

university or research council for the time spent doing laboratory work or writing papers into the small hours. At senior level a similar disparity in remuneration between teaching staff and NHS consultant staff has also been created, for NHS staff working full time are now permitted to do limited private practice for their personal gain. And while Dr Johnson reminds us that there are few ways in which a man can be more innocently employed than in the getting of money, the Bible warns that the love of money is the root of all evil.

New breed of clinician investigator

There is also the problem of training. In a previous generation the clinical investigator who had had a firm grounding in physiology as a medical student could decide to attack a problem in clinical physiology and simply get going. He now requires further training at postgraduate level not only in research techniques but also in new subjects, and this has to be undertaken as well as postgraduate training in his chosen clinical discipline. He then has to follow that uncertain road that lies between studies of laboratory animals on the one hand and the more lucrative pastures of clinical and private practice on the other. He has to learn to be sufficiently thick skinned to pay scant attention to the views of scientists who say that he is not a proper scientist and to those of his clinical colleagues who say that he is not a proper clinician. To undertake postgraduate clinical training to the level required for the acquisition of specialist registration, to do an MSc or PhD degree, in addition to post-doctoral work often overseas in a laboratory of basic science for some years, that is the sort of career that the new breed of clinician investigator has to follow. It is a daunting prospect for our young people and only the most dedicated are now succeeding. For all of these reasons it is vitally important that we ensure, firstly, that there are adequate training posts in clinical subjects for academic staff and, secondly, that such staff can see a satisfactory career in front of them. At a time when manpower constraints are becoming increasingly important this association clearly has a deep interest not only in ensuring that young doctors working in the NHS have a reasonable career structure—and they need it badly—but also that there are sufficient training posts available for academic staff. Such posts are not, as some have put it, a back door to consultant status. They are of vital importance to the training of the profession's teachers and research workers of the future.

There have been, however, influences other than finance, training, and career structure which have been at work in recent years to inhibit the investigative zeal of the young. It is unlikely that there has been any reduction in the overall ability of medical students in this field because I do not think that the inquiring spirit of the human mind is likely to vary from one generation to another. It is more likely that in terms of the recruitment of young clinician scientists it is environmental influences rather than inherent ability that determines attitudes. Perhaps one of the most important of these through the years has been the attack on élitism. Science is associated with an élite, élitism is incompatible with egalitarianism. In an egalitarian society, therefore, science is suspect. For this and other reasons science has been attacked, particularly following the development of nuclear weapons, and populists have at the same time sown a deep distrust of scientists in the public mind. This has been paralleled by assaults on scientific medicine by writers such as Ivan Illich, by that Reith lecturer for 1980, Ian Kennedy, as well as by doctors themselves. The writings of the epidemiologist, Tom McKeown, have also been influential in showing that too much credit may have been given in the past to advances in medical science, when in fact social change was more important in influencing declining mortality rates. McKeown might now reflect that, by contrast, it is that same social change that has been responsible for the current epidemic of sexually transmitted disease and the tragedy of the acquired immune deficiency syndrome (AIDS), a condition to whose control only science can effectively contribute. There are others who have attacked clinical investigation as unethical, and Pappworth, in a book entitled *Human Guinea Pigs*, castigated clinical research workers for carrying out dangerous and callous investigations on patients without their consent. Modern tech-

nology has also been under attack. Doctors are portrayed as clinical Dr Strangeloves and medicine has been represented as unfeeling, losing sight of the needs of the suffering individual. Undoubtedly, we have been passing through a phase where some of these criticisms have rubbed off on young medical students and there has been a feeling among them that relevance is all important—the desire to cure and care more praiseworthy than to investigate.

So what of the future? "There are many events in the womb of time to be delivered." But for the moment we need to ensure that young people in medical school are encouraged to the view that research is not only interesting and intellectually satisfying but also that it is vital to the future of the practice of medicine. Our research must not, as the late Lord Platt once complained, simply be an absorbing hobby. It must be relevant to important and common problems of human suffering, so that we give no reason for poets to write, as A P Herbert did:

I love the doctors, they are dears,
But must they spend such years and years
Investigating such a lot
Of illnesses that no one's got?

We clearly need more cash to support better training facilities for young men and women entering research, better staffing levels in university departments, better and more modern equipment. Finally, and most important of all, we must persuade our legislators that health and research into ways of relieving human suffering are infinitely more deserving of the nation's resources than the endless commitment to missiles, the military, and the melancholy prospect of nuclear war.

A woman aged 29 has always feared hospitals, doctors, and nurses. She does not fear the pain, discomfort, investigations, etc, but the power that doctors and nurses have over her. She realises that this fear is unreasonable and yet finds it impossible to overcome. What treatment would you advise?

This woman's phobia would be best treated with exposure in vivo. More information would be required about the precise nature of what provokes the anxiety—are particular hospitals, departments, or specialty of doctor or nurse more frightening than others? Which aspect of medical appointments produce fear—the waiting room, the consultation, or aspects of the examination? Once a full profile of fear evoking situations has been produced the patient should be asked to arrange them in a rough hierarchy from the most to the least frightening. The principle of exposure in vivo is that through prolonged and repeated confrontation with the feared and avoided phobic situation the anxiety experienced habituates both during treatment sessions and from one session to the next. Although there is now good evidence that self exposure alone is effective in treating phobias,¹ it might be best with this particular patient to undertake, at least initially, weekly therapist aided sessions. The therapist should explain the rationale of exposure and the principles of habituation, and the patient should then be asked to select a situation or item from somewhere near the middle of the hierarchy for the first treatment session. If, for example, the patient agreed to enter a hospital waiting room in the first session the therapist would stay with her and encourage her to remain there for at least one hour or until her anxiety had reached tolerable levels, whichever was the longer. The therapist would encourage her to concentrate on where she was and what she was doing. Between therapist aided sessions it is vital for the patient to practise tasks such as homework, preferably for two hours daily. In subsequent sessions she should be encouraged to confront the most feared situations as soon as she is able to tolerate them. Provided that her phobia is not associated with a severe depressive illness and she complies with therapy this patient should completely overcome her exaggerated fears.—P LELLIOTT, honorary senior registrar, London.

¹ Ghosh A, Marks IM, Carr AC. Controlled study of self-exposure treatment for phobics: preliminary communication. *J R Soc Med* 1984;77:483-7.

Correction

Consultation skills of young doctors

We regret that the full address of Professor Charles Fletcher was left out of this article (14 June, p 1573). He can be contacted at 24 West Square, London SE11 4SN.