

An instrument for assessment of videotapes of general practitioners' performance

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Abstract

Objectives—To identify those important characteristics of doctors' and patients' behaviour that distinguish between "good" and "bad" consultations when viewed on videotape; to use these characteristics to develop a reliable instrument for assessing general practitioners' performance in their own consultations.

Design—Questionnaires completed by patients, general practitioner trainers, and general practitioner trainees. Reliability of draft instrument tested by general practitioner trainers.

Setting—All vocational training schemes for general practice in the Northern region of England.

Subjects—First stage: 76 patients in seven groups, 108 general practice trainers in 12 groups, and 122 general practice trainees in 10 groups. Second stage: 85 general practice trainers in 12 groups.

Main outcome measures—Trainers' ratings of importance; α coefficients of draft instrument by trainee, group, and consultation.

Results—6890 characteristics of good and bad consultations were consolidated into a draft assessment instrument consisting of 46 pairs of definitions separated by six point bipolar scales. Nine statement pairs given low importance ratings by trainers were eliminated, reducing the instrument to 37 statement pairs. To test reliability, general practitioner trainers used the instrument to assess three consultations. With the exception of one group of trainers, all α coefficients exceeded the acceptable level of 0.80.

Conclusion—The instrument produced is reliable for assessing general practitioners' performance in their own consultations.

Introduction

Assessment in medical education is an integral part of the "educational triangle" of aims, methods, and assessment.¹ Once a trainee's strengths and weaknesses have been identified, training can be focused on his or her individual needs. On completion of training the trainee, the teachers, and society should know that an acceptable standard of competence has been reached.

In general practice in the United Kingdom there is agreement that regular formative assessment using a variety of methods to measure different trainee attributes is a necessary part of the educational process. Since January 1993 assessment has been mandatory.²

Existing methods of assessment such as written papers, oral examinations, long and short cases, and objective structured clinical examinations have inbuilt problems of validity. Although it is important to know what candidates can do, it is equally or more important to know what they actually do.³ The relation between what a doctor is capable of doing (competence) and

what he or she does in practice (performance) is tenuous.⁴⁻⁸ There is considerable interest in the use of objective structured clinical examinations and simulated, standardised patients in assessment,⁹⁻¹³ but it is not easy to ensure that simulated patients behave consistently in consultations with different candidates.^{14 15}

Encounters with simulated patients also require the doctor and patient to establish a new relationship and deal with a problem for the first time. In reality, however, many general practice consultations are part of a longer term relationship in which, for example, diagnoses and management plans emerge over series of encounters. We attempted to improve validity by looking at the doctor's actual performance in real life consultations, including those with patients already known to the doctor.

Analysis of videotaped consultations is widely used in medical education in many disciplines.^{16 17} Methods include "mapping" of consultations, in which observers describe the processes of problem definition, taking action, etc,¹⁸ or more general judgments about the interaction between doctor and patient, including attitudes such as the trainee's confidence.¹⁹ However, a valid, reliable, and feasible method for measuring a general practitioner's performance by using videotape is not yet available. The purpose of this study was to develop such an instrument, which could be used together with other assessment methods that test different attributes such as knowledge and problem solving²⁰ to produce an overall profile²¹ of a candidate's competence and performance.

To develop an assessment instrument one must first decide what attributes should be measured.^{22 23} There are many attributes of a competent general practitioner,^{24 25} not all of which can be tested by one type of test. We started from basic principles and asked patients, experienced general practitioners, and trainees to identify the important characteristics of "good" and "bad" general practitioners which could be assessed through videotaped consultations.

Methods

The study was carried out in two stages: constructing the instrument and validating it.

CONSTRUCTING THE INSTRUMENT

All general practice trainers in the Northern region are members of trainer groups that meet regularly. Trainees also meet regularly for the "academic" part of their vocational training courses. One meeting of each of the 12 trainer groups and 10 trainee groups was dedicated to the first stage of the study. Participants were asked to identify those important characteristics of doctor and patient behaviour that distinguish between good and bad consultations when viewed on video.

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Instrument for assessing videotapes of doctors' performance in consultations

Markers circle the vertical line on each scale that most closely describes agreement with the statements at each end of the scale. If they have insufficient information to give a mark they write X in the box.

The doctor concentrates on records / computer / or elsewhere than the patient / avoids eye contact	<input type="checkbox"/>	There is eye contact between doctor and patient most of the time
The doctor is relaxed / tolerant	<input type="checkbox"/>	The doctor is tense / uncomfortable / impatient / irritated / rude / loses temper / has irritating habits
The patient is not involved in decision making	<input type="checkbox"/>	The patient is involved in decision making
The doctor is cold / distant / frightening / unfriendly / abrupt / sarcastic	<input type="checkbox"/>	The doctor smiles / is warm / friendly / pleasant / touches patient when appropriate
The doctor explains diagnosis / management / side effects of treatment	<input type="checkbox"/>	The doctor does not explain diagnosis / management / side effects of treatment
The doctor is discreet / respects confidentiality	<input type="checkbox"/>	The doctor breaches confidentiality
The doctor makes an appropriate physical examination when necessary	<input type="checkbox"/>	Physical examination of the patient is inadequate / examination inappropriate
The doctor is knowledgeable / up to date	<input type="checkbox"/>	The doctor lacks up to date knowledge
The doctor is authoritarian / patronising / judgmental / moralising / pompous / condescending	<input type="checkbox"/>	The doctor is humble / approachable / flexible / treats the patient as an equal
The doctor is honest	<input type="checkbox"/>	The doctor is dishonest / evasive / insincere / oversincere
The doctor's diagnosis and management appear to be sensible / safe / helpful / correct / considers alternatives	<input type="checkbox"/>	The doctor's diagnosis and management are irrational / unjustified / dangerous
Follow up arrangements are inadequate / unnecessary / unclear	<input type="checkbox"/>	The doctor arranges appropriate follow up
The doctor prescribes prematurely / inappropriately	<input type="checkbox"/>	The doctor prescribes appropriately
The doctor wastes time	<input type="checkbox"/>	The doctor uses time efficiently
The doctor answers questions	<input type="checkbox"/>	The doctor ignores or evades questions
The doctor considers patient and family history / background	<input type="checkbox"/>	The doctor makes incorrect assumptions / jumps to conclusions
The doctor is not courteous	<input type="checkbox"/>	The doctor is courteous
At the end of the consultation the patient appears unnecessarily angry / irritated / unhappy / complains	<input type="checkbox"/>	Allowing for the nature of the consultation the patient appears satisfied at the end
The doctor allows patient opportunity to discuss other problems	<input type="checkbox"/>	There is no opportunity for the patient to discuss other problems with the doctor
The doctor is reassuring / encouraging / decisive / inspires confidence	<input type="checkbox"/>	The doctor fails to reassure the patient or inspire confidence / indecisive / overconfident
The doctor ends the consultation well	<input type="checkbox"/>	The end of the consultation is rude / prolonged / abrupt
The doctor explores patient's ideas / concerns / expectations	<input type="checkbox"/>	The doctor ignores the patient's ideas / concerns / expectations / fails to recognise reason for consultation
The doctor ignores continuing problems	<input type="checkbox"/>	The doctor inquires about and manages continuing problems
Investigations are neglected / illogical / unjustifiable	<input type="checkbox"/>	If necessary, the doctor undertakes appropriate investigations / x rays, etc
The doctor is empathetic	<input type="checkbox"/>	The doctor disregards / dismisses / trivialises patient's views / feelings
The doctor uses inappropriate language / medical jargon / swamps patient with information	<input type="checkbox"/>	The patient understands the doctor
The doctor listens to the patient / looks interested	<input type="checkbox"/>	The doctor ignores the patient / talks too much / is offhand / aloof / uninterested / bored
The doctor's approach is thorough	<input type="checkbox"/>	The doctor's approach is superficial / casual
The doctor is thoughtless / unkind / uncaring	<input type="checkbox"/>	The doctor is caring / kind
The doctor misses or misinterprets cues / clues / body language / hidden agenda	<input type="checkbox"/>	The doctor picks up cues / clues / body language / hidden agenda
The doctor gives appropriate advice	<input type="checkbox"/>	The doctor gives inappropriate / impractical advice or fails to respond to verbal or non-verbal request for advice
The doctor allows time for the patient	<input type="checkbox"/>	The consultation is hurried / rushed
The doctor makes unnecessary or inappropriate referrals or fails to refer when necessary	<input type="checkbox"/>	If necessary, the doctor makes an appropriate referral (within or without the practice)
Allowing for the nature of the consultation the patient appears to be as relaxed / at ease as possible	<input type="checkbox"/>	The patient appears unnecessarily uncomfortable / confused / dissatisfied during the consultation
The doctor is confused / contradictory / disorganised / dithers / fumbles	<input type="checkbox"/>	The consultation is logical / well organised
The doctor interrupts the patient unnecessarily	<input type="checkbox"/>	The doctor does not interrupt the patient inappropriately
The doctor takes an adequate and appropriate history from the patient	<input type="checkbox"/>	The history taken is inadequate / inappropriate / irrelevant / disorganised

Organisers of patient groups in a range of urban, rural, and geographically mixed practices were selected to reflect the region as a whole. Organisers were asked to invite a group of about 12 patients including a range of age (from 16 upwards), sex, and social class in proportion to their practice population.

Definitions of "good" and "bad" were deliberately left open to encourage participants to generate ideas. Participants were given the following information:

We are trying to find out what you think are the most important characteristics of a good general practice consultation and what are the features of a bad consultation.

We are interested only in assessing the doctors' conduct of the consultation—not other aspects of the practice such as organisation, decor, and staff.

Please make two lists—not necessarily in order of importance. Firstly, list the things about the doctor that you think are good (in the left hand column) then list the things you think are "bad" in the right hand column.

The principles of ethnography, a qualitative research method used in sociological studies to understand behaviour,^{26,27} were used to consolidate 6890 responses into a draft assessment instrument containing 46 statement pairs of good and bad characteristics. Essentially, the method requires the researcher to focus on findings or events that do not fit into existing concepts (breakdowns) and repeatedly resynthesise the concepts until breakdowns are eliminated and a coherent account that accommodates them has been achieved.

The resulting draft assessment instrument consisted of 46 pairs of descriptive adjectives that defined extreme good and bad characteristics. Each pair was attached to a six point bipolar rating scale. An even number of divisions was used so that respondents could not choose the midpoint but must make a decision.

VALIDATION AND RELIABILITY TESTING

On the premise that the instrument is to be used by professional general practice educators, the second stage—validation—was confined to general practice trainers. At a second meeting, each trainer group member was asked to score the importance of each statement pair in the draft instrument on a scale from 0 (of no importance at all) to 5 (extremely important), to propose any additional items that should have been included, and to suggest any other modifications to the instrument.

We eliminated statement pairs with a mean score of less than 3.5 from the questionnaire. The remaining statement pairs were randomised in two ways: good and bad characteristics were randomly allocated to the left or right hand ends of the scales and the order of statement pairs was randomised so that the characteristics to be assessed were not arranged in sequence.

We tested the reliability for each statement pair by asking each trainer to use the draft instrument to assess videotapes of three trainee consultations at the second group meeting. We selected consultations to reflect a variety of patients by age and sex and to include patients known and not known to the doctor. Each group of trainers watched two consultations by one trainee and a third by a different trainee. Between 13 and 26 markers scored each consultation.

By systematically assigning different consultations to different groups it was possible to calculate reliability of scores for each trainee, for each consultation, and between markers within each group. The measure of reliability used was the α coefficient, a measure of the degree of consistency within a test.²⁸ The higher the value, the greater the reliability; an acceptable value is 0.80.²⁹

Results

INSTRUMENT CONSTRUCTION

A total of 6890 (5585 individual and 1305 group) responses were derived from 29 groups, of which 3829 (55.6%) responses were good characteristics and 3061 (44.4%) bad. Table I shows the composition of the groups. Although trainer and trainee groups were representative of the region as a whole, patient groups tended towards older, female participants.

More than 90% of responses could be incorporated into statement pairs. Table II shows the 10 statement pairs supported by most individuals and groups.

The only statement pair supported by more trainees than trainers concerned the importance of humility, approachability, flexibility, and treating the patient as an equal. Conversely, trainers more than trainees emphasised the importance of time management, physical examination, investigations, diagnoses, management, and follow up arrangements.

There was considerable agreement between doctors and patients that good doctors listen to their patients and that bad doctors ignore them, that good doctors allow time for their patients whereas bad doctors hurry or rush, and that good doctors explain the diagnosis, management, and side effects of treatment whereas bad doctors do not.

VALIDATION AND RELIABILITY TESTING

Eighty five (54%) of the region's 156 trainers met for a second time. Table III shows their importance scores for each statement pair. The mean rating of 37 of the 46 statement pairs was greater than 3.5. The nine statement pairs with a mean rating of less than 3.5 were eliminated from the instrument.

No additional items were proposed. Several trainers suggested rewording of statements but there were no consistent comments so we did not make any changes.

TABLE I—Instrument construction: composition of groups and numbers of responses

	Trainers	Trainees	Patients
No of groups	12	10	7
No of participants	108	122	76
No (%) in region	156 (69)	269 (45)	
Mean (range) group size	9.1 (4-13)	12.2 (8-17)	10.8 (6-13)
Mean (range) age (years)	41 (30-64)	28 (23-53)	50 (17-79)
Male:female ratio	88:10	64:47	26:48
No (%) with age or sex not given	10 (10)	11 (9)	2 (3)
No of responses:			
"Good" individual responses	1307	1307	498
"Bad" individual responses	1169	962	342
"Good" group responses	334	260	123
"Bad" group responses	285	207	96
Total responses	3095	2736	1059
Mean responses per participant	28.6	27.4	13.9

TABLE II—Statement pairs most often volunteered as distinguishing "good" and "bad" doctors

Statement pair	No (%) of individuals	No (%) of groups
1 The doctor listens to the patient/looks interested. The doctor ignores the patient/talks too much/is offhand/alooof/uninterested/bored.	252 (82)	27 (93)
2 There is eye contact between the doctor and patient most of the time. The doctor concentrates on records/computer/elsewhere than the patient/avoids eye contact.	196 (64)	29 (100)
3 The doctor explains diagnosis/management/side effects of treatment. The doctor does not explain diagnosis/management/side effects of treatment.	186 (61)	28 (96)
4 The doctor allows time for the patient. The consultation is hurried/rushed.	176 (57)	24 (83)
5 The doctor is empathetic. The doctor disregards/dismisses/trivialises the patient's views/feelings.	176 (57)	22 (76)
6 The doctor smiles/is warm/friendly/pleasant/touches the patient when appropriate. The doctor is cold/distant/frightening/unfriendly/abrupt/sarcastic.	167 (54)	23 (79)
7 The doctor is humble/approachable/flexible/treats the patient as an equal. The doctor is authoritarian/patronising/judgmental/moralising/pompous/condescending.	142 (46)	24 (83)
8 The doctor is reassuring/encouraging/decisive/inspires confidence. The doctor fails to reassure the patient or inspire confidence/indecisive/overconfident.	140 (46)	25 (86)
9 The doctor is relaxed/tolerant. The doctor is tense/uncomfortable/impatient/irritated/rude/loses temper/has irritating habits.	136 (44)	21 (72)
10 The patient is involved in decision making. The patient is not involved in decision making.	132 (43)	24 (83)

TABLE III—Mean importance ratings for statement pairs

Mean (scale 0-5)	Frequency	Cumulative frequency
2.5-	2	2
3.0-	7	9
3.5-	11	20
4.0-	24	44
4.5-5.0	2	46

TABLE IV—Reliability analysis (individual statement pairs)

	α Coefficient
Trainee No:	
1	0.89
2	0.88
3	0.88
4	0.92
5	0.95
6	0.90
Group No (No in group):	
1 (7)	0.91
2 (8)	0.85
3 (9)	0.91
4 (9)	0.93
5 (8)	0.84
6 (6)	0.95
7 (8)	0.92
8 (4)	0.96
9 (9)	0.91
10 (3)	0.79
11 (6)	0.96
12 (8)	0.91
Consultation No (trainee No):	
1 (1)	0.91
2 (1)	0.85
3 (2)	0.89
4 (2)	0.84
5 (3)	0.90
6 (3)	0.89
7 (4)	0.91
8 (4)	0.88
9 (5)	0.93
10 (5)	0.93
11 (6)	0.91
12 (6)	0.83

Reliability of scores both by consultation and by trainee was greater than 0.83 for every statement pair and is shown in table IV together with intermarker reliability for each trainer group. With the exception of group 10, which consisted of only three trainers, all the α coefficients exceeded the acceptable level of 0.80.

The final instrument, which consisted of 37 statement pairs separated by a 6 point scale, is shown in the box.

Discussion

Most descriptions of general practice consultations are still based, at least in part, on the pioneering work of Byrne and Long³⁰ who in the early 1970s analysed audiotapes of consultations. They listed behaviours that occurred frequently and described a logical (but rare) sequence of six stages of an "ideal" consultation.

Hays in Australia,¹⁹ Pendleton *et al*,¹⁸ and Fraser *et al*¹ have developed Byrne and Long's model, devising instruments for assessing the process of consultations. These methods are based on descriptions of consultations developed for teaching and learning. The model or "construct" in this study is different. It was specifically developed for the purpose of assessment.

Instead of using existing models of the consultation we went back to basic principles and asked trainers, trainees, and patients to characterise those qualities of a consultation that distinguish between good and bad general practitioners. Thus we established face validity from basic principles. By assessing real life consultations, without the use of simulated, standardised patients, our method bridges the gap between competence and performance.

The doctors and patients who contributed to the study emphasised the importance of doctors' attitudes when distinguishing between good and bad doctors.

This view is confirmed by the General Medical Council in their proposals for new performance review procedures.³²

The instrument could be used to assess only those attributes (including doctors' attitudes) that can be seen, heard, or deduced through observation of videotaped consultations. Attributes such as problem solving ability, record keeping, or depth and breadth of knowledge can not be assessed in this way. If an instrument such as ours was, for example, to be used by trainers or other assessors for the summative assessment of trainees at the end of training or of doctors whose standards of performance were in doubt then it would also be necessary to use other assessment methods to obtain a profile of their strengths and weaknesses.

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A PATIENT WHO CHANGED MY PRACTICE

Defining the limits of empathy

Steve was a policeman in his 30s, retired on medical grounds because of chronic glomerulonephritis. I got to know him in 1971 as one of the patients on the renal unit at the London Hospital, where I had just been appointed as a lecturer. In the early 1970s I was an outspoken radical and intent on demonstrating a different approach. A major component was accessibility. I was John and the patients were friends. Steve lived in a council house in suburban Essex and I was invited to meet his wife and his 12 year old son Martin. Like me, Martin was an Arsenal fan, and on a couple of occasions I took him to Highbury.

One morning I came on to the dialysis unit to find Steve ghostly pale and unconscious with a blood transfusion running. The night before he had connected himself up to his home haemodialysis machine, apparently without properly checking the connections, and a line had come apart during the night. It seems that the machine alarm had not worked, either because it, too, had not been checked or because of a mechanical fault. For the next two or three days I was unable to function properly. I was as worried as any relative could be about what would happen. That my anxieties were informed anxieties made me, if anything, more worried rather than less.

Steve did recover, with nothing more than a little retrograde amnesia. When I went to see him he had been discussing with the staff and his wife what might have gone wrong and he was expecting a severe carpeting from

me. But I was far too relieved to be cross with him and just said, "Well, I don't suppose you'll do that again, Steve."

I think my practice has changed in two ways. Firstly, I'm much more at arm's length in my involvement with, but I hope not in my sympathy for, patients. It has to be possible to be sympathetic and caring without your patient's problems becoming your problems. I am convinced that any gains that could accrue are far outweighed by the loss of objectivity that we experience when someone we love is ill. Caring practice is the need to walk a tightrope, being neither heartless nor paralysed by emotion. Secondly, I now realise that it is not necessary to chastise and rap knuckles. A few weeks after his discharge Steve told me that the thing that frightened him most when he recovered consciousness was what I was going to say. The fact that I made light of it, he said, made him feel more determined to be careful than any telling off could possibly have done. Most people are pretty well aware of having failed to follow instructions or having done something stupid or damaging to their health. The return to the schoolteacher and pupil paradigm, with lines and standing in corners, is only a recipe for truancy.—JOHN S YUDKIN is professor of medicine, University College London

We welcome contributions to fillers: *A patient who changed my practice; A paper that changed my practice; A memorable patient; The message I would most like to leave behind, or similar topics.*