The first freedom

D. J. G. BAIN, M.B., Ch.B., D.Obst. R.C.O.G.
Edinburgh

THE main tasks facing a doctor are the diagnosis and treatment of disease, and the initiation of preventive measures to maintain the health of the community.

During my years at medical school, I studied the human body in all its complexity, found by modern scientific methods of investigation clues pointing to the causes of physical suffering and learned the methods of alleviating pain. The teaching in those medical school days was geared in the main to the hospital service. During my years of study, and in junior hospital posts, I was trained to stand in awe of the specialist who has studied his subject exhaustively, but of the general practitioner who sees sickness impinge on daily living and who is at hand at the onset, the follow-through and the after care of illness, I saw very little. To me there was insufficient liaison between the hospital and family doctor services, while certain ignorant hospital doctors patronizingly regarded the general practitioner as a failed specialist. With these thoughts, and being a little disillusioned by the rigidity of teaching hospital life, I decided with some trepidation to step into the unknown world of general practice.

Having spent my pre-clinical and early clinical years in Aberdeen, I decided to go to Edinburgh where, with a Department of General Practice within the University, and in addition a well organized trainee scheme under the South East of Scotland faculty, there would be ample opportunities to study medicine 'in the round'.

In this paper I will describe my initial experiences in general practice, and the satisfaction and frustration of what I regarded as my 'first freedom'. I will give some statistical data of the work carried out during my year as a trainee, and comment on the Course for Trainee Assistants organized by the Department of General Practice.

Background data

The practice in which I was a trainee was a three-man practice comprising 7,452 patients, and I was under the guidance of one of the partners. Each member of the practice consulted from separate premises (which I shall comment on later) and each had his own list of patients. The partner to whom I was attached had a list size of 2,886 (*see* figure 1). The practice was circumscribed and drew its patients from all walks of life predominantly from three large housing schemes in the area.

The majority of patients in the practice were drawn from social classes III and IV with small percentage of upper and lower social classes. There were relatively few patients in the 25–40 age group. This, I think, was because the main housing estates in the area were well established where many of the parents had been living for a number of years and the majority of their children were in the 12–20 age group and still staying at home. It was the tendency for the 20–30 age group who had grown up in the area to leave home at this stage in their lives, often get married and set up house in different districts of the city. This gap in the age-sex structure of the practice will gradually correct itself as new housing schemes develop, and younger families occupy these houses.

Impressions of general practice

My interests in clinical work had been in maternal and child care and a large proportion of my work was spent in this field. However, all aspects of medicine were soon

revealed to me, but in a totally different environment from the one I had been trained in. My medical school and hospital training stood me in good stead in the diagnosis of symptoms and signs of disease, but in general practice the problems did not finish there.

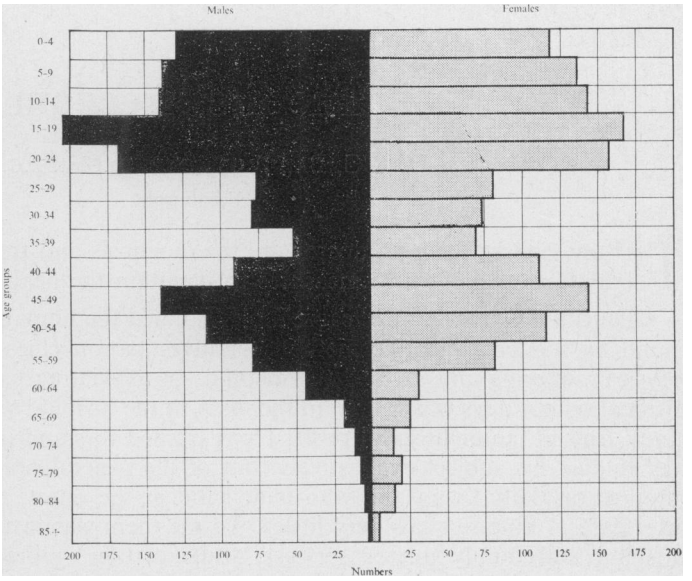

Figure 1
Composition of practice list

The return of a patient to his working environment, the alleviation of anxiety and depression, the problems of the aged with regard to nursing care and help in the home are matters which concern the general practitioner. Although there are specialized para-medical agencies which can cope with these social problems, it is the duty of the general practitioner to have a thorough working knowledge of these before delegating responsibility to others, and also to show a keen interest in the ultimate result as far as his patient is concerned. These were the problems, essentially social in nature, which really opened my eyes to another side of medicine.

Although a large proportion of a general practitioner's time is spent in the treatment of trivial complaints, a considerable number of serious pathological conditions present themselves. My trainer had a 'well-educated' practice population and patients with very minor complaints were not encouraged to make undue use of the doctor's time.

There were, of course, the chronic high users, but they are a group who, if studied carefully, can also be of some interest. However, the majority of patients had 'real' complaints and it was rather shattering to discover how many of these seemingly minor upsets, when studied in detail turned out to be of a serious nature. It may have been pure chance that I diagnosed more serious disease in the second half of my traineeship than in the first half. I shudder to think of the wrong diagnoses I may have made in the initial stages.

It is generally accepted that psychiatric disorders have a large part to play in any doctor's work-load, and this was brought home to me very forcibly. It is reasonable that effort should be made to find an organic cause for a symptom but it is equally important to look for a psychological cause. Time and patience are of paramount importance in sifting out all the vague symptoms and complaints presented and dealing with them appropriately. There is no substitute for experience in dealing with the psychiatric and social upheavals and it was right that my trainer who had an intimate knowledge of his patients, dealt with the majority of these cases.

One very useful asset in Edinburgh was the Family Doctor (Diagnostic) Centre where ancillary nursing and secretarial help was available.

This centre provided x-ray facilities including IVPs, cholecystograms, Barium meals, ECG facilities, and more extensive laboratory tests such as glucose tolerance tests could be carried out at the unit. All x-rays, ECGs etc. were reported by consultants of Edin-

burgh Royal Infirmary. To me, the great benefit of such a centre was the ability to continue investigations on patients without having to refer them for simple diagnostic measures *via* an outpatient consultation. Patients were also much happier to be saved waiting, and they were having continuity of care which they certainly preferred. I was surprised that so few doctors utilized the services of this centre, and I feel that too often general practitioners seem to be 'brain washed' by the tripartite system and when additional investigations are required a letter to the appropriate outpatient department is the easy way out.

However, in defence of the general practitioner, I feel that ancillary help is not organized in a method suitable to the family doctor. If doctors are prepared to work in a group practice, which, to my mind, is the only way to enable continuing cross-fertilization of thoughts and ideas, they must have paramedical workers attached. I realize that the present system of district nurses, health visitors, midwives, and social workers, etc., being attached to districts of a town or city is probably governed by economics. This, I thought unsatisfactory; continuity of care was impossible and individual paramedical workers were often under the direction of too many doctors. There is no doubt in my mind that teamwork is of paramount importance and with appropriate assistants attached to practices, rather than districts, both patient and doctor would benefit. In addition, a nurse, or properly-trained medical secretary could help in taking throat swabs, samples of urine and assisting in simple dressings, etc. Without reorganization of this aspect of general practice, the family doctor cannot possibly offer an efficient front-line service.

Finally, there is the problem presented by the lack of social workers to support the general practitioners in the management of cases which are at root social or psychological. It seems that the medical social worker is more suitably trained to deal with patients and ensure for them continuous care in their own homes, in schools or at work, but most social workers are hospital based and have little personal communication with the patient's family doctor.

Work-load in a year as a trainee assistant

As stated previously, the practice consisted of 2,886 patients. The practice had risen steadily since 1950 when the list size was nil to its present state.

There were three partners in the practice, the other two partners working from their own surgeries and from a surgery within one of the housing schemes. I thought it rather unusual for a 'partnership' to be working from four different surgery centres, and I was surprised to find that this was by no means unusual in Edinburgh. Doctors must pool their resources or young doctors will never be attracted to this field of medicine.

My trainer had purpose-built premises with waiting room, reception room, two surgeries and one examination room.

My studies on the patterns and profiles of disease which I encountered were based on simple observational methods of recording. The clinical records were kept in standard N.H.S. envelopes and the daily volume of work was recorded in a day book. In addition, I maintained, throughout my year as a trainee, details of all visits and consultations with which I dealt. My trainer had a similar system and from his records I have obtained the total 'work-load' throughout the year.

My initial weeks in the practice were spent accompanying my trainer on his rounds and 'sitting in' on his surgeries, and after a short period of time duties were delegated to me. After three months of my trainee post, the practice instituted an appointment system.

Details of consultations, visits and revisits are shown in tables I, II and III. I certainly did not have an excessive 'work-load' as a trainee assistant. The total consulta-

tions which I dealt with at the surgery was 27 per cent beginning with 10–20 per cent and ending with 30–40 per cent. The drop in consultation rate in March and April was due to a holiday and my attendance at a trainee course. The number of consultations made in August was low as this was a holiday period for both my trainer and myself.

Turning to the home visits made during the year, the most revealing fact to me was the large proportion of revisits (46 per cent of all visits). My own revisits were only slightly more than this, namely 47 per cent. Of the total number of visits, my share was 40 per cent throughout the year. These figures do not take into account visits to patients where both my trainer and myself were present. The peak demands on the practice were in the winter months—54 per cent of all consultations were between October and March, and 59 per cent of all visits carried out were during these months. Furthermore, between October and February, the percentage of visits exceeded that of consultations and thereafter the tendency was for the proportion of consultations to be in excess of that of home visits. In addition to participating in the work of a practice I had ample time for a hospital attachment, a course designed for trainee assistants, and opportunity for reading and attending postgraduate lectures, all of which are an integral part of a trainee year.

TABLE I
CONSULTATIONS IN ONE YEAR

Month	*Total*	*Percentage of year's total*	*Trainee's total*	*Trainee's percentage*
October ..	653	*8.28*	72	*11*
November	697	*8.83*	152	*22*
December	722	*9.15*	208	*29*
January ..	786	*9.96*	233	*30*
February ..	672	*8.52*	190	*29*
March ..	765	*9.70*	170	*22*
	6 month percentage = *54.4*			
April ..	525	*6.65*	108	*21*
May ..	782	*9.91*	247	*32*
June ..	740	*9.38*	225	*30*
July } ..	650	*8.24*	280	*43*
August }				
September	899	*11.40*	270	*30*
	6 month percentage = *45.6*			
1 year total	7,891		2,138	*27*

TABLE II
HOME VISITS IN ONE YEAR

Month	*Total*	*Percentage of year's total*	*Trainee's total*	*Trainee's percentage*
October ..	260	*9.14*	32	*12*
November	310	*10.90*	55	*18*
December	283	*9.95*	86	*30*
January ..	298	*10.47*	143	*48*
February ..	245	*8.60*	122	*50*
March ..	244	*8.58*	86	*35*
	6 month percentage = *59.0*			
April ..	206	*7.24*	87	*42*
May ..	233	*8.12*	126	*53*
June ..	236	*8.20*	127	*54*
July } ..	223	*7.84*	127	*57*
August }				
September	307	*10.8*	151	*49*
	6 month percentage = *41.0*			
1 year total	2,845		1,142	*40.1*

At ten per cent of all consultations a medical certificate was given, most of which were for National Insurance.

The range of disease was wide and this was in some ways disconcerting to me because it was difficult to focus attention on any particular branch of medicine. It was thought-provoking to discover in how many cases a firm diagnosis was never made, and it has been suggested in some quarters that if half the treatment carried out by family doctors in Britain were stopped overnight, the effect on the nation's health would be nil.

This view is rather sweeping and cynical but it emphasizes the problem of the patient who will not believe he is receiving adequate care unless he has something to take or apply. I was perhaps fortunate that I saw very few of this type of patient.

Trainee scheme organized by the Edinburgh University Department of General Practice

The Edinburgh Trainee Scheme is divided into four periods of three months. The first two periods are spent with the trainer and attending clinical attachments. I had a three month part-time attachment in paediatrics, which, although useful, lacked any real responsibilities. However, I saw, both in the wards and in the outpatient department, interesting cases, new techniques, and the latest management of certain diseases. Weekly lunch-time meetings were held to discuss cases and these informal gatherings were very useful in enlarging my medical knowledge. The major criticism at these meetings was the non-attendance of general practitioners, and especially the practitioner of the particular child whose case was being discussed. I got the impression that many of the teaching hospital staff lacked real knowledge of the care of children in their own homes, and were hypercritical of the family doctor.

TABLE III

NEW VISITS AND REVISITS

	Total	*Percentage*
Total home visits ..	2,845	
New visits	1,531	*53.8*
Revisits	1,314	*46.2*
Trainee's visits ..	1,142	*40.1*
Trainee's new visits ..	601	*52.6*
Trainee's revisits ..	541	*47.4*

After six months had been completed, trainees were released from their practices for one half day per week so that they were free to attend a systematic course of lectures; discussions and visits of observation arranged by the University Department of General Practice. In the course of a three-month period we visited different practices in and around Edinburgh each having individual features of organization and clinical interests. These visits highlighted the wide range of clinical work undertaken by the family doctor, and the initiative of certain practitioners was very revealing. One particularly large practice with a fully comprehensive morbidity and family register for over 15,000 patients stood out as an example of what could be done when enthusiastic doctors had co-operated to form an ideal basis for a multitude of epidemiological research.

In addition to visits to individual practices, a whole day was spent studying the medical services in a new town and the lesson to be learnt from this visit was painfully obvious, and I am sure has been noted for future new town projects. There had been no long-term planning of the integration of the medical services with the needs of a growing population. The end result was haphazard organization with no provision for training of young doctors who will be required for the town. There was limited scope for extension of practice premises and the doctors were working with a minimum of ancillary help and poor diagnostic facilities. The experiences of having seen both the ideal side of general practice and the mistakes which could be made brought home to me the very real problem of how much thought must be put into the planning of a properly-run practice.

During this period organized by the University General Practice Department, trainees were provided with written material and references, and each trainee or pair of trainees was given a project to complete. Once completed, these projects were followed by a group discussion with a member of the Department of General Practice acting as tutor. Matters which came under discussion were interesting, but to me were orientated too much towards practice administration rather than clinical and human problems. We had, after all, had ample opportunity to discuss administrative problems with doctors whom we visited, and visits made to the Scottish Home and Health Department, the local executive council and the Ministry of Social Security had highlighted these

aspects of medical care. These seminars, under the auspices of the Department of General Practice, were rather disappointing and I formed the impression that it would be a great pity to see University Departments of General Practice being over enthusiastic about instruction on practice organization, note-filling, surgery architecture, appointments systems, medical manpower etc. I know that these matters are important but it is the basic clinical sciences and the management of patients *in toto* whether it be at home or in hospital, that is paramount in the training of the general practitioner of tomorrow.

However, the main aims of the Department of General Practice were successful in that the Edinburgh trainee-assistants were able to meet and discuss mutual interests, and we had the opportunity to see a selection of different types of practices which proved very stimulating.

Vocational training

My final comments in this paper will be on the subject of 'vocational training' which seems to be the current 'with it' phrase in certain medical circles. There are a number of schemes in operation under the heading "Vocational training for general practice" which would probably be better described as vocational training in medical practice and avoid this differentiation between general practice and hospital doctors.

Training in medicine commences at medical school and it is here that community medicine should be an integral part of any curriculum. My own training gave a very limited view of the care of patients outwith the hospital environment. General practitioners should be encouraged to be part of any medical school's teaching programme, and be able to impart the knowledge they have gained to students, and as a result both students and family doctors would gain from this. As general practice covers all aspects of medicine there is nothing to be gained by giving lectures on this side of medicine. In the last half of their clinical years, students should have compulsory attachments to selected practices, and attend once or twice a week for say three months. In addition, a continuous period of three to four weeks should be spent with one particular practice. During this time the student could be given more responsibility and see the problems of making an assessment when disease first presents. From what I saw, the students in Edinburgh were given a very good introduction to general practice and were able to discuss clinical problems and cases with their general-practitioner tutors.

I must at this point come back to an issue which I have made previously in this paper, and that is the conditions under which general practitioners have to work. As long as students have their basic training in hospital and see family doctors divorced from the nursing and diagnostic aid which is the right of every doctor, they will not be keen to plan their futures in the field of community medicine. The Edinburgh students may have been misled by the ideal set-up of the University's General Practice Unit, which employed in addition to five doctors, two nursing sisters, two social workers, adequate secretarial help, and no lack of diagnostic aids which the average general practitioner lacks. My own experiences as a student were probably unfortunate in that the general practitioners with whom I had contact were working without ancillary staff. Another point which surprised me in Edinburgh was that the General Practice Department, despite being a pioneer in this side of medical education had no facilities for the doctors in the unit to care for their patient in hospital beds and there was no provision for junior members of staff to hold clinical attachments in hospital.

There is one further point I would like to make concerning undergraduate training in university departments of general practice such as the one in Edinburgh, and other units which are being formed. They seem to be very much orientated towards social medicine, and senior staff are often appointed from social medicine departments. While accepting that the role of the practitioner is the responsibility for patients in a community setting it is still the basic medical sciences which are the tools of the doctor's trade. I think that many of the social problems are often over-emphasized and it is not lectures

on these subjects that will help students to understand this side of medicine but good common-sense and years of experience that will enable a doctor to recognize and cope with this aspect of medical practice.

At the postgraduate level, the recommendations by the Royal College of General Practitioners that, before entering general practice, a doctor should have completed a minimum of three years in hospital posts plus a year as a trainee assistant is very sound. After the pre-registration year, rotating internships in subjects such as obstetrics, gynaecology, paediatrics, psychiatry, ENT, and dermatology have been emphasized but surely one essential would be a further six to 12 months' experience in general medicine—a field in which the majority of disease in general practice comes from. Extension of training programmes all appear to be aiming at more hospital experience, but I believe that more time spent with a recognized trainer would be invaluable. A period of 18 months to two years as a trainee assistant would not be amiss and be of mutual benefit to both trainer and trainee alike. These suggestions would lead to a longer period of training before entering general practice as a principal but, if the practitioner of the future wishes respect from both patients and colleagues, he must be prepared to show that he has earned the right to it. There are only limited posts open to a doctor who has undergone postgraduate training as outlined. Without purpose-built premises, without a breakdown of the rather rigid tripartite system, without access to hospital beds and without adequate nursing help attached to group practice and health centres and not to districts, young doctors will continue to be disillusioned by the prospects offered in general practice.

It is not financial inducements that will encourage me to enter general practice, but the practical application of the many words which have been spoken by both politicians and leaders of the medical profession about the 'new deal' in general practice.

With general practice re-organized on the group practice and health-centre scheme, the family doctor will be able to practise medicine in a scientific fashion and make full use of what was a very long period of training at both undergraduate and postgraduate level. I, for one, hope that the recent recommendations of the Royal Commission on Medical Education are implemented soon and the irrelevant barriers to progress broken down.

Summary

In this paper, I have recounted my experiences and impressions as a trainee assistant in general practice and voiced some views on the type of general practice which I envisage as the best method of practising medicine in the community. I realize that many of my thoughts are perhaps idealistic but if one does not aim high, one will be left with a second rate system of primary medical care and this country must not let this occur. I am sure that I will enjoy practising medicine vastly more as a result of my introduction to general practice through the trainee scheme in Edinburgh, and, in the long run, I hope that the patients I have to deal with in the future will benefit from the training which I underwent.

Acknowledgement

I am indebted to Dr W. P. Thomson for the encouragement and advice I received in the preparation of this paper.