because he does not pay the price. He attends with interest, he tries to take it in, indeed he thinks he has done so; he goes home feeling stimulated, he has enjoyed his afternoon or evening. Yet when, a week or two later, he would fain recollect what he had heard or seen it has become hazy or is clean gone "like a dream when one awaketh."

There are special excuses for the practitioner. The mind half occupied with the pressing problems of the day does not lend itself to "good reception," but the main cause lies deeper. It is notorious that the lecture and the sermon rarely dint the mind, and that that marvellous machine, the memory, shows signs of wear as early as the neuromuscular machinery of the athlete—perhaps earlier.

It is too much to hope that the Sabbatical months could altogether rejuvenate the memory, but complete respite from the cares of practice would vastly improve reception, and if the practitioner-student did indeed swallow his pride to the extent of standing up to questions and being made to prove his knowledge or his skill by demonstration he would unquestionably learn and retain far more than he is likely to do by the present accepted methods of instruction.

Nor would the educational traffic move all one way. Practitioners made to feel at home, stimulated by what they saw and heard, with time to form opinions and opportunity to speak their minds, could bring into a teaching hospital a current of fresh thought and a point of view it cannot get either from its own specialized staff or from distinguished visitors from other schools. The trade in ideas between seniors and juniors, specialists and "generalists" (to borrow an Americanism), workers within and workers without the walls, given good mixing machinery and a skilful and determined mixer in charge of the enterprise, should prove most fruitful.

A Formidable Objection

Possible variants of the general idea "Back to a university or even school atmosphere every five or ten years" are many. One might move from school to school—most of us have experience of only one. Perhaps, even, something might be done towards making good those lost sixth-form years. Two months might go to learning something of a foreign tongue and four to studying medicine in the place where it is spoken. I have sketched only one possible example, and that, deliberately, only from the practitioner's point of view. The gains and goods that could accrue are manifold and manifest. But manifold and manifest also are the obstacles and the costs. I have no notion who would or could finance the plan (unless the world went sane, we stopped making arms and had money to burn), nor do I know what universities or teaching schools would or could open their hospitable gates and undertake the burden of instruction, but from the beneficiaries' end also there is one most formidable objection.

It lies in the nature of general practice, which, far more profoundly and essentially than any specialty, binds the practitioner to his patients and his practice. The whole essence of the thing is personal and continuing responsibility. For myself, I have never understood how, except very partially and transiently, responsibility for patients can be shared or shunted. It is possible to leave one's practice to a trusted colleague for a few short weeks and to pick up most of the threads still unbroken. More I should guess to be impossible. There may be evidence from war experience to prove me wrong; no doubt there is a difference between one practice and another, and perhaps between country and town; but I fear the very doctor with most to gain from the refreshment and instruction of the Sabbatical months would have most to lose from the abandonment of his practice, and that the price would be more than he could afford to pay.

One way and another I am afraid the conception is, and must remain, a dream. But it is a bright and maybe a pregnant dream and merits more than a brief, longing glance. Much has sprung before now from "Suppose and suppose."

ADULT MEDICAL EDUCATION FOR THE GENERAL PRACTITIONER

BY

C. W. WALKER, M.B., B.Chir.

"Read, read widely or your sermons will become deadly dull!" So did the first Archbishop Temple adjure his ordinands. The same advice and warning might literally be applied to general practitioners and their treatments.

We all have thrust through our letter boxes a daily cascade of literature which purports to educate us on modern therapy. Most of this, but not quite all, is thrown unread into the wastepaper basket. It is incredible that manufacturing chemists should continue this practice if none of this were read, so it is probable that some modern terminology, even if little knowledge, is acquired by the practitioner from advertising circulars.

The Royal Society of Medicine and the British Medical Association, to mention only two, possess excellent libraries. I am indebted to the B.M.A. librarian for the information that in 1954 31,509 books were taken out by more than 5,000 members, of whom over 2,000 were general practitioners. The demands came from all over Great Britain. Textbooks and *British Medical Journal* publications such as *Refresher Courses for General Practitioners* and *Any Questions?* were popular.

Hadfield (1953) found that most general practitioners read one or more medical journals. Whether such a journal as the *British Medical Journal* is read right through by a general practitioner is doubtful, but there is no doubt that a journal written down to an editor's idea of the mental level of a general practitioner would make dull reading.

All this seems to indicate that given the time and the inclination there is no lack of opportunity for reading widely. As general practice is hardly the sort of profession a scholar would choose, it is perhaps surprising and gratifying to find how much the general practitioner reads. Nevertheless, many practitioners will turn to more practical methods of education.

Hospitals

Most will agree that intimate contact with a hospital forms the easiest method of keeping up to date with medical knowledge. There are various ways in which this contact may be achieved. First, there are general-practitioner beds in hospital. Ogilvie (1953) and Hamilton (1953) both agree that practitioners should have the use of beds in hospital, not necessarily in a teaching hospital, where patients could be treated for relatively simple conditions such as pneumonia and congestive heart failure. The best way to provide these beds is in cottage hospitals. Unfortunately regional hospital boards have tended more and more to remove these hospitals from the general practitioner and to incorporate them under the specialist staff. Their argument is that they can be put to better use thereby. Certainly the standard of treatment, particularly surgical treatment, in these hospitals has been raised, but it is a severe loss to the general practitioners. The answer would seem to be to allow general practitioners to use their cottage hospitals as before, but for them to be under the supervision of consultants. In this way the general practitioner retains the valuable experience of working with colleagues in a hospital, and the danger of his trying to do too much, owing to over-enthusiasm or lack of experience, is avoided.

The second method of achieving contacts in hospitals is by having general practitioners on the staff of general or specialist hospitals either as specialists—anaesthetists, for example—or as paid clinical assistants. In the United Cambridge Hospitals there are eight general practitioners on

the staff out of a total number of 50 practitioners in this area. Further trial might be made of the experiment whereby general practitioners are attached as clinical assistants for a short time to various departments (Ogilvie, 1953).

Thirdly, there are refresher courses arranged by teaching hospitals. The University of Cambridge provides postgraduate teaching through the United Cambridge Hospitals. The teaching of general practitioners is provided in three ways.

1. *Ward Rounds and Attendance at Out-patient Departments and Special Clinics.*—Once a month a ward round or clinic is open to general practitioners to attend. The programme is so arranged that a practitioner can spend a fortnight attending rounds or clinics, both morning and afternoon, so that he collects 22 sessions, which will allow him to claim his expenses from the Government for the course, for out-of-pocket expenditure, and for a locum tenent. In other words, he can bring his wife to Cambridge for a fortnight and get his own expenses paid and has quite an interesting education outside his profession as well as in medicine. This method is becoming increasingly popular with doctors who live outside East Anglia. The local practitioner is more likely to sign on for one monthly ward round or clinic, but he is by no means a constant attendant.

2. *Symposia.*—These are held every month on a Saturday, both morning and afternoon. A subject of general interest such as rheumatism or anaemia is advertised and a number of experts give short papers followed by demonstrations and discussions. There is no doubt that for the most part the standard of teaching is very high, so that the practitioner not only has the opportunity of listening to an expert but to one who is an expert teacher. This combination is, of course, most likely to be found in a university teaching centre. The discussion that follows the lecture often takes the form of question and answer. Indeed, any real discussion or argument by a member of the audience is unpopular. Practitioners are, with difficulty, persuaded to listen to the expert. They quickly incline to be intolerant towards an argumentative and long-winded colleague. This is understandable, but it does mean that the expert gets away with it every time and that real criticism of some of the methods and ideas of modern medicine is not easy to get across.

3. *Clinico-Pathological Conference.*—This form of teaching originated, I believe, in the United States. It is entertaining as well as educative. The expert is given the hospital notes of a patient who is unknown to him and who usually has already died. The expert, after discussing the history and the findings, makes a diagnosis. The case is then open to discussion and anyone may make suggestions. Finally, the pathologist reports on the post-mortem findings. These conferences provide good entertainment, because there is always a chance that the expert may be completely wrong. He must be brave as well as able, because general practitioners take special delight in watching their learned colleague make mistakes, chiefly because they so often make mistakes themselves. However, it is certainly true that the conferences are excellent education. It is an education to listen to a masterly exposition by a great mind. In this connexion the male gender includes the female. We have been privileged to listen to a masterly presentation of a case by a lady. There is, too, the chance that the general practitioner may sometimes, but not very often, because the case is generally obscure, contribute something of value to the discussion. The conferences are held once a month.

Attendances of General Practitioners

The question now arises of how much these opportunities are used by general practitioners. I am indebted to the secretary of the postgraduate school by kind permission of Sir Lionel Whitby for the following.

Ward rounds and clinics are not well attended by local practitioners, although more strangers are coming to Cambridge for a fortnight to attend 22 sessions. As the number attending in any particular fortnight is very small, the

stranger may expect to receive almost special coaching by this method, and if must be an attractive way of spending a holiday with pay.

The average attendance for Saturday symposia is 30; the numbers vary from 18 to 65. About 600 general practitioners in East Anglia are circularized. If different practitioners attended each time and there were 10 symposia in a year, it would mean that about half those circularized attended, but, of course, there are a number of constant attenders, so probably less than 25% ever use this method of education. An interesting point is that more and more requests for programmes of these courses are coming from the periphery of the area, so that already there are many more doctors from Norfolk, Suffolk, Essex, and the outskirts of London than from Cambridge itself. It is not, I believe, so much that a prophet is not without honour save in his own country as that most practitioners feel that they are able to meet and learn from their own consultants at medical society meetings, by correspondence, or at domiciliary visits. If they wish to be refreshed they like to go right away from home. While this is to be encouraged it is still true that continuous education means frequent contact with colleagues in the neighbourhood and in the local hospital.

Some 300 general practitioners are notified about clinico-pathological conferences. The attendance is usually between 30 and 40, but of these only six to eight are general practitioners, the remainder being specialists of different kinds. The time of the meeting may have something to do with the poor muster of general practitioners. Five to 6 o'clock means as a rule no cup of tea before evening surgery, and that is a hard penalty for one whose supper is after 8 o'clock. On the other hand, there seems to be no optimum time for a meeting except one that has become habitual. General practitioners, like others, are creatures of habit, and habits they say are difficult to acquire or break after the age of 30.

Any collection of doctors or division of the B.M.A. will hold clinical meetings from time to time. The Cambridge Medical Society meets once a month. All members of the branch are entitled to attend, some 378 persons. The average attendance is 25. For special occasions, such as a B.M.A. lecture, the attendance rises to 50 or 60.

In spite of this wealth of opportunity there will be a proportion of general practitioners who do not feel it necessary to make contact with their teaching hospital for purposes of education. These men may feel that the general practitioner may learn more from his patients in their own homes than from trying to learn about hospital technique and methods; that the educated man is not a specialist; that life teaches more than medicine. Others may be so tied to the routine of practice that they are unable to give the time to attend hospital lectures. Whatever the reason, it is to be deplored, because hospitals and hospital treatment are becoming more and more necessary for our patients. Those who never go near a hospital themselves are not those who never send a patient to hospital. If we wish to be the patient's adviser as well as friend, we must know what goes on in these places, what they can do, and what they cannot do.

To some general practitioners the domiciliary visit with a consultant to a patient's house forms about the only physical contact between hospital doctor and general practitioner. This merely emphasizes the importance of such domiciliary visits in the education of all doctors. Regional hospital boards that discourage such combined visits are doing a real disservice to medicine in this country.

Sabbatical Year

The Editor of the *British Medical Journal* has suggested that everyone needs a change at some time, and that it would be a good idea for every general practitioner to have a Sabbatical year away from his practice. This need not be a whole year and need not necessarily occur every seven years, but perhaps every five or ten. The simplest change

would be for a general practitioner to take a fairly junior job in a hospital—say, two jobs in the year—and for a junior or possibly senior registrar to do a locumtenency in a practice. In this way the practitioner and his wife would make new contacts and find new interests and the registrar would be able to have a good look at general practice before deciding to burn his boats and train for a specialty, or, if he had already made up his mind to specialize, he would gain first-hand knowledge of general practice which would stand him in good stead for life. Such a scheme might help to solve two of our present difficulties.

First, it would, by mixing up general practitioners and hospital doctors, help to bridge the gap which has developed between the two. Hadfield (1953) showed that all three parts of the National Health Service—consultant, public health, and general practitioner—were growing apart, and so creating a lack of sympathy and understanding amongst doctors which must surely in the end destroy the Service. Since his report a real effort has been made to bring the public health services and general practitioners closer together, with encouraging results. This is now so far true that a general practitioner may even be seen talking with a health visitor instead of shouting at her, the conversation appearing to be mutually enjoyable. Relations between consultant and general practitioner have not been so obviously bad, but patients are bewildered by what they overhear when practitioners run down the hospital and the hospital doctors slander the practitioner. All this will quite easily be overcome if each side learns about the other's work.

The second advantage of the Sabbatical year might be that the practitioner and his wife who felt tied and bound to a practice isolated perhaps in unsalubrious surroundings would be able for a year to find social as well as intellectual amenities in a complete change. There are obvious difficulties such as change of salary, change of school for the children, but none that could not be overcome given the will. I dare swear that the wife would have the will and find the way.

Whatever is done to provide postgraduate education in hospitals, there will be some practitioners, perhaps a majority, who feel that education is something more than acquiring potted knowledge even from experts, something more than acquiring technical skills. These men and women educate themselves by learning from their patients. They will discuss crops and beasts and the weather in the country, the technicalities and traditions of mining in coal-mining areas, the hazards and benefits of a university education in university towns. In other words, they wish to learn about their patients as human beings rather than as vehicles of modern diseases. Who shall say they are wrong? Somehow in this hurried world we have to combine science and the humanities. Time is too short for anyone to be a real general practitioner. We must all be more or less degraded into becoming specialists.

Conclusion

Education involves contact with the minds and methods of other men. This may be achieved by reading or by talking and working with colleagues. It is important that hospital doctors and general practitioners should have frequent close contact in order that each may learn from the other. In this area strenuous efforts have been made to encourage this contact, with only moderate success. The efforts might be more successful if there were a common medical library, a common dining or luncheon room, and more hospital beds for general practitioners. Everyone must decide how to balance education in science and the humanities, but, whatever the proportion, education must be a discipline as habitual as the 9 o'clock surgery, not something to be fitted in if time permits.

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THE PLACE OF PSYCHOLOGY AND PSYCHIATRY IN MEDICAL EDUCATION*

BY

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We are all aware that psychiatrists are not solely responsible for the education of medical students in psychology and psychiatry. Indeed, our medical and surgical colleagues play a far more important part than we do, both directly and indirectly, in determining the attitude of future doctors to psychological and psychiatric problems and the amount of knowledge they may have about them. For example, looking back to the time when I first went as a medical student to St. George's thirty years ago, a remark made repeatedly by one of our senior surgeons always stuck in my mind, as I also find it has done in the minds of other St. George's men. It was: "Always remember that patients only go to hospital because they are either very ill or very frightened, and they must therefore be treated with consideration." Which indeed this surgeon did do, when he attended the hospital, which was not often; for he was one of those who were what is known as kind to their juniors and left much to them.

The more specific psychiatric instruction in my day as a medical student consisted of about half a dozen

visits to a mental hospital, and resembled a visit to a music-hall or a grand guignol according to one's temperament.

Inevitably I shall approach the subject from the point of view of the psychiatrist and with special reference to the contribution that a psychiatrist can or should make.

Needs of the Psychiatrist

Wilfred Trotter (1941) has said that typically the lay attitude to the doctor or medicine man is a "strange mixture of distrust and inordinate expectation." Many psychiatrists would, I think, agree that precisely this lay attitude is often held by our medical and surgical colleagues towards us. We may regret this, but we must recognize it. And we must also recognize that we are not likely to get what we want quickly. Our main psychiatric needs are quite simple, and are two in number—better facilities for work and more time. Unfortunately most of our medical and surgical colleagues feel the same, and naturally want to keep their slice of the cake and to have a bigger one.

I am increasingly convinced, however, as I have maintained previously (Curran, 1952), that "the biggest practical step forward for the teaching of psychiatry to undergraduate students in this country would be to have a compulsory examination, as in Edinburgh, or at least one compulsory

*Read at the Joint Annual Meeting of the British Medical Association, Canadian Medical Association, and Ontario Medical Association, Toronto, 1955.