philosopher John Gray puts up a good case for Mill's consistency here.¹²

In the first place, Mill's "absolutism" is only apparent, for he builds in the qualification that respect for an individual's autonomy governs absolutely provided that this does not harm others¹³ or deprive others of beneficial acts "which he may rightfully be compelled to perform."¹⁴ In the second place, Mill may be interpreted as arguing that the principle of utility (maximising overall welfare) entails this respect for autonomy, for the welfare to be maximised is "in the largest sense grounded on the permanent interests of man as a progressive being."¹⁴ Given that human happiness (in the broad Aristotelian sense of eudaemonia or flourishing) is constituted to a large extent in the exercise of people's autonomy and that people's autonomous requirements are so very different, indeed unique, it follows that respect for their autonomy will be at any rate a major obligation if the utilitarian objective of maximising welfare is to be achieved.

Bearing in mind the qualifications indicated above it is possible to understand how Mill as a utilitarian was able (arguably hardly less strongly than Kant) to advocate the principle of respect for autonomy:

"The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control. . . . That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-

protection. That the only purpose for which power can rightfully be exercised over any member of a civilised community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant."¹⁵

In my next article I shall look at some counterarguments to this position.

I thank Dr Michael Lockwood for drawing to my attention the argument of A MacIntyre.

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Green College Lectures

Educating the doctor: postgraduate, vocational, and continuing education

PHILIP RHODES

At graduation the doctor is still a raw recruit. The increase in specialisation of medical practice over the past few decades has made it almost impossible for the student to learn many skills which are needed for practice. The recognition of this inadequacy led to the introduction of the preregistration year in 1953. Specialisation has increased since then, making the educational task more difficult for both the student and teacher. Moreover, the rate of accumulation and obsolescence of knowledge and skills is now so great that it is trite to say that education must continue throughout the whole of professional life.

The problem is how to get each doctor to a state of competence for

his chosen tasks, and how to keep him at least at that level of competence and preferably beyond it. It is an enterprise demanding commitment from every doctor, but especially consultants and principals in general practice. They are ultimately responsible for maintaining and improving standards of medical practice, and for seeing that the juniors for whom they are responsible attain and keep to the standards consonant with their experience and degree of responsibility. Many senior doctors understand their places in the educational scheme of things, but by no means all of them shoulder their responsibilities and fully discharge such duties.

Preregistration house officers

The aims of the preregistration year¹ are laid down in the *Recommendations on Basic Medical Education* of the General Medical Council.² Inevitably the aims are vague. Even the code of good practice for the preregistration year, also from the General Medical Council, is vague about educational duties towards preregistration house officers. These should now be more closely defined, and made into objectives, so that consultants in charge of these posts know just what is required of them. It is not enough simply to assume that they will work this out for themselves on the basis of the recommenda-

University of Southampton, Southampton SO9 4XY

PHILIP RHODES, FRCS, FRCOG, professor of postgraduate medical education. Postgraduate dean of medicine for the Wessex Region

Based on a lecture given at Green College, Oxford, on 28 January 1985.

tions and the code. The question to be answered is: What do you require that the preregistration house officer shall know and be able to do at the end of his year of provisional registration?

Evidence from examinations for higher diplomas shows that many candidates are not as competent as they should be in clinical method. Obviously this should be learnt and inculcated throughout the graduate period, but it is important that clinical drill should be emphasised during the preregistration year. The new graduate is then especially impressionable and willing to learn about and work with the tools which will make his theoretical knowledge practical in the clinical encounter. Registrars in particular and also consultants should supervise housemen, often through proper review of notes, in eliciting relevant histories, and in ensuring careful complete physical examinations, or at least as complete as warranted. There is here, once again, the problem of specialisation in that many preregistration house officer posts have to be at least part time in a specialty. But the drill to be gone through in that specialty must be practised and learnt until it is second nature, and the preregistration house officer should feel uncomfortable if he has not done it and made notes on what he has done.

Always, of course, there is the cry that consultants and their juniors are so overwhelmed with service work that they have no time to supervise their preregistration house officers thus. The answer is that it is extremely inefficient to do otherwise than see that juniors know what to do and can be relied on to do it. If they do, then other members of the firm are relieved from constant checking and repeating clinical investigations which the preregistration house officer has omitted because of ignorance which it is the duty of his seniors to correct. "More things are missed by not doing than not knowing" is an axiom of medical practice. The preregistration year is the time par excellence to make sure that housemen know what to do and do it.

There needs to be help, too, with communication skills, in evaluating evidence, drawing up problem lists or diagnoses, ordering relevant special investigations, and initiating appropriate treatments. This needs constant interaction between teacher and taught. The functions of all more senior doctors include service to patients, teaching their staffs (medical and other), research (often operational and critical review), and administration/management. In present day contexts of medical practice it is not enough to overemphasise service to the detriment of other functions. Without recognition of these last three the service is not as good as it might be—and ought to be. This is such an obvious point that it should not be necessary to have to state it over and over again.

Skills are often equated with simple techniques, which, though important, are not as important as those enumerated in the practice of clinical drill. Techniques in use on a particular firm are easy to list, and this should be given to the preregistration house officer at the beginning of his job so that he knows which techniques he should practise.

General practice

General practice was in the doldrums just after the second world war, which ushered in so many new advances in surgery, transfusion, fluid balance, chemotherapy and antibiotics, and anaesthesia. These esoteric practices tended to take nearly everything into hospital and convert general practitioners into sorting clerks directing patients appropriately to specialist departments of hospitals. To their lasting credit the leaders of the general practitioners would have none of this and they turned to the old friend of education as the remedy. They defined the nature and content of general practice, with especial emphasis on the consultation.¹ On these preliminaries they were able to define desirable standards and then to assess them, by introducing vocational training and more formally by the examination for membership of the Royal College of General Practitioners.

The results have been astonishing in the improvement of general practice, with sanctions reinforced in 1979 by the Vocational Training Act. Perhaps the most important matter has been that trainers have to be specially selected from among applicants. Their

practices have to conform with minimum standards based on questionnaires and inspection, but, above all, the trainers have to learn something of educational philosophy and method and know how to teach and help learning in their trainees. It is a far cry from the hospital educational system, where it seems to be assumed that all are capable and competent to teach, as if by the light of nature.

The role of education in the furtherance of general practice has been triumphantly vindicated and should be recognised for being so. It has shown the interaction of education with standards of service over the course of only 30 years or so. From being the Cinderella of medicine general practice now attracts from among the best graduates, who are technically competent in a narrow medical sense, but in addition know of and consider the contexts in which their branch of medicine is practised. They begin to appreciate the nature of the interactions between general practice and the various types of societies in which it operates. These have various nuances of psychology, sociology, and ethical and moral values, as well as political ones. General practitioners know that medicine is not autonomous but shades off into many activities often not thought to be subsumed under the heading of medicine in a way that hospitals and their specialists seem not always to do. It is a matter of understanding, awareness, and consideration of the cultural environment which pervades general practice and which may be lacking in hospitals.

Senior house officers and registrars

In hospitals the first few years after full registration are taken up with what has been called vocational training, general professional training,² and basic specialist training.³ Perhaps it might be better to use the non-committal term "intermediate training." The other names are bound up with the concept that there is some special merit in general education before proceeding to specialist education. The proposition is doubtful, even though in some vague way it appears a priori to be right. Many junior doctors enter into their specialist training immediately after obtaining full registration—especially in disciplines such as anaesthesia, psychiatry, pathology, and paediatrics. Possibly those who know exactly what they want to do and get on with it turn out just as well as those who start general and later go special. If you look at them 10 years on it will not be possible to distinguish between the "pure" specialist and the one who has had a spell in general training.

The fact is that there are no generalists left. Specialisation has overtaken them all. In hospitals and general practices the key word is teamwork. The doctor who thinks himself capable of a very wide variety of practice may be a menace, doing a disservice to his patients and his colleagues. The doctor who because of his general training and experience comes to believe that he is as well equipped as a specialist in his appropriate sphere is deluded. Our patients must be protected from amateur dabblers. What "general" knowledge and skill should mean in this context is that all doctors must be able to make reasonable diagnoses of the problem questions for their patients so that they may be referred to those who know how to make a more exact diagnosis and act technically on that basis. This does not demand a high level of education, training, knowledge, and skill, but more especially an acute awareness of where one's own competence runs out so that those more skilled may be called in to help. It is this relatively low level generality that all specialists need, and it is mainly a question of attitudes with a continuing and unremitting effort to use clinical method. When problems outreach the specialist (which now means every doctor) he must realise the fact and find someone with a better chance than himself of solving them.

In their role of determining standards the royal colleges and faculties inspect a variety of junior posts to see that incumbents obtain satisfactory experience. This lays duties on local consultants and principals which are those of teacher and assessor. Examinations of the usual kind are imperfect tools for testing clinical skills. Day to day work in the wards, outpatient departments, and operating theatres bears little resemblance to that in the clinical examination for a higher diploma. The only assessor of clinical competence can

be the consultant with whom a junior doctor works, yet this is still incompletely realised. One thought is that consultants might be asked by their colleges to certify competence in each of their juniors before they are allowed to sit for the more theoretical parts of their examinations.

Senior registrars and consultants

Among senior registrars and consultants there is still much misunderstanding of the place of teaching and of research in education.⁷ They are as much, if not more, for the benefit of the teacher and researcher than for others. Both teaching and research demand a mastery of the subject which can be gained in no other ways. There has to be arrangement of material, criticism of it, investigation, and delivery which is either oral or written. In these activities there may be little contribution to public knowledge but an immense amount to personal knowledge. The doctor who takes on research and teaching has his attitudes to knowledge and evidence changed beyond recognition, and these attributes carry over into everything that he does. He develops heightened awareness to all the problems that beset him daily and becomes lively, interested, and enthusiastic and so makes his clinical work more effective and at the same time self critical.

In general, senior registrars and consultants are full of knowledge and are very competent in their skills. They know how to keep up to date and to polish their various techniques. Yet from the public and from the profession come some criticisms of the ways in which medicine is practised. In a word we can be accused of insensitivity in the application of medicine. The doctors might be said by these critics to be well trained but ill educated. It is not knowledge and skills that seem to be deficient but inadequate attitudes to and for the task. The complaints are about the relationships of doctors and the profession with patients and with society. There is not enough understanding by the doctors of the societal contexts in which they work. That is the burden of public anxiety.

Doctors, and particularly consultants and principals, who willy nilly are the leaders of the profession in its frontiers with the public and their juniors, must increasingly consider what they are doing, why they are doing it, and for whom, and whether they ought to be doing all of the things that they do. Medicine can no longer retreat to its ivory tower and repel all potential attackers. Already there are many signs, in articles, symposia and seminars, and in the media, that doctors are coming to appreciate this relatively new factor in their practices. But the pace of acceptance is still too slow. There will have to come more formal consideration of ethics, morals, human relationships, psychology, and sociology. And the key word is consideration. These matters are not for dogma or for didactic presentation: they are for discussion and self directed learning, though with help from many experts outside the immediate confines of what is now classic medical practice.

The present education of the doctor has thrust immense responsibilities on all members of the profession, but especially on consultants and principals, who may never have thought of themselves in this light. The growth of the large institutions, such as universities and medical faculties and schools, the royal colleges and faculties, the General Medical Council, and the councils for postgraduate medical education, may have seemed to put the responsibility for education on more or less defined teachers, allowing others to think that they have been edged out of their traditional roles as masters in charge of apprentices. But all recent history shows that we need this old system more than ever before. It is the only way in which both profession and public will remain reasonably content with the qualities and competence of its doctors. The responsibilities of the masters must be more definitively shouldered and they need the continuing more detailed support of the major institutions in helping them to carry out their increasingly onerous educational tasks.

All consultants and principals have now become the important figures in education, of their juniors and of themselves. Through teaching and learning, education and training these seniors are the setters and maintainers of standards of practice, in their various

disciplines. The best of them have always known this, but in modern medicine it now needs more formal recognition and action. Time has to be found for these activities. This is in short supply for most consultants and they can often use this as an excuse for side stepping and avoiding their educational duties, which may be hard work. The proper solution for this is that NHS contracts should be written so that at least one session each week is set aside for "academic" purposes. These would include administration, review of clinical work, study, preparing material for teaching, writing, tutorials, seminars, devising assessments, correcting written exercises, and so on. The work of a doctor, and especially a consultant, is not now always in the clinical encounter with an endless stream of patients. The fact is recognized in the terms and conditions of service in the matter of study leave, which for junior staff is almost one day in five. This privilege, which is becoming a necessity for education, should be contractually and individually offered to consultants. Almost inevitably some consultants might abuse this "free time" in the contract, but most would not and the results in terms of standards of medical care, in enthusiasm for the job, and in increased morale might greatly increase.

These tutors at the place of work obviously need support in educational duties.⁸ This comes from clinical tutors and their postgraduate medical centres, and for every region there is a postgraduate dean, backed by the university and its resources. But there should be an increasing role for central bodies such as the General Medical Council and the royal colleges and their faculties. How they could help has already been suggested, in putting more definite formal duties on to senior doctors in charge of junior posts, which are now recognised as being in large measure for education of the incumbents, as well as for the services those render. The General Medical Council might be more precise in what it expects for the education and training of preregistration house officers and what the council decides could be published and circulated. The royal colleges and faculties should also be more precise about what they require from their members and fellows in carrying out their educational policies. Consultants might be made especially aware of their duties as examiners of clinical competence on behalf of their parent bodies. No other examiners are as well placed for assessing junior doctors, nor need those feel under undue strain as they work alongside their masters as apprentices. The log books of work done are a step in the right direction, when each entry is countersigned by the appropriate consultant.

It is futile to bemoan the growth and development of formality in education. It has progressed steadily over at least the past 2000 years.⁹ There is no stemming it now. The pace has quickened and made it more obvious recently because of the immense increase in specialisation and the knowledge and skill required to keep up with it. Professional competence becomes ever harder to acquire and maintain, and therefore demands more and more effort in education and training. Society in general demands the best of its doctors in knowledge, skills, and attitudes, which together make up education. Nothing less than an adequate response to the challenges by each doctor will do. In particular, the leaders must lead, and leadership means persuading others to do what they otherwise would not have done. That in turn means using education, which in some degree is the duty of every doctor.

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(Accepted 4 March 1985)