

Learning Medicine

Doubts

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Doubts are a very normal part of life. No university course and no professional training is more likely to raise doubts than medicine: academic doubts, vocational doubts, and personal doubts.

Few intending medical students have no reservations about whether medicine is right for them and they for medicine, and those few who have no doubts may perhaps overestimate both their own capability and their suitability. Not many medical students survive five years without wondering if they are on the right road. Few doctors in their first few years escape nagging doubts about the direction in which they would like to go and whether their aspirations are realistic in terms of skills, higher qualifications, and opportunity.

Alongside these various academic and vocational doubts the world of doctors in training also creaks and groans with all the normal difficulties of men and women finding their feet in an adult world. If newly from school they must find accommodation and adjust to life away from home. Mature students must acclimatise to a world that is often very different and more juvenile than that in which their feet had already been firmly planted for some years; they also often have to survive greatly reduced financial circumstances. Any one problem or doubt can be coped with, but several simultaneously, together with a course which demands continual concentration and a clear mind, can overwhelm the strongest constitution.

One thing is reasonably certain: decisions either to learn medicine or to abandon the task should not be taken too quickly. As Lilian Hellman wrote in *The Little Foxes*, "Sometimes it's better to let the sun rise again. . . ."

Academic doubts

Academic doubts are probably the easiest of all to resolve. The academic demands of the course and the academic capacity of an individual are susceptible to reasonably objective analysis. The course demands the ability to learn and retain much information and many concepts in different subjects simultaneously and to integrate this learning. An intellect sufficient to achieve at least three C grades in A level science subjects simultaneously at the first attempt with average teaching, together with the ability to persevere should cope with the medical course without serious difficulty. A determined, well organised person with these academic credentials should not be an academic risk, but more clever people who lack motivation may fail to pass their first or second year examinations.

It is harder for mature students to assess realistically whether or not they have the necessary academic ability for the course, partly because learning does not come so easily after the early

20s and partly because many mature students have little or no background of science. If studying full time they should set themselves a similar standard to those straight from school. If continuing to earn their living while studying part time they may reasonably assemble their A level qualifications piecemeal (so long as each is at a good standard when taken).

One of the saddest sights is the applicant of any age whose academic ability is clearly inadequate for the course but who will not accept that there is no hope. However uncertain the need for a doctor to be clever (and certainly history has shown that a doctor can be successful without being either clever or even safe), the public deserves the best it can get and there are plenty of talented people on offer. Against the competition of more intelligent, equally dedicated, and widely accomplished young men and women, the academically questionable inevitably stand little chance unless possessed of other outstanding qualities. A realistic personal assessment of academic ability is a first necessity in deciding whether medicine is the right choice, a matter of judging correctly the subtle balance between optimism and reality.

Most academic doubts develop in the preclinical years as a reaction to the apparent irrelevance of much of the course to the goal of clinical medicine. These are not doubts of ability to learn but of patience or commitment. Many of these doubts are the consequence of failure to find out enough at the outset about the course itself. Also it is natural in the first two years to question the ability to endure five years of undergraduate study followed by even more years of postgraduate training.

Dealing with patients

Doubts before and during the preclinical years whether medicine is the right career are understandable and may partly be avoided by a careful assessment of oneself and the job at the beginning. There may perhaps be no real doubt about academic ability, but what about the ability to handle people sufficiently well and to acquire the necessary practical skills?

There is no way of being absolutely certain of the answers to these questions but indications can be found. Resourceful, practical, sympathetic people who relate easily to others, including those with whom they may disagree, are likely to be suitable. High intelligence is not enough. Those who have taken the trouble to find out what a doctor's work entails by seeing for themselves something of general practice and hospital work and find it attractive have good reason to consider medicine seriously. They might, of course, also be suited to nursing or related careers.

Teachers can help to reinforce motivation by designing undergraduate medical courses which bring together so far as possible science and its clinical applications, keeping the carrot of practical medicine before preclinical students who might otherwise be tempted to abandon their studies, not fully realising how radically preclinical studies differ from clinical medicine.

Learning from patients in the clinical years may be both disturbing and unsettling. Some students have great difficulty in coming to terms with blood, disfigurement, suffering, disability, mental illness, incurable disease, and death. All have some difficulty but most overcome it without becoming hard and completely detached.

A few others find it very difficult to relate to patients. They feel that they are intruding, that they are merely spectators and they may therefore fail to develop essential skills in talking to and examining patients. Usually the best remedy in these cases is to engineer a greater degree of involvement and responsibility but teachers need to be perceptive to the need and the student needs determined application. Occasionally this gulf seems unbridgeable, and the student may have to decide whether to change course or to press on to qualification in the knowledge that many careers in medicine are not clinical.

Tempering steel

The importance of seeking help and advice before problems become overwhelming cannot be too strongly emphasised. Most difficulties tend to grow if incubated. In the first place there is no substitute for sharing problems with good friends, and that is one reason why a successful school needs to be a happy, considerate community and not just an academic factory. But the advice of friends may need to be supplemented by tutors, other teachers, doctors in the student health service, pastors, priests, or parents. No problems are unique and none insuperable. Very occasionally the right move is to change

course. To change direction for good reason is the beginning of a new opportunity, not a disaster.

Vocational doubts and academic failures occasionally occur during the clinical years because of psychiatric illness, which is sometimes the outcome of relentless parental pressure to follow a career which a student either did not want or for which he or she was unsuited. Depression is the usual response. Expert advice is needed. Psychiatric illness may be self limiting but it may be persistent or recurrent and incompatible with the standards of service and judgment which patients have a right to expect.

The clinical course introduces so many aspects of medicine that it is not surprising that intelligent, self critical students wonder from time to time whether they will ever master enough to qualify let alone to become expert in one discipline while retaining some knowledge of many others. Generations of students have, however, performed very competently as soon as they have been given a job to do as a preregistration houseman, and there is every reason to suppose that future generations will do at least as well.

The overloaded preclinical course is academically stressful, the more so because of the knowledge that failure in end of year examinations and the subsequent resits is final. The clinical course is less taxing academically but far more demanding in human terms. Throughout all these years students are subject to all the other stresses and strains of life, storms which have to be ridden out along with academic and vocational uncertainties. The process is one of tempering steel; most manage very well and emerge able to cope not only with their own problems but with those of their patients.

MATERIA NON MEDICA

Vimy Ridge—a pilgrimage

No traveller in northern France during the past decades can have failed to be moved and impressed by the innumerable first world war cemeteries and by the devoted care given to them by the Commonwealth War Graves Commission.

With the construction of the A26 autoroute from Arras towards the Channel there has emerged into the gaze of the passing motorist the most imposing memorial yet encountered in the form of the Canadian memorial on Vimy Ridge; this is now clearly visible through a gap in the trees to the north east of the autoroute north of Arras, but a tantalising glimpse is all that can be obtained from a moving car. Having clear recollections of listening to the radio commentary on the unveiling of the memorial by King Edward VIII during his brief reign in 1936, we have frequently wished to have a closer look at the monument and on returning from the south last summer we made good our resolve and left time to leave the motorway and make a belated pilgrimage.

The memorial stands a few kilometres north of Arras on the N17 towards Lens; the memorial park is clearly signposted. This covers 250 acres and has been designated as the free gift in perpetuity of the French nation to the people of Canada. As one proceeds along the winding road leading to the actual monument one notices that the terrain remains pitted to this day with shell holes from the thousands upon thousands of tons of high explosive which rained upon the area, now grass covered and peacefully cropped by sheep, in sharp contrast to the quagmire in which so many thousands perished; some of the tunnels and trenches which honeycombed the ridge are also preserved.

The memorial itself stands on the highest part of the ridge, overlooking the steep descent to the Douai plain. It takes the form of two pylons 200 feet high, one bearing the Canadian maple leaf and the other the French fleur de lys; the French had sustained 130 000 casualties in 1915, two years before the final successful Canadian capture of the ridge. The base of the memorial consists of 12 000 tons of concrete and masonry while the pylons are made from stone brought from the Dalmatian coast of Yugoslavia. Between the pylons

are sculpted symbolic figures of Peace and Justice and the heroic figure of Mother Canada grieving over her dead. The construction of the monument took 11 years.

The onslaught of the four Canadian divisions, fighting for the first time together as a complete corps, began on Easter Monday 1917, and during the course of the attack 10 600 Canadian casualties were sustained; four VCs were gained, three of them unhappily posthumous. The memorial commemorates the 60 000 Canadians killed during the course of the war, and the names of 11 285 of those with no known grave are inscribed on the ramparts of the memorial. Although we have no family connections with Canada we found our brief pilgrimage impressive and inspiring, and continued our homeward journey in a sombre yet uplifted mood.—A L TULK, retired general practitioner, Cheshire.

What is Duane's syndrome and how can it be treated?

Duane's syndrome is a reduction or loss of abduction of the eye, retraction on adduction and occasional limitation of this movement, narrowing of the palpebral aperture on adduction, and widening of the fissure on abduction. There is also a deficiency of convergence and occasionally an up and down deviation on adduction. The syndrome is congenital and sometimes runs in families. Numerous theories have been brought forward to explain the curious changes in the ocular motility, and many of the older hypotheses attributed this to muscular fascial abnormalities. Newer work, however, has cast doubt on this, and advanced electrical myographic tests have suggested that there may well be a central reason for these odd ocular movements. They will present as a squint and indeed are often treated in a similar fashion with orthoptics and surgery if indicated. Sometimes the form of treatment may be difficult to decide and occasionally it is worth while referring children suffering from such syndrome to eye surgeons who specialise in the treatment of squint.—M A BEDFORD, consultant ophthalmologist, London.