LETTERS

Failing sick doctors

EDITOR,—Recent experience has shown me some of the deficiencies in the National Advisory Service for Sick Doctors and the health section of the General Medical Council.[1] I became aware of another doctor with alcohol problems and received comments from a district nurse, a local pharmacist, and several local doctors. The doctor concerned was not known directly to me, but I thought that I should take some action before a disaster occurred. I had received comments about serious errors in prescriptions and his apparent confusion at times.

I contacted the National Advisory Service for Sick Doctors. The advice I was given was neither helpful nor practical: I was told to give the doctor the telephone number of the service and ask him to get in contact. From what I had heard I knew that this would not be well received. I also contacted the General Medical Council, which required specific information about incidents involving the practitioner. Clearly I was not in a position to provide this as I had no first hand knowledge. Finally, I was able to speak to the secretary of the local medical committee, who knew of the problem and was acquainted with the doctor's own general practitioner. Unfortunately, this "softly softly" approach does not seem to have borne much fruit. The doctor concerned continues to practise when there is some likelihood that he is unfit to do so.

While I realise that the bodies concerned are reluctant to act on rumour and innuendo, it seems impossible for them to take action when a colleague has adequate grounds for at least some concern.

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1 So easy to start. *BMJ* 1995;310:337. (5 February.)

The inhumanity of medicine

Interpersonal and communication skills can be taught

EDITOR,—D J Weatherall asks, with regard to the teaching of interpersonal relationships in medical educations, "can such attitudes be taught?" and, "given our track record, who is to teach them?"[1] He asserts that, "except by example, no medical school can teach a young person to be understanding and caring—this can only come from experience of life." Earlier, however, he mentions "the delightful, caring, and extremely gifted young people" entering medical school.

Perhaps the problem is not so much "teaching" caring as ensuring that it is nurtured rather than squeezed out by the very process of medical education. In 1970 Helfer first showed that as medical students moved through their training their interpersonal communication skills diminished.[2] Often, doctors who have had little training in communication skills provide a poor role model for students. Even when excellent interpersonal skills are evident, the care that would routinely be taken to explain and impart the skills of, say, the physical examination is missing.

We know from research into medical education that interpersonal and communication skills can be taught and that the benefits of this teaching persist.[3] Students can, for instance, be trained to empathise.[4] Teaching by use of observation, well intentioned feedback, and rehearsal enable the acquisition of interpersonal skills; in contrast, experience alone may well only reinforce bad habits.

This research has now been turned into practical teaching programmes. For instance, at the University of Calgary training in communication skills has been a major plank of the medical school's curriculum for 19 years, tackling increasingly complex areas as the course progresses.[5] In the vocational training scheme for general practice in Cambridge, central importance has been given to attending to both disease (the symptoms and signs, diagnostic reasoning, and biomedical understanding that characterise Western medicine) and illness (the unique experience of the individual patient—or his or her ideas, concerns, expectations, feelings, and thoughts) in every consultation.

Skills that lead to better caring and understanding can therefore be taught. Perhaps of even greater importance is that considerable research now shows that interpersonal and communication skills make a difference not only to patients' satisfaction but also to compliance and the outcome of disease. Accurate and efficient care, not just supportiveness, is therefore the prize to be achieved through the teaching of these skills.

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2 Helfer RE. An objective comparison of the pediatric interviewing skills of freshman and senior medical students. *Pediatrics* 1970;45:623-7.
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Medical education is brutalising

EDITOR,—We believe that the dehumanisation of medicine that D J Weatherall describes lies behind much of the miscontent, demoralisation, and mental ill health of doctors, increasing numbers of whom are being referred for help.[1] Last year we piloted a preventive intervention, which was not entirely successful. We invite discussion on why this might be so.

We taught psychotherapy to fifth year medical students over eight weeks. We covered subjects such as death and dying, the doctor-patient relationship, difficult patients, the BMA's video *A Stressful Shift*, and somatic presentation of emotional disorder. We deliberately left the last session unstructured to allow free discussion. Much alienation and distress were clearly expressed, and students reported how helpful that was.

Encouraged by this, we decided to set up "more of the same" for when the students became house officers. Fourteen expressed interest, and we planned a fortnightly discussion group over six months, with periodic evaluation by use of the interval general health questonnaire and questions about drinking, smoking, and difficulties with relationships. The group was led by two doctors: a male registrar on one year attachment in psychotherapy (JA) and a female psychotherapist who had been a general practitioner (AB); the work was supervised by senior registrar in psychotherapy who was trained in working with groups (RH). The intention was to discuss and try to understand the psychological aspects of normal medical and surgical care.

Nine house officers started coming, but attendance dwindled rapidly; numbers were down to ones, twos, and threes after two months. The discussions seemed valuable, with clear articulation and some understanding of difficult emotional situations at work. The last three scheduled meetings were not attended by any house officers, although the participants had been reminded by letter that the group was available. The meetings therefore stopped, and evaluation of the questionnaires was not possible.

We believe that we were observing one of the brutalising processes of medical education. Enthusiastic and interested medical students had become busy and stressed house officers without time or inclination to consider the more difficult aspects of their work. It is a small conceptual leap to hypothesise that it becomes too difficult for house officers to think about these issues because they then also need to ask themselves difficult questions: about what is happening to them, their ideals, and their self image. Perhaps such questions provoke too much anxiety at this stage of their careers.

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1 Weatherall DJ. The inhumanity of medicine. *BMJ* 1994;309:1671-2. (24-31 December.)

Falling quality of caring mirrors the rise of materialism

EDITOR,—D J Weatherall seeks an explanation of the apparent downgrading of the quality of medical caring.[1] I believe that this mirrors the ascendency of materialism and the decline in spiritual and moral values that have taken place over the past 50 years. A good example is to be found in the classified advertisement section of the issue containing Weatherall's editorial: the MEDICS Locum Agency advertises that "Money answers all things."

The main concern is not what is responsible for

this but what can be done about it. We must all share the blame; the responsibility is proportionate to the responsibilities that we each hold in the health service, diminishing in increments from deans, professors, and directors to medical students. Each can play a part in putting things right. I do not think that making medical trainees "more rounded people before they enter medical school" is feasible.

I have six suggestions. Firstly, two articles on palliative care in the Christmas issue[2,3] should be given to every medical student on qualifying under a front sheet stating that the traditional role of a doctor is "comfort always, help sometimes, cure rarely."

Secondly, a lecture on great doctors of the past whose lives in medicine have been of great benefit to those who have suffered illness should be given termly or annually. For instance, in orthopaedic surgery I think of Hugh Owen Thomas, Robert Jones, and Gaythorne R Girdlestone.

Thirdly, I have seen leading orthopaedic surgeons competing in "my most instructive mistake" competitions." There is nothing more refreshing than to learn of mistakes: they are a wonderful antidote to the constantly trumpeted records of clinical success. It would be extremely valuable to witness such a competition played out among physicians, surgeons, nurse managers, and hospital administrators; final year students could adjudicate.

Fourthly, I suggest that the *BMJ* should invite consultant A, mentioned in one of the articles on palliative care,[2] to submit an account about how he is going to improve matters in his team so that the suffering described in the article is less likely to happen again.

Fifthly, assessment of medical students by their teachers is now common, but as far as I know few medical schools in Britain, if any, ask pupils to assess teachers. This was once done unofficially in Birmingham, and the student responsible was threatened with expulsion when the assessment was widely circulated.

Sixthly, one or more terminal care physicians from the hospice movement should be given honorary university appointments and medical students should be attached on secondment for a week or two.

Others will find their own inspiration for moves to improve the quality of care, which is a complement to technological achievement, not an alternative. The current rearrangements in the NHS are likely to aggravate the problem because admissions and medical hours worked will both be shorter.

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1 Weatherhall DJ. The inhumanity of medicine. *BMJ* 1994;**309**: 1671-2. (24-31 December.)
2 Dying for palliative care. *BMJ* 1994;**309**:1696-9. (24-31 December.)
3 Going private: time for change. *BMJ* 1994;**309**:1699-700. (24-31 December.)

Audit of doctors and patients' views may help

Editor,—D J Weatherall's comments on the interpersonal skills of clinical staff highlight how good communication enhances clinical effectiveness.[1] This has been shown by several studies.[2,3] While communication skills are increasingly being included in undergraduate courses and postgraduate training in general practice and psychiatry, for example, there remain the questions of how communication between a clinician and a patient may be assessed and improved for established health care professionals and how the patient might have a direct input.

The former Wessex Regional Health Authority has worked with the College of Health and a communication skills facilitator to pilot a simple approach to an audit of consultations. The basic premise is that the doctor and the patient should hold the same views of the nature and effectiveness of the exchange of information at a consultation. Focus groups were arranged to determine patients' views of the key features of visits to a consultant. Results, combined with a review of video recordings of consultations, provided seven key elements in the exchange of information. These seven elements were incorporated into statements included in two questionnaires, one from the patient's perspective and one from the doctor's perspective. Both doctor and patient were asked to assess the statements, with respect to the consultation just completed, on a five point Likert scale; space was available for free text comments as well. In a pilot study, in which the patients remained anonymous but the consultants could be identified, 120 paired questionnaires were analysed by the College of Health and results were fed back to the five consultants (two surgical and three medical specialties) who participated in the study.

The process encouraged the doctors to reflect on their approach to communication with patients during consultations and enhanced their interest in this topic. The patients also found the exercise valuable and expressed their feeling of involvement in an important aspect of care. Free text comments from patients were a valuable stimulus to discussion when the five consultants met to discuss the findings. Feedback was generally positive, probably because of the way in which the group had been chosen and its willingness to participate. When this approach is used more widely, however, specific training needs may be identified; these should be met by courses for health care professionals in communication skills, counselling, etc. This audit approach may help to enhance communication in clinical practice.

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1 Weatherall DJ. The inhumanity of medicine. *BMJ* 1994;**309**: 1671-2. (24-31 December.)
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Medical students are positive about the future

Editor,—It is unfortunate that an editorial entitled "The inhumanity of medicine" should focus on medical students.[1] Many would argue that students are in a better position than hardened professionals to spot inhumanities in established procedures and are more perceptive of insensitive behaviour towards patients. D J Weatherall seems to blame students and juniors for the situation in which they find themselves rather than the educational, political, and medical authorities. Can 15 year olds be held responsible for the system that requires them to become "narrow specialists" by choosing just three or four subjects at A level? Is it medical students' fault that they do not have the time or money to pursue a broad range of interests including "enjoying the arts" and "learning about the world at large"?

I have never heard of a medical school that has had trouble filling student positions on committees, and the membership of the BMA among students has never been higher. We cannot be accused of not contributing to the improvement of our situation.

In contrast with Weatherall, I feel positive about the future humanity of medicine. The wholesale reform of the curriculum going on at medical schools throughout Britain to meet the recommendations of the General Medical Council's framework document *Tomorrow's Doctors* is revitalising teaching, thanks to the daring and commitment of many staff. Despite the problems of the profession at large the calibre of applicants attracted to the undergraduate course is as high as ever. I take issue with Weatherall over what he claims to be the increasingly narrow experience of life of today's students. Large numbers of students take a year off between school and university to broaden their outlook by travel, voluntary work, or employment of various kinds. Modern courses place emphasis on awareness of and respect for the diversity of modern family and social circumstances. Despite pressure on their time many students maintain interests outside medicine—perhaps the fictitious "goal oriented" grade VIII musician whom Weatherall derides now plays in a jazz trio or busks in the high street on a Saturday morning to supplement a student loan.

If students are to be targeted in calls to improve the humanity of the profession the onus falls equally on their teachers to be committed to this crucial feature of their professional lives.

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1 Weatherall DJ. The inhumanity of medicine. *BMJ* 1994;**309**: 1671-2. (24-31 December.)

Plato on social inequality

Editor,—"In Britain inequality is spiralling out of control," Peter Townsend writes as the subtitle of his editorial,[1] published in juxtaposition to an editorial carrying the subtitle "*Homelessness is an avoidable cause of ill health.*"[2] It may be salutary to take into consideration the views of Plato, writing in the 4th century BC on the topic of inequality in the distribution of wealth.[3]

> The form of law which I should propose as the natural sequel would be as follows: In a state which is desirous of being saved from all plagues—not faction but rather distraction—there should exist among the citizens neither extreme poverty, nor, again, excess of wealth, for both are productive of both these evils. Now the legislator should determine what is to be the limit of poverty or wealth. Let the limit of poverty be the value of the lot; this ought to be preserved, and no ruler, nor any one else who aspires after a reputation for virtue, will allow the lot to be impaired in any case. This the legislator gives as a measure, and he will permit a man to acquire double or triple, or as much as four times the amount of this.

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2 Heath I. The poor man at his gate. *BMJ* 1994;**309**:1675-6. (24-31 December.)
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