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Clinical competence and curiosity

Medicine is both science and art; small wonder, then, that clinical competence—a blend of knowledge, intellect, attitudes, wisdom, and practical skills—is not precisely measurable. Critics are calling for attempts to refine the testing of clinical competence; but would greater precision be useful? Would the microscope be better focused instead on another area of the large slide of medical education?

In the eyes of examiners, candidates, and the General Medical Council the prime purpose of the medical qualifying examination is to certify sufficient knowledge, sense, and practical skill for a safe start to a long apprenticeship. The examination is not and does not pretend to be an assay of all aspects of medical education nor a complete test of medical competence, several facets of which will develop only later during supervised responsibility.

The emphasis in both the qualifying and later specialist clinical examinations is on a sensible approach and technical competence—more the science than the art. That is not to say that examiners overlook sympathetic consideration of the patient as a person, even if most would hesitate to put a numerical value to their judgment of this aspect. Sympathy, human insight, and the art of communication are all tested in a pragmatic way as part of the flesh on the skeleton of clinical wisdom and technical competence. Even the marks awarded for clinical ability are softer than hard digits might imply: performance depends both on the particular case given and on the individual opinions of examiners.¹ So should we be trying to standardise both examiners and patients? Should we be attempting to eliminate the rough edges of real clinical settings from the circumstances of assessment—or is that not the point at all?

If we had a more precise rank order of candidates in the qualifying examination would we make any use of it? Could we be convinced that the ranking had any more meaning than one shake of a kaleidoscope that will be shaken many more times before the doctor's education is complete? Would attempts at greater precision in ascertaining the outcome of an educational process yield information valuable enough to justify loading students with a further burden of assessment? Might it not be sensible and sufficient to settle for the current written, oral, and practical examinations—which most candidates pass because they are competent for their years and able to continue to learn? A few who perform outstandingly well on the day get honours; a few lazy, uninterested, distracted, or simply unlucky fail.

The qualifying examination is only one (important) hurdle in a long continued process of education and training. The best academic acrobats by no means necessarily turn out to be the most effective members of the professional circus, which is not surprising because enthusiasms wax and wane, individuals mature at different rates, the wide variety of jobs in medicine demands a panopoly of different skills and catches

different imaginations, and there are many and varied colleagues and consumers to satisfy.

None the less, it is an interesting task and, indeed, the academic fodder of educationalists to dissect out the components of competence and to improve assessment. Some, such as Neufeld and his colleagues at McMaster,² have approached the issue with critical good sense. They ask of any proposed test of clinical competence whether it tests what it claims to test, measures performance consistently, is applicable, is acceptable, and whether it achieves a useful educational purpose. Examinations are not only milestones of achievement but also useful means of instruction and correction, instruments of emphasis, and avenues of insight into the success or failure of education. Clearly assessments should be as informative and reliable as possible, but at the same time their pragmatic purpose may be achieved without fine (and probably illusory) precision.

Neufeld has aptly described clinical competence as a "battered child": "child" because a relatively new topic of interest; "battered" because maltreated by some researchers.³ Some have lacked understanding of the nature of clinical practice and responsibility; others have failed to appreciate the gap between their untreated theories and obscure jargon and the down to earth views of those whom they seek to persuade. Educationalists who, for example, write that they "wish to challenge the view that competence in medicine is completely specified by the acquisition of a body of facts" are tilting at windmills and cannot expect the confidence of either those who teach or those who learn.⁴ Nor can clinical teachers take seriously those who write "In considering the potentially large number of exposures required to adequately interpret any finding and the large number of physical signs available, it is a frightening possibility that the amount of exposure of a typical undergraduate may be woefully inadequate."⁵

It is not just "possible" but certain that clinical skills are incomplete on qualification; incompleteness does not prevent newly qualified students rapidly turning into competent house officers. Certainly every attempt should be made to ensure that clinical experience before qualification is as extensive as possible. The remedy is not "research . . . to further explore actual exposure in the undergraduate curriculum"⁶ but action to ensure that teaching and experience proceed hand in hand and that students are personally accountable and, as far as is possible, responsible for their patients.

Where gaps exist in knowledge untested theories all too easily creep in. The message of Hans Anderson's story of *The Emperor's New Clothes* is evergreen: we need to see through the eyes of the small boy who, being unable to see gold or silver thread, concluded not that he alone was unable to see the fine cloth but that it was not there. To use another metaphor, we should view education theory with an open mind but not "so open that our brains fall out."⁶

Academic study of clinical skills and their assessment ought to be worth while, but whether they are of practical value remains to be seen. A more important question is how high should such a study rank in the list of priorities for the academic study of the process of medical education? Surely a much more pressing issue is why so many medical students the world over lose their curiosity and enthusiasm as they pass through their course. Nearly 20 years ago a student wrote: "In every clinical student a spark of enthusiasm for medicine must grow, else he would never have taken to the profession, but somewhere along the line of medical school the spark becomes very dim. . . ."

His criticism is as forceful and relevant today as it was then. This surely is a more pressing issue for medical educationalists to research. The greatest challenge is to inspire students to curiosity, to fan the flames of their own enthusiasm and the empathy which goes with it. All else will then fall into place.

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Bereaved children

The death of a parent is known to be associated with psychological ill health for the child,^{1,4} but we are unsure how this comes about; the common explanation in adults—problems in grieving and mourning—is more difficult to establish in children. Indeed, some children do not appear to grieve openly at all. Other uncertainties include whether the effects are short term or delayed^{5, 6}; some evidence suggests that loss of a parent in childhood may be one of the factors associated with later depressive illness.^{7, 8}

Such questions are now being answered by controlled studies of children's responses to the death of a parent.^{9, 10} These have shown the presence of a "grieving" or dysphoric depressive syndrome expressed through sadness, crying, and irritability combined with sleeping disturbances, nightmares, a general loss of interest, and poor school performance. These patterns are universal in children who are bereaved but are particularly evident in older girls. Younger children may show an additional or perhaps alternative pattern: temper tantrums, fighting, and a diminishment of interest in activities which are normally associated with parents. This may account for apparent lack of a grief reaction. Fortunately, in most children these responses are short term and limited; but any of the patterns may become permanent. Whether they do depends in part on how the children's needs are met and how the adults caring for them respond.

Children seem particularly vulnerable to the state of mental health of the surviving parent. A mother who has been bereaved of her husband may in her own grieving find herself responding with indifference or may fail to be protective, particularly if a specific severe psychiatric state is present.¹¹ The age of the child is also important, with loss before the age of 4 particularly stressing.² Which parent has died is another factor. At one time loss of a parent of the same sex was thought to be more distressing than loss of one of the opposite sex. This has not, however, been borne out in recent research.¹⁰ Husbands who are bereaved seem to recover their own functioning more rapidly than wives.¹² This may be due to the different social and economic supports available for the surviving parent. The quality of relations within the wider family network both before and after death also has an effect

on the child's own ability to cope. Perhaps children try to help by turning their own sadness into activity as a way of not further burdening their parent.

What specific help should we be giving to bereaved families? Studies on adults have shown that difficulty in mourning—in expressing and sharing grief—may have a profound effect on the recovery from bereavement and may be one of the factors which can trigger a severe depressive reaction.¹³ The organisation Cruse has played a valuable part in promoting more effective mourning and in helping adults confront their painful feelings rather than avoiding them; such activities are known to help avoid long term mental health hazards.^{14, 15}

Should similar work be attempted with children and parents? Black and Urbanowicz have carried out an important controlled study of treatment in which they approached six families within two months of bereavement and offered six family sessions to help with family problems.¹⁶ The aim was to explore feelings and try to help with emotional and practical problems and to facilitate communication and the expression and resolution of grief. Only half of the families approached wanted help, but the results showed over a 12 month follow up that children were improved in their functioning compared with controls: they had fewer sleep problems, fewer learning difficulties, were less restless, and were more able to cry and talk about the dead parent. The surviving parents were less depressed and seemed to need less help, though there was a universal need expressed for domestic support in the period after loss, whether the surviving parent was a father or a mother.

These observations suggest that, though children's bereavement responses are limited, their symptoms are important and the fact that those symptoms are likely to be self limiting should not prevent us promoting the expression of grief within the family. As professionals we may prefer to avoid the work; we may wish to avoid and postpone such painful issues, but we must be aware that self limiting short term reactions may become long term in adverse circumstances and may have substantial effects on mental health.

Family based treatment approaches give us means of ameliorating long term distress by promoting the natural resources of the family. We should begin to think of how this can be achieved in a systematic and broadly based fashion.

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