Letter from... Brisbane

Con-men and bother boys

DEREK MEYERS

British Medical Journal, 1977, 1, 368-369

Australia has long had an unenviable reputation for producing highly talented confidence men. The confidence man, or con-man, as he is popularly known, is a person who sells things to which he has no title; thus a good con-man will sell the Sydney Harbour Bridge or the Brisbane City Hall to an unsuspecting visitor, who, until the last minute, is convinced he has made a good bargain. But a con-man cannot succeed in his calling without a supply of suitable clients, and so it follows that Australia produces many gullible and uncritical people, ready to accept what any expert, real or self-styled, tells them.

The new con-men

Are professional educationalists the new con-men? Do they sell to the public as facts theories that are far from being proved? Education is a matter of training for citizenship; the end product goes on developing for a lifetime and is influenced by many conditioning factors outside the formal education process. Can a primary or secondary school teacher be sure that his precepts have determined the performance of his pupil 20 or 30 years later? Can the medical professor or college lecturer be sure that his methods of testing relate in any way to professional performance?

THE MCQ

The vogue test here these days is the multiple choice question or MCQ, acceptance of which has been forced by the sheer number of candidates for medical examinations. It can be marked by a machine and the marks can be fed into a computer—to the great joy of the “measure-it-at-any-price bother boys.”¹ Consider the results of the examination for the primary fellowship of the Royal Australasian College of Physicians. The machine tells us that some questions are too hard, in that only a few candidates get them right, while others are too easy—almost every candidate knows the answer. Not that the questions are wasted: the easy ones can be passed over to the final MB examiners and the hard ones to the examiners in advanced training.

Educationalists claim that MCQs are objective and can be devised to measure different types of intellectual functions, but Professor Cox of Sydney has shown² that this is not necessarily so: he has produced evidence to suggest that MCQs are often a test of cue words connected to the brain's picture bank.

THE MKSAP

The MCQ now extends far into the postgraduate field. The Medical Knowledge Self-Assessment Programme of the American College of Physicians (MKSAP) is available from the Australasian College for a few dollars. The questions are based on a book of some 130 pages—a résumé of medical progress up to 1973, put in simple dogmatic language, with a minimum of discussion. On this are based 720 MCQs, which the self-assessor can answer at his leisure and then mark with the aid of a special sheet. The advantages are clear: a list can be kept of those who have done the test, what mark they have got, and to their curriculum vitae the candidates can add something like “passed MKSAP 1973” rather like the army man who has “passed staff college.” The drawbacks are also obvious. While our doctor is reading these 130 pages he cannot read other reports that may be more useful to him. Better annual reviews of medicine are available—especially those with discussion of controversial topics and editorial comment. Many doctors reading a wide variety of publications will have a wider total cover than will be the case if all read the same material.

From a different point of view, snippets of information on topics far removed from one's usual work—for instance, recondite endocrinology for a cardiologist—will, in the absence of repetition and reinforcement, be rapidly forgotten. But perhaps I am wrong. Perhaps MKSAP should be done in addition to other current postgraduate reading. If so, the time must be taken from some other part of the day—family life, church work, service club, or other community activity—in which case medicine may gain but the community may lose.

Bother boys

Not content with measuring knowledge alone, the bother boys now propose to measure attitudes, motivation, and personality. In this area criteria are easy to establish. Anybody like me is a good chap; those who differ much are probably undesirable. Difficult cases will be referred to committees that generally will follow a safe middle course, so that over the years a standard type will emerge. The day of diversity will have gone, and the physicians will lead the rest of the community into a blue ant society, after the admirable example set in Mao's China.

Areas to which the bother boys are paying even greater attention are audits, peer reviews and professional standards review organisations—rich fields for bureaucrats, mediclerks, and administrators. I believe tissue audits to be highly desirable, provided that they are planned and conducted by clinicians, pathologists, and radiologists in active practice under the leadership of an elected audit chairman. The value of other types of audit is open to considerable doubt, as Brooke and Appel have shown.³ More recently, McSherry⁴ produced instructive figures illustrating the cost of a form of audit aimed at identifying wasteful prolongation of hospital stay. Over a four-year period, a review committee found 24 patients who had been kept in hospital longer than necessary. The cost of the exercise was

\$34 212 per patient. Clearly, utilisation review is in its infancy, and should be restricted to pilot studies until methods of proven value and acceptable cost have been developed.

POSTGRADUATE ACTIVITIES

What accounts for the collective masochism of the medical profession? Are our standards low? Do we give a poor service? Do we suffer by comparison with other professional groups—dentists, lawyers, architects? While nobody would urge complacent acceptance of things as they are, must we go to the other extreme and wallow in self-criticism and public confessions, again like the Chinese at street committees, our lives being punctuated by periodical assessments? I think not. The profession should fit the framework of the country in which it works. Democratic processes are traditionally regulated by a system of checks and balances. The Queensland general practitioner, through whose door pass 40 to 60 patients a day, may not have much time for self-assessment, but his college already has a programme of continuing education, and if he is lucky enough to get a locum, or works in a group, he can get away for a week or a month each year to a refresher course. The private consultant must convince his referring doctors that he is competent. The hospital specialist, be he visiting or whole-time, is ever conscious of the critical eyes of colleagues, juniors, and paramedicals. At my own hospital there is more postgraduate activity than I have time to take part in, and though, like every other doctor, I ought to read more, I am unlikely to do so unless some philanthropist pays me for the purpose. If a Queensland country general practitioner, run off his feet most of the year, fails to attend some postgraduate activity prescribed for him by a city-based bother boy, and is delicensed, will his community

be better served by having one less doctor? Are we to increase out hospital staff by, say, 10%, especially in a time of economic constraint, in order to let the present staff have more reading time? What evidence is there that postgraduate activities, "structured" by educationalists, will develop better practitioners than we have now, when doctors select their own reading, meetings, courses, and study tours from the plethora available?

I suggest it is time for the profession to examine the claims of educationalists; see if the return in useful training is commensurate with the administrative costs of formal training and assessment programmes; and form an opinion on whether some of the money and effort spent on elaborate administrative arrangements could not be better spent on providing opportunities for doctors to make more use of present facilities—for instance, by finding locums (who better than the programme planners themselves?) to go to the country to enable country-based practitioners to attend teaching centres.

Bother boys are usually motivated by the inborn conviction that they have not only the ability but the duty to tell other people how to regulate their lives. If we are not careful, they will soon convince us, with the aid of the con-men, that this is so. We must look critically at the claims and plans of these people. Doctors of the land, unite! You have nothing to lose but the risk of chains.

References

- ¹ Bradshaw, J S, *British Medical Journal*, 1976, **1**, 767.
- ² Cox, K R, *Medical Journal of Australia*, 1976, **1**, 884.
- ³ Brook, R H, and Appel, B A, *New England Journal of Medicine*, 1973, **288**, 1323.
- ⁴ McSherry, C K, *Surgery*, 1976, **80**, 122.

General Practice Observed

Sexual knowledge and attitudes of general practitioners in Wessex

MAX ELSTEIN, A D G GORDON, M S BUCKINGHAM

British Medical Journal, 1977, **1**, 369-371

Summary

A survey of the sexual attitudes and knowledge of general practitioners in Wessex found that GP trainees and those in practice for less than 10 years were less conservative

University of Southampton, Southampton

MAX ELSTEIN, MD, MRCP, reader in human reproduction and obstetrics and honorary consultant obstetrician and gynaecologist, Southampton University Hospital

M S BUCKINGHAM, MB, MRCP, research fellow, human reproduction and obstetrics

Hythe Medical Centre, Hythe, Hampshire

A D G GORDON, MB, BS, general practitioner

and better informed than doctors in practice for 20 years or more. The results suggest that the attitudes of the doctors are determined by their early environmental influences rather than their clinical experience.

Introduction

Masters and Johnson's publications in 1966¹ and 1970² highlighted the shortcomings in medical education about sexual behaviour. Since then growing public awareness of sexual problems and their treatment has led to an increasing demand for advice on them within the Health Service. Part of the difficulty in dealing with sexual problems is that the average practitioner has not been trained to handle these cases and, therefore, feels uncomfortable when confronted with them. In addition, many doctors need to overcome and recognise their own prejudices relating to sexuality so that an objective assessment of the couple's difficulties might be made. Indeed, this deficiency