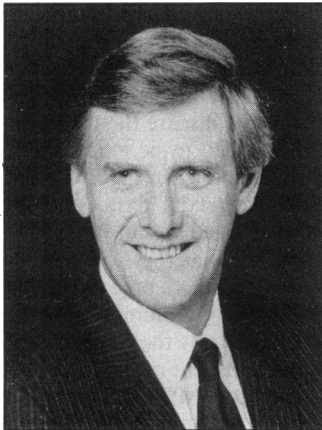


# The crucible

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## Introduction

I NEVER had the privilege of meeting our first President, William Pickles, but I remember well the tape-recorded message he sent on the occasion of the inaugural Pickles lecture in 1967. Only a few weeks ago I enjoyed a quiet ramble down Wensleydale, where his practice was established — the district which provided him with his laboratory for *Epidemiology in a country practice*.<sup>1</sup> Alas, its railway, which furnished Pat Byrne with his memorable title for that lecture, 'The passing of the eight train'<sup>2</sup> is no more, but the skein of villages threading the valley which the railway served have lost none of their beauty. These villages of course were Pickles' laboratory, and in his patients' journeys and meetings up and down the Dale, he was able to discern the patterns of illness and, more importantly, of individual illnesses in a defined population, because he was determined to learn from every consultation, both during it, and in analysing the data collected in it afterwards. I will return to this theme, but there is one other thing which I would like you to know about Wensleydale — that it is the origin and first home of the Metcalfe family, who were well established when William of Normandy had his Doomsday book compiled 900 years ago this year. Indeed, Nappa Hall, a typical fortified manor house, is still owned by a Metcalfe, although he is no close relation.

A closer connection with the Pickles lecture of course is that the first one was delivered by my old friend and respected predecessor in the Chair at Manchester, Pat Byrne. He was, by any standards, a considerable orator — who, with an Irish background and a Liverpool foreground, could fail to be? By the time he gave the first Pickles lecture, this College had already made much progress in establishing the academic credibility of general practice, drawing on the inspiration of Pickles and McKenzie before him, and on its own burgeoning research achievement under the leadership of such people as John Fry, Ian Watson, Keith Hodgkin, Robin Pinsent and Donald Crom-

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bie, to all of whom I owe an enormous personal debt. Their work allowed us to identify the body of knowledge that we could contribute to medical education, perhaps uniquely, and to evolve proper educational objectives and develop appropriate methods for achieving them. I believe that Pat Byrne's Pickles lecture established the rightful place of general practice in undergraduate medical education. Since then, John Wright and his colleagues have reinforced the extent to which learning in general practice is essential to the achievement of the educational objectives set by the General Medical Council.<sup>3</sup> I believe that the time has come to extend that claim to say that learning in general practice should be a central (rather than a peripheral) part of the medical curriculum, running through it like a core and providing the fundamental learning experiences to which all the others can be related.

I base this assertion on three considerations: first that the Declaration of Alma-Ata<sup>4</sup> — 'Health for all by the year 2000' — places new responsibilities on medical education which undoubtedly necessitate changes; secondly that conventional clinical teaching is becoming increasingly compromised by the financial stringencies to which all hospitals have become subject; and lastly because as the main providers of the fundamental transaction of medical care — the consultation — general practitioners can introduce students to the very crucible of learning.

## Our contribution

Wherever we practice, and whatever the health care system within which we practice, we share some of the responsibility for achieving health for all by the year 2000. Moreover, we share the central transaction of medical primary care, the consultation: that direct, intense, personal, and private interaction best described by Sir James Spence as 'the occasion when, in the intimacy of the consulting room or sick room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation and all else in the practice of medicine derives from it.'<sup>5</sup>

But what about the WHO declaration? Does not the scale and the urgency of the world's ill health make the niceties of the general practitioner's consultations not only irrelevant but impertinent? Half the world is malnourished, and for at least a third of the world's population after hunger comes the burden of endemic disease such as malaria, leprosy, bilharzia and gastroenteritis, exacting a toll not only of mortality, but of chronic debility which inhibits effectiveness, condemning them to a subsistence existence. In many developing countries these problems have been exacerbated by the export of 'top-down' high technology medicine, and the provision of inappropriate postgraduate education which often results in the country's valuable graduates leaving to practice (often being exploited) in richer countries. The massive problems that I have outlined are mainly in the realm of population medicine, sanitary engineering and political and economic action. Perhaps the most we can do is not get in the way. (That is not actually true: we ought as world citizens to be doing something about the obscene trade in arms which distorts the economies of so many developing countries. The world spends more every day on instruments of death than the WHO spent to eradicate smallpox. In this country half of all government funded research is in defence projects and only 5% of the other half goes into medical research.)

I believe, however, that general practice does have a part to play in 'Health for all by the year 2000', wherever it has become

established with a mandate from the people of the country concerned, provided that general practice deals with those tasks for which it is equipped, and does not compete for resources with other workers who can make equally great, or greater contributions. Essentially our proper expertise is in individual patient care and we must seek to attain health for our registered populations if we have them, or for those who consult if we do not. But what is health? The WHO definition of health as 'complete physical, social, and psychological well-being' says something that we must acknowledge: it is about a person's potential for living, which is a matter of autonomy and 'personal space', of having room to make choices. These are the concerns of general practice because our professional objectives are wider than the diagnosis and treatment of disease, but we too need to be careful lest diagnostic or therapeutic exuberance in the individual case blind us to our patients' needs for space and stature. Both Hannu Vuori<sup>6</sup> and John Horder<sup>7</sup> have pointed out that peoples' autonomy, both in general, and in terms of their health behaviour, is a central concern in the Alma-Ata Declaration. Abraham Maslow<sup>8</sup> said that peoples' ability to learn was limited by their level on a hierarchy of need: not knowing where the next meal is coming from absorbs all consciousness and leaves no room for choices. Rene Dubos<sup>9</sup> said that health is the ability to adapt your environment: to exercise choice.

The goals of a general practitioner are: to eliminate avoidable death; to eliminate avoidable disability; to eliminate avoidable suffering; and to eliminate avoidable risk in our practice populations or those who consult us. Nothing closes off space as much as death, and bereavement can be seen as loss of options, space, and therefore health in those left. Disability obviously diminishes personal space by constraining choices. But so, sometimes, does medical activism: sometimes people need permission to be invalids. Suffering, pain and distress have always been a concern of doctors, and always will be. Usually they diminish the sufferers' quality of life, narrow their choices, and dominate their feelings. At the same time we must remember that Ivan Illich<sup>10</sup> claims that suffering can be a stimulus to personal growth. We are often humbled by a patient's raw courage in struggling on, or finishing off something before acquiescing to our offers of anodyne. Immunization and protection from the squalid infectious diseases is unarguably important, but when we enter the realms of behaviour we must be cautious: if we take no risks we climb no mountains, explore no wildernesses, push back no frontiers. Our role is to teach people so that they can make informed choices, not to restrict them.

If, therefore, we as general practitioners are to make our unique contribution to health for all by the year 2000, it will be as personal doctors whose way of listening, examining, diagnosing, advising, treating and monitoring has as its objective not only the cure or control of disease but the protection or expansion of our patients' stature, autonomy and personal space. That is the kind of health we can deliver, even to people with disease, even to people who are dying. We do it in the consultation.

### The crucible

A crucible is used to enclose a raw material such as a metallic ore with a reducing agent and to subject them in the first place to outside energy, which results in the emergence of the pure metal. In our case the starting material is the situation presented by the patient, the reducing agent is the doctor, and the outcome is clinical reality. By clinical reality I mean the most rigorous interpretation of the evidence available, which pertains not only to the nature of the disease present (if any) but to the patient's physical, social and psychological environment in which management of the disease must be accomplished. 'Clinical reality' not only goes beyond diagnosis but is a safer, more

rigorous description of the outcome of the consultation. For one thing diagnosis and the management decision are not separate and sequential actions, but are intimately bound up with each other. More importantly 'diagnosis' as a concept has certain dangers which are important to avoid in medical learning.

First, the word diagnosis has a ring of finality and absolute truth about it which is misleading. Carl Popper, the great philosopher of science showed us that a statement only has scientific value if it is refutable (it can never be proved to be ultimately true).<sup>11</sup> Secondly, precise definition and measurement of pathophysiology is not always an appropriate objective, either because the illness is too minor to justify intensive investigation, or because in patients with chronic disease the diagnosis was made long ago but the decisions need to be made today. Thirdly, 'diagnosis' is not a 'pure' statement when stated in what our American friends have come to call 'triaxial' terms, and not all the components of assessment contained within it have the same degree of validity or reliability, so that they will have to be handled differently. Lastly, as both Sir George Pickering (Report of the Medical School Advisory Committee to the University of Nottingham) and, more recently the Chairman of our Scientific Foundation Board and President of the Irish College, James McCormick (Presentation to GMC Conference on Medical Education, 13 February 1986) have emphasized, the fundamental duty of medical education is to teach students to evaluate evidence scientifically. 'Clinical reality' is a safer concept, in these terms, than 'diagnosis' which is often imprecise but carries a spurious connotation of scientific value.

The crucible in our case is the consultation, and in it we try to refine the rich, many faceted, and sometimes confusing perceptions of the patient into clinical reality. It is a very intense interaction. The stakes are high, the time is relatively short and the information available incomplete. These stresses are compounded when the illness presented is due to, or complicated by, external malaise such as poverty, rotten housing, unemployment or fear — few of which factors the doctor can do anything about.

Once the reaction between the substrate and the reducing agent has started it may be exothermic or endothermic. We all experience two sorts of exothermic consultations. The good ones are those in which the patient expresses warmth, gratitude, trust or affection, usually unexpectedly, and often unjustifiably. Of course this warmth diminishes doctor stress. The other sort of exothermic reaction, however, is very stressful to the doctor: in this case some behaviour of the patient, verbal or otherwise, generates in us anger, aggression or distrust which we find even more difficult to handle. Sometimes the patient's behaviour may signal ingratitude, rejection or personal criticism of us whether or not we deserve it, but as often as not he is trying to find a way to express his pain in an unpalatable or even disastrous situation and sometimes we are the only safe recipient of such feelings available to him. Failure to understand precludes the doctor being able to help.

Some reactions on the other hand are endothermic, needing a continuing input of energy from the doctor, which is almost always emotional rather than intellectual, and is to do with commitment expressed as empathy. This is something highly valued by patients. Empathy, as opposed to mere sympathy, actually requires a certain amount of self-exposure and therefore risk.

There are two problems residing in the consultation itself, which tend to impede productive reactions in the crucible. The first is that there is a gross imbalance in intensity. What for us is a low arousal event, the bread and butter of our daily routine, is for the patient a rare occasion of at least some anxiety, and sometimes intense fear. Their senses are heightened, and their perceptions sharpened. While it would be unrealistic to expect doctors to work themselves up to an equivalent pitch of arousal,

the imbalance can be ameliorated by paying attention to the patient's dignity and personal importance.

The second problem, more important yet more difficult to redress, is the in-built imbalance in power. It is easy to lose sight of the amount of power we have just because we are the doctors. Let me spell it out. First, the doctor belongs to the highest social stratum in any society, therefore most patients will be from lower strata. Secondly, the doctor is, by definition, knowledgeable, and the patient unknowledgeable. Thirdly, the doctor is healthy (or not letting on if he is not) while the patient of course is poorly (a lovely Northern word). Fourthly, the doctor is usually on his own territory and the patient is not. Lastly, most doctors are men, while women who consult more often, constitute most of the patients. High social status, certified wisdom, health, territory and maleness are all appurtenances of power, and they are all held by the doctor. Just by being who we are, and where we are, we can diminish our patients' personal space. Within the consultation this may produce in the patient defensiveness, reserve and a tendency to non-compliance, and scepticism about the doctor's wisdom: all very human reactions to feeling 'one down'. We need to find ways of evening up the balance, perhaps first of all by being more prepared to share information and decision-making with our patients. There are important lessons here for students, which are better learned in general practice than in hospital where the power distribution is even more unbalanced.

#### Clinical reality: a model

Let us look for a moment at this concept of clinical reality in terms of its content, so that we can see what has to be learned by all concerned in our crucible of learning, the consultation. The theory and practice of medicine are centred on interactions (between for instance, host and pathogen, hormone and target organ, or disease and patient), and interactions can only take place in, or could be said to constitute, relationships, whether human or biochemical. Descriptions which, for a variety of reasons, exclude some components, factors or circumstances in such relationships conceal some of the reality of them. The lack of predictiveness, in the individual case — as opposed to populations where probabilities can be fairly reliably established — probably reflects the paucity of the components that we take into account, or even know about. We say, rather basking in the feeling of maturity and hard-earned wisdom, 'There is no always

and no never in medicine', but this does not help our student very much, especially when he faces a multiple choice question examination. Classically medicine has concentrated on the 'pathogen-host interaction'. Disease is seen as an invader. Paul Hodgkin<sup>12</sup> drew attention to the way in which medical terminology has drawn heavily on that of warfare: we kill bugs, we fight disease, we block the advance of pathology. This way of seeing medicine as a dyadic process between deadly adversaries has two important sequelae: first, the patient becomes essentially inactive, a spectator (Andromeda or the dragon's captive maiden) or even just the battleground; and secondly, the doctor's roles are tightly circumscribed (Perseus or St George or the US Cavalry). Such dashing and heroic roles are of course strongly attractive to our less mature students. Literature tells us little about these protagonists' feelings for each other. Presumably the heroes were vaguely grateful to the victims for giving them an opportunity for another go at their traditional adversary, and the maidens grateful for their salvation but perhaps somewhat frustrated by the inevitable departure of the hero to his next appointment!

But have we a model of clinical reality which provides a better basis for learning medicine than the conventional, classical one, and will it inform our teaching in, and about, the consultation?

Let us start in Figure 1 with the classical, reductionist model based on the pathophysiological foundation: genes determine the effectiveness of the mechanisms on which we depend for defence and/or homeostasis, and pathogens challenge them. If the mechanisms are effective there will be no disease, or it will be swiftly contained. But there are other insults than pathogens: for example toxins or trauma which may challenge the defence mechanisms, or do direct damage. In effect these can best be looked at as environmental or behavioural hazards. Of course there is an intimate relationship between environment and behaviour, particularly when 'environment' is not seen in exclusively physical terms, but includes social and psychological components.

Within the individual case there is something else, an intangible but important factor which I shall call 'factor X', something to do with the inner-self, essential vitality, an innate trust in ones own body; vaguely perceived characteristics with which we as general practitioners are very familiar, recognizing in some of our patients deep wells of such resources, and in others the parched ground of vulnerability and dependency. I do not know what the X factor is, but I do know that its presence or absence

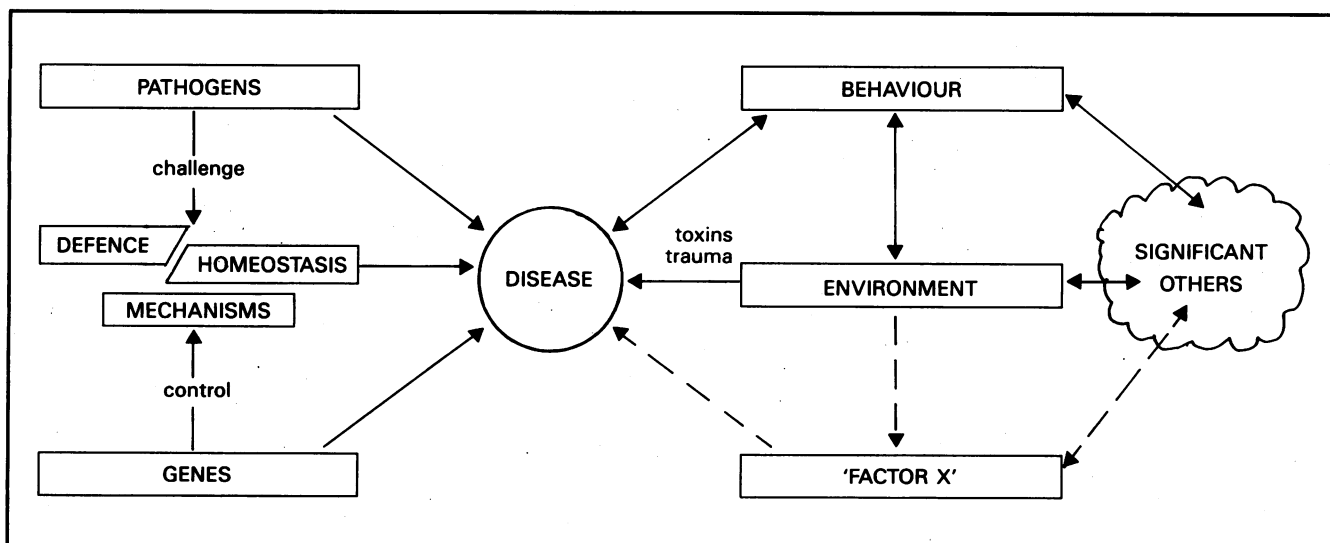


Figure 1. A model of clinical reality

make large differences to my patients' needs of me, both quantitatively and qualitatively. It is this factor which denies us the predictive accuracies of the laboratory scientist, and perhaps it is this that forces us to say 'There is no always and no never in medicine'.

But, as Donne said, 'no man is an island', and while the disease process may be contained by the interaction of these six factors, the experience of disease is not. Behaviour, environment and the X factor interact with each other not only inside the person but also outside, and are in turn influenced by those with whom that person is closely involved.

This model has enough components to claim to represent clinical reality, and enough features from which the wide range of medical tasks and roles can be worked out by the student.

In that part of the model mainly used by our specialist colleagues to achieve and transmit their elegant and exciting advances in diagnosis and treatment the patient is essentially inactive: the recipient of care, the battleground for the struggle between the forces of good and evil. We general practitioners must include wider aspects of behaviour and environment, and the X factor, as well as the roles and feelings of 'significant others' in our formulations of the illness. Above all, our patients have to be seen and treated as active partners in the process of care. Note that at the right-hand side of the model (Figure 1) our concern and curiosity must be open-ended (provided that we have a mandate from the patient to venture into such fields, and remembering that the further to the right we go the less expert we are).

This distribution of interest, concern, expertise and activity between specialists and generalists is entirely justifiable and desirable for the delivery of care, in order to achieve a rational health service and provided that we achieve a competent interface; it cannot, however, be so justified in medical education. Here the stated objective is to give the student a thorough understanding of health and illness as a basis for further professional development. Because our specialist colleagues have pursued depth (of knowledge) at the expense of breadth, and because they demonstrate their skills on highly selected patients they can only demonstrate some of the relationships in the model. This leaves a gap in that education that we are, in theory best qualified to fill. Where must we look to learn how to fill it? To the consultation, as a crucible from which we should be able, eventually, to pour a shining stream of comprehensible clinical reality for the student.

### The consultation as a crucible of learning

We sometimes remind each other that 'doctor' is the Latin word for teacher. Perhaps it would be better to hang on to the determination to be learners, because once we lose curiosity, or the culture of enquiry, we are intellectually burned out. To rely on what 'every doctor knows' is to risk stagnation, shortly followed by regression. Reliance on the 'as is' when the societies we serve, and to which we belong, and the technology and ecology of medicine itself are changing rapidly seems a self-destructive strategy.

But change and adaptation (in Dubos' terms the 'health' of the profession) demand a continuity of learning. If we are to learn what we need to function effectively we must create a 'learning laboratory' in which we can increase our knowledge, develop skills, and tune our attitudes. My thesis is that our consultations provide that laboratory exactly as William Pickles' consultations did. But we are not the only occupants of that laboratory: with us are our patients, our students, and often the lay carers. Let us then look at the consultation as a crucible of learning.

It is, of course our job to explain to the patients the nature

of their disease, and to relate it to their perceptions; and to explain the reasons for the management regimes we are advising. But we should be prepared to go further: they need to come to a proper understanding of the origin of their illness (and often be absolved of guilt feelings about it) and its probable course and effect on their lives, including their family and their work. In any significant disease they need to readjust their self-image. They also need to learn about us, the people on whom they are dependent for care. Will we expose enough of ourselves to allow them to assess our trustworthiness, our caringness, and our technical competence?

If the principal carer is present in the consultation she (nearly all principal carers are women) has much to learn too: about the illness, the treatment, the prognosis, the likely course and the possible complications (in other words, what she is up against); but also about the patient in whom new depths or shallows may become apparent, and for whom new needs will have to be met. Do we ensure that the consultation meets the carer's needs when she attends? We ought to, because we are going to be very dependent on her help. She too can learn about herself, and we can help there too, for example by giving her a chance to explore her feelings in a safe space, and by 'permission-giving', allowing her to accept her own feelings of entrapment and resentment without adding guilt.

Many of us are trainers and a surprisingly large number of us now teach medical students from time to time, so there may well be a student or trainee present at the consultation. He will be expecting to learn, by both precept and example, about disease and its treatment: after all that is what he is there for. But what else can he, should he, learn? Obviously, as much as possible about the patient as a person, and the physical, social and psychological environment. But general practitioner consultations with new patients offer a learning opportunity of great importance that is virtually unobtainable in the teaching hospital. First, the patient's presentation is completely undifferentiated, so that the diagnostic process is demonstrated *ab initio*, with no precluded possibilities (including that of absence of illness). Secondly, diagnosis, or problem definition, proceeds by the formation and testing of hypotheses rather than the unthinking collection of a standard 'complete history and physical' followed by an attempt to reach a diagnosis by induction. But beyond that the student should gain some insights into the craft of medicine, the nature of doctoring, its successes and failures, its confidence and its doubts, and how to handle them. From that should come his learning about himself. Students have to come to terms with their feelings about illness and ill people. A recent paper<sup>13</sup> which reported a study of stress levels and their causes in students at three medical schools found that about a third were seriously affected by stress. Perhaps that is why our 'St Georges' wear their armour!

What about us though? We must be learners too. Given the patient's mandate (and where necessary the principal carer's) there is no area on our model that we could not usefully learn more about. If, as Pope says, 'the proper study of mankind is man', it is arguable that the proper study of illness is the ill man, and here we must explore the patient's views and values as well as his behaviour and environment. To plan long-term care we need to know about resources, and there is no more important resource than the principal carer: what are her strengths and weaknesses, her needs, and her feelings? Lastly, every consultation, if pondered later, is an opportunity to learn about ourselves. Michael Balint<sup>14</sup> showed the way; by making us look at the drug 'doctor' as we would look at other agents he forced us to abandon the cool, emotionally uninvolved, professional self-

image and examine the ways in which our own feelings are generated, affect our clinical behaviour and are responded to by the patient.

Julian Tudor Hart, in his brilliant George Swift lecture 'The world turned upside down' said that the structure of conventional education was inappropriate 'now that medical care depends on measurement and doubt'.<sup>15</sup> As soon as we shift the emphasis from teaching (patients, carers, students) to learning, and include ourselves among the learners, we are talking about research. It was in his consultations with the people of Wensleydale, asking and listening in progressively more focussed ways about the details of their journeys and meetings that William Pickles did his epidemiology to such good effect. Yet most general practitioners, ardent to provide excellence in the consultation, and enthusiastic about sharing their learning with students and trainees, will reject 'research' as a proper role or interest. They know that people are unique, and present a dense weave of rich qualitative characteristics. So they are sceptical of, or at least uninterested in, reducing people and their features to numbers. Some questions to which we need answers can only be approached numerically. But there are, I believe, rigorous and well-validated non-numerate methods in use in anthropology, sociology and social psychology which we should explore. But we could also look backwards, for the case study was the main method of medical research long before the need to examine cohorts and populations took us into statistical methods, and for some purposes the case study would still be illuminating. Research, therefore is another of the powerful reactions which can take place in that crucible, the consultation. Taking care to check with the patient that we have got it right is not only good consulting technique, it can be research.

### Problems in conventional medical education

There is no doubt then that there is a lot to learn in any consultation, for everyone involved. But how can this provide an argument for giving general practice a more central role in medical education? It is important to emphasize that making such a claim for the place of general practice in medical education is not an attack on our specialist colleagues, nor a criticism of what they teach. There are, however, things which I believe students must learn which cannot be learned properly, or even learned at all, in hospital, but which can be learned from consultations in general practice. Furthermore, current circumstances and past history combine to compound the limitations on student learning inherent in hospital inpatient-based teaching.

If the recognition and understanding of my model of clinical reality is accepted as a proper goal of medical education it must be seen that it cannot be fully demonstrated on the ward or even in outpatient departments. Apart from the fact that care and teaching directed at the pathophysiology of patients is bound to be reductionist, concentrating on the left-hand side of the model (Figure 1), little or nothing can be demonstrated of the patient's environment and behaviour, and it is unlikely that much attention or credence would be given to my putative 'X factor'.

Even if the basic skill of diagnosis — that is, the acquisition of data and their incorporation into a sustainable hypothesis — is accepted as the central goal of clinical instruction, teaching it in hospital has serious limitations. For one thing most patients' illnesses have been diagnosed before they are admitted, so the student cannot observe the whole process. For another, even in undiagnosed patients, much prior screening and selection have occurred before they appear on the ward, or even come to outpatient departments, so that the students form a very limited

range of hypotheses. This limitation is compounded by the gross difference between the pattern of morbidity in the hospital and that in the community, which in turn gravely distorts students' appreciation of the probability of the complaint.

If Sir James Spence were right and the consultation as he defined it is the basis of medical practice, it seems odd that the student will seldom experience one in hospital. The person is always ill, is usually seen by a doctor whom he does not know personally, and has only the most general reasons to trust, and is most unlikely to be afforded real privacy. Few specialists seem to recognize the alienation experienced by patients in hospital. Safety and protection are bought at the expense of independence and autonomy. For those who have not been unfortunate enough to require inpatient care, the nearest experience to it is being a long-haul air passenger!

Furthermore, what the patient learns in hospital about himself and the illness is remarkably limited, judging by the questions they ask when they come home. This important part of the caring transaction, therefore, is not clearly seen or properly valued by the student. Similarly, the student is unlikely even to meet the principal carer, let alone find out what she needs to learn and whether she does so.

These four fundamental limitations to what can be taught in hospital are compounded by four features of conventional medical education. First, the mismatches between the pattern of learning and the nature of the medical task include: learning inductive diagnosis, but using hypothetico-deductive; learning in high certainty areas, but working in low certainty situations; learning on passive materials including horizontal undressed and non-autonomous inpatients, but working with vertical, fully dressed and very autonomous people outside; and learning in a doctor-controlled environment, but providing care, whether specialist or general practitioner, in a patient-controlled environment.

Secondly, the exponential growth of bioscience has promoted a reductionist approach, which in turn distorts the balance between knowledge, skills and attitudes (and this is in turn compounded by over-reliance on multiple choice question examinations).

Thirdly, the fierce constraints on hospital finance have altered the learning environment: patients have short stays, so students do not have time to get to know them as people; the activity is very intense, so that students often cannot get at their patients to take histories and do physical examinations because the patients are attending for X-ray, physiotherapy or special investigations; investigations are done on a 'shotgun' basis to save time, rather than sequentially, which precludes the student fulfilling James McCormick's aim of learning to assess the strength of evidence; and students feel that they have no real role, and are just getting in the way, and that nurses do not have time to help them.

Lastly, no one seems to have time to help the student come to terms with his feelings about ill people, their suffering, the limitations of care, and the distressing physical effects of both disease and treatment (perhaps because medical staff have their own problems with these stresses).

General practitioners usually consult in the way Sir James Spence describes. We undertake the diagnostic process from the first open-field presentation of undifferentiated need. We practice, teach and research medicine across many boundaries in our concern for our patients' autonomy, space and health. We seek to achieve a rigorous and responsible synthesis between technical

medicine and personal care. We are striving to attain clinical standards as high as any of our specialist colleagues by increasingly accepting the discipline of clinical audit, and are seeking ways to be more directly accountable to our patients. We are acknowledged by our specialist colleagues to have achieved the best programme of postgraduate education and training. The best of our young members are intellectually ambitious, and impatient of sheltering within the tattered fabric of what may be called 'conventional wisdom' but which is sometimes a cloak for ignorance and laziness. General practitioners, led and enabled by this College, but not confined to its members, have identified what can be learned in general practice, and how it can be taught: factors which are important and valuable in our struggle to deliver health for all by the year 2000.

I believe that we are now in a position to claim that learning in general practice should be an integral part of every clinical attachment (and provide the framework for pre-clinical learning in the behavioural sciences). The student should spend enough time there, taught by general practitioners and specialists, but most importantly by the patients, to be able to establish a comprehensive model of clinical reality within which the powerful learning opportunities available in hospital attachments can be properly accommodated. If each of us were to accept the rigour with which William Pickles endowed his consultations, our claim to a central role in medical education would be unanswerable.

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## EDITORIAL NOTICE

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Original articles should normally be no longer than 2000 words, arranged in the usual order of summary, introduction, method, results, discussion, references, and acknowledgements. Short reports of up to 600 words are acceptable. Letters to the Editor should be brief — 400 words maximum — and should be typed in double spacing.

Illustrations of all kinds, including photographs, are welcomed. Graphs and other line drawings need not be submitted as finished artwork — rough drawings are sufficient, provided they are clear and adequately annotated.

Metric units, SI units and the 24-hour clock are preferred. Numerals up to 10 should be spelt, 10 and over as figures. Use the approved names of drugs, though proprietary names may follow in brackets. Avoid abbreviations.

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Three copies of each article should be submitted, with a stamped addressed envelope, and the author should keep a copy. One copy will be returned if the paper is rejected.

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