight enjoying the full facilities of the galley when a call for a doctor comes, you might be worried that your medical judgment could have been a little clouded by that second glass of wine. Everyone has different tolerances to alcohol, so you must decide for yourself whether you are in a fit state to help. Any decision to intervene would depend on whether the condition was life threatening. If you do decide to help you should inform the appropriate person. If it transpires that there is someone else on board who is in a better position to assist, you can happily and safely step back.

If you manage to pull off a “back from the dead” miracle using a copy of the in-flight magazine, a sick bag, and plastic knife and fork don't expect Harley Street levels of remuneration. You might ask for payment for your time and expertise, but none of the major world airlines has a policy of hourly rates for good Samaritan acts. However, some do offer a seat upgrade, free flight vouchers, bottles of champagne, and other in-flight goodies.

If all this information has not been enough to convince you to be a good Samaritan just imagine the career suicide it would be if your colleagues referred to you behind your back as “Dr Walk-on-by.”

Anahita Kirkpatrick *senior adviser, Medical Defence Union*

PROFILE

David Greaves

The turbulent career course of the coeditor of the journal Medical Humanities highlights how even the greatest sceptic can eventually find his or her medical niche

I have been told that medicine mirrors the whole range of life. Although it initially seemed to have nothing for me, I have eventually discovered that even I could find a niche.

By the time I started at secondary school, my secret determined ambition was to become a medical missionary. My uncle was a medical missionary, and his tales had implanted a heroic image in my mind. I began to read the Bible from end to end, a chapter a day, to demonstrate my commitment to myself. I gave up somewhere in the middle but regarded this as no more than a minor setback to my long term project.

My career could be viewed as a tortuous journey moving further and further away from the perceived centre of medicine

Like most teenagers, I soon lost my evangelical zeal and also found that I was better at arts than sciences. However, my family's and my own expectations seemed to have an unstoppable momentum so that when I was accepted at medical school I was too over-awed to call a halt, even though I knew that I no longer wanted to be a missionary and had never wanted to be "just" a doctor.

At medical school, I felt as if I had regressed to the worst aspects of my grammar school. Facts were driven into us with bullying threats, and encouragement was reserved for those picked out as high flyers. Many of my fellow students shared these feelings, but they thought these hardships were worth suffering for the sake of the great prize of becoming a doctor. I just felt a dull emptiness that left me isolated from my peers. I adopted a strategy of dogged survival with every intention of leaving medicine as soon as I qualified. The only career advice I received was that I should complete my pre-registration year so I could then become fully registered. I felt as though a door had slammed in my face. I was being condemned to life imprisonment in medicine.

After house jobs in surgery, medicine, and geriatrics, I tried general practice for a year as a trainee assistant, allowing me to dip a toe in the water without committing myself. This experience revealed a new world to me, but I



The modern day medical missionary

still felt hopelessly incompetent clinically. As a stream of patients paraded through the surgery day after day, I was never quite sure what I was missing in those brief encounters and whether I had done anything positive for the patients at all. I was happy just talking to people, but this hardly seemed enough, and I soon knew that I couldn't do this job for the rest of my life. So hospital medicine and general practice were out, but what else was there?

Two strange coincidences were to lead me in an entirely different direction. One of my general practice patients was a medical geographer, and, through talking with her, I started reading about epidemiology and public health. These had passed me by at medical school since they hardly featured in the curriculum. Then an advert for a research assistant caught my attention: on inquiring about it, I was instantly offered the post, despite my almost total ignorance of what was involved. I was both amazed and daunted, but it was too good an opportunity to miss. Two years later, I was appointed to a lectureship in epidemiology and was responsible for teaching a substantial course to postgraduate students. For the first time I had to think and reflect on how best to approach a subject and found myself confronting some philosophical questions. Without quite being conscious of it, I was starting to develop a critique of Western biomedicine.

Hoping to pursue these ideas further I took the opportunity to spend a year with the Medical Research Council's medical sociology unit, where I was the only doctor working alongside a team of social scientists. I found the openness to critical debate very refreshing, and a mental cloud that had settled on me since I entered medical school lifted from me. On my return to the medical world the qualitative sociological research I had undertaken was judged to be scientifically invalid and so unacceptable by the examiners for the Membership of the Faculty of Community Medicine (now public health medicine).

This failure led me to abandon an academic career for five years, but the underlying questions had not gone away, it was just that mainstream medicine was not ready to take them on board.

Altogether, I spent some 15 years in epidemiology, sociology, and public health, and what became clear to me during this time was that the questions I kept returning to were fundamentally philosophical. They invited a new vision that integrated the arts, social sciences, and natural sciences in relation to the whole of medical knowledge, education, and practice.

I developed these ideas in the second half of my career, when new academic opportunities became available—first in medical ethics and philosophy and more recently in medical humanities. It has been a long struggle, though, which has produced results only late in my professional life, with my book *Mystery in Western Medicine* (1996), the initiation of the first postgraduate degree in medical humanities in Britain in 1997, and the joint editorship (with Martyn Evans) of a new journal, *Medical Humanities*, since 2000.

More positively, it could be seen as a meandering pilgrimage, which has eventually and unexpectedly led me back to where I originally hoped to be

In all this time I have been searching for a role in which I both fit and have something to contribute, and I am now perhaps nearer that goal than at any other time. In hindsight my career could be viewed as a tortuous journey moving further and further away from the perceived centre of medicine, without ever quite leaving altogether. More positively, it could be seen as a meandering pilgrimage, which has eventually and unexpectedly led me back to where I originally hoped to be. Maybe I have become a medical missionary after all by bringing tangential and sometimes disturbing insights into medicine in the rich developed world.

Corrections

Apologies to Rachel Besser and Catriona Richardson for our inconsistency with their names. We referred to Rachel as Rachel Blesser in "This Week" (12 January) and to Catriona as Catriona Robertson in the article she did on "Problem doctors" (19 January).

THE WAY I SEE IT ...

Working with teenagers is fun and may change the way you consider the “patient’s perspective”

Despite various friends and colleagues smirking at the prospect of my working with teenagers, I recently finished a stint working as a doctor in a young persons’ sexual health service. I am not known for my in depth knowledge of daytime television or an ability to discern Boyzone from Britney, and there might have been threats of compulsory belly piercing and glittering boob tubes. But geriatricians don’t all play bridge and wear beige cardigans, and I was relieved to discover that dressing informally was enough.

I worked in a truly multidisciplinary team, which was not always easy but usually stretching. The nurse team involved had a huge breadth of experience, but it was the community education workers (also known as youth workers) who made this a truly unique team experience. No tattoos or street language, just people who have training and experience in working with young people.

They forced me to revise my use of language again and again

Their remit was to provide a welcoming, non-intimidating space for the clients (I use that word to emphasise the social model of health we aspired to) to sit and chat while they waited or decided whether to see one of the clinicians. There was no rocket science, and nothing really new behind it, but it did challenge many of the norms that we in the health service accept on a daily basis. What was unique about the youth workers was that they saw us healthcare professionals through the lens of the punter. There is no denying that we were intimidated by each other at the start, but, as the weeks unfolded, we got talking.

Many of the ways of working in this service were an attempt to engage the clients on a more equal footing. These were practices that the whole team had chosen to adopt: the use of first names for all staff, informal dress, allowing clients to hold their own records while waiting to be seen, welcoming (rather than allowing) friends into the consultations, and the design of the consulting rooms, which had the clients primarily in mind.

I enjoyed people remembering my name rather than my title, I enjoyed getting the accompanying friends’ perspective on the reliability (or otherwise) of the boyfriend in question, and I enjoyed not having a visible



NICK CUNNINGHAM

Belly piercing not compulsory

desk for the paper work to pile up on (what else is it for?). But the community education workers added something else as well. As we spent time together and got to know each other, they asked questions. Why does a nurse or doctor have to know when a client’s last period started? What does speculum mean? Are you sure a coil isn’t the size of a large water heater?

They forced me to revise my use of language again and again, and explain the hows and whys of every little thing we do as healthcare professionals. They uncovered issues the rest of us had never thought of, such as clients needing to be given explicit information about seeking antenatal care once they found out they were pregnant. They acted as a constant reminder of the view from the other side of the pill packet. I want to share my experience, not to enthrall or repel you or to make the obvious point that teenagers are great folk to work with (which, of course, they are), but to emphasise the point that, no matter how person centred or patient oriented we are and no matter how accessible we think we are making our services, we are firmly at the other end of the foil wrap. Our knowledge and experience put us there.

We need people with no healthcare background to engage with on an equal footing, to ask the often small but fundamental questions that will propel us into providing truly more accessible health services. How we engage clients in this process is a further challenge.

I finish with a client’s perspective on who should be involved in the arduous decision about whether to be referred for a termination of pregnancy: “My boyfriend? He wouldn’t cope. He’s far too young to be getting involved in serious things like that.” I could not have predicted that one.

Andrea E Williamson *fellow in general practice*

TIPS ON ...

Psychometric testing

Psychometric tests are used in selecting new staff, promoting staff, career counselling and development, assessing performance difficulties, and personal development.

Information they provide

Different tests focus on different aspects of ability or personality, but the following are typically of interest in the context of medical practice:

- Verbal and numerical reasoning ability
- Emotional stability and resilience
- Styles of influencing decisions and leadership style
- Styles of interpersonal relationships
- Problem solving and decision making abilities
- Openness to new ideas and experience
- Career beliefs and motivation (including occupational interests)
- Team roles and contributions.

Applications

Psychometric tests have recently been used in the following medical contexts:

- Assessing behavioural factors in poorly performing doctors
- Career guidance for senior house officers
- Personal development and career guidance for senior doctors
- Identifying different leadership styles in senior doctors and health service managers (as part of team development).

Limitations of psychometric testing

Although psychological tests can aid and inform a decision, they cannot provide a definitive answer. They should always be used in conjunction with a thorough interview by qualified individuals who have the British Psychological Society or equivalent qualifications in psychological testing. Some publishers of tests offer their own qualifying courses in specific tests. Robust measures are not easy to fake, but the potential for bias is there.

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Further information

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