

The Department of General Practice at the Erasmus University of Rotterdam

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SUMMARY. The philosophy which provides the framework for looking after patients, teaching, and research at the University Department of General Practice in Rotterdam is described and the need stressed that this philosophy should be discussed continually with other departments and with local general practitioners.

In particular I believe that young doctors need to be trained in the skill of deciding whether patients in general practice need any treatment at all and who is the most appropriate adviser. Analysis of the doctor-patient relationship is essential in order to train young doctors to develop supportive rather than authoritarian relationships with patients.

Introduction

ACHESON (1976) has stated that university departments of general practice should examine their role and create a philosophy which should guide their functions. This philosophy "should include the department's view of its role in teaching, in research, and in the providing of care for patients" and further "should indicate the main values for the development of teaching and research in the department". Since I joined the medical faculty of the Erasmus University in Rotterdam we have developed a philosophy which provides a framework for our teaching and research in the Department of General Practice.

Training physicians

The basis for training physicians in general is a scientific education at a university. This should provide the knowledge, skills, and the attitudes required to help people in need. This scientific education, like the medical care system itself, is still largely orientated towards hospital and laboratory activities and has a

technical nature. The question is how can we relate the training of health care workers more strongly to primary health care than to hospital medicine? The university as a scientific institution will have to increase its concern of primary health care in the future. In the past, the study of human biology has been directed too much towards the body, and not enough towards the behaviour of man in his environment. Moreover, too little attention has been paid to considering how far clinical and laboratory data are relevant to health care as a whole. We must re-evaluate the relationship between science and health care, and if possible change the direction of medical research. Departments of general practice have an important role in changing the direction of medical teaching and medical research.

Training general practitioners

The general practitioner should receive a training based on human biology, that is, of the normal and pathological functioning of man in relation to his body, his mind, and his environment. He derives his identity from his knowledge of human biology and he should certainly preserve this identity. An intensive feedback from practical work in general practice should be built into the training. All this gives the general practitioner the tools to meet the needs and demands of his patients in a practical way. In our health care system the general practitioner is the first point of contact. He decides whether the patient is to be launched into the health care system or not. It is important that the general practitioner takes this decision on proper grounds because it can sometimes be detrimental for the patient somatically and psychologically if a wrong decision is made.

Definition of health

Dokter and Milikowski (1973) showed that it is important to formulate a clear definition of health and health care. Health should be understood as a process of development which man undergoes in relation to his immediate environment and to society as a whole. From

the beginning to the end of his life, man should be able to develop physically, mentally, and socially as far as possible. Health services in collaboration with social services should make this possible.

Dokter and Milikowski also pointed out that 'dis-ease' is an inevitable part of human existence: not all 'dis-ease' needs to be 'treated'. In fact, there is a tendency today for all 'dis-ease' to receive medical treatment. In this way, we make people too dependent on medical institutions, so that they do not learn to take sufficient care of their own development. This acts as a warning that when the physician accepts all complaints as treatable by himself, the individual is manoeuvred into a position of dependence, which can make him worse instead of better. I would like to make a plea for the creation of a generation of doctors who are able to reject certain complaints as being outside the sphere of their competence. It is then quite possible that the patient will take responsibility for his own health and try to find the solution to his underlying problems himself.

This idea was supported by the Dutch College of General Practitioners (1975) in a report which stated: "General practitioners and other workers do not reject complaints often enough" and "they should make it clear to the patient that at this stage they have nothing to offer which will help in solving the problems." I therefore suggest that the general practitioner should be able to decide with his patient where the origin of the complaint should be sought. If the origin is found in the body, the doctor is the expert. However, if the origin of the complaint is not found in the body, the doctor is no longer the expert and he should discuss with the patient and possibly with health and social workers who, if anyone, is the most suitable person to 'diagnose' and 'treat' the complaint.

Authority to support

The accent in the doctor-patient relationship should be shifted from authority to support (Dokter, 1967). Van den Berg (1964) has clarified the difference between authority and support in the social service context. He describes authority as having the power to restrict the freedom of action of other persons or groups in the interests of one's own aims or the aims of one's group. Support, on the other hand, involves the possibility of increasing the freedom of action of other people or groups, in accordance with their aims.

In an authoritarian relationship, it is one's own aims that are central, not those of the other person, while in a supporting relationship it is the other way round.

We doctors have created the impression that we are working within a supportive relationship, while we are really working within an authoritarian relationship—one that increases the patient's dependence. Of course, one can criticize that there is too great a concentration on support at the expense of authority. There may well be moments when a doctor has to take a decision which

will have a radical influence on the patient's life. He then uses his power to intervene (for example in admitting a patient to hospital) in the context of a supportive relationship where the interests of the other person are central.

Young doctors should be trained more in terms of the supportive relationship than in terms of an authoritarian relationship. They should be able to understand that while knowledge is a necessary condition for the practice of the healing art this knowledge may not be absolutely necessary for entering into a supportive relationship—in fact their knowledge can act as a hindrance if they use it to camouflage their inability to deal with the relationship. Thus the general practitioner should be able to enter into a supportive relationship within the limits set by his profession, on the basis of a clear understanding that the aims of the person who is asking for help must be central.

Co-operation

The principle of co-operation is important for the philosophy of our department. If the general practitioner wants to practise whole-person medicine, he will find that he cannot do it on his own. The problems with which he will be confronted can be solved only in collaboration with others. This is necessary in order to achieve better results. We have to teach the doctors of the future about both the factual and the emotional aspects of co-operation. Co-operation can be defined as working with other people or groups on the same task.

Flexibility in the future

Finally, I regard it not only as important that the doctor of the future should be able to adapt to changes in society and changes in the health care system, but equally important that he should be able to *contribute* to such changes. We are engaged at present in training doctors who will have to function in health care for many decades ahead. It is to be expected that great changes, the full extent of which we cannot begin to appreciate, will take place both in medicine and in health care during this period. Doctors, like other health workers, will have to be able to anticipate these changes and help to guide them. As far as possible, they should also be able to bring about changes themselves, although the history of medicine shows clearly that the improvements in national health which have so far been realized have more often been due to political and economic measures than to the initiative of medical men. This may also continue to be true in the future, but I hope that later generations of doctors will follow political and economic events with more attention than ours has done.

Conclusion

I believe that the aims put forward in this article are

central in the training of doctors in general and general practitioners in particular and they form the framework for our teaching and care of our patients. They also serve as a basis for our philosophy on research in general practice.

In the near future, departments of general practice must decide how to make these broad aims more specific and how to put them into effect. Discussion should not take place behind closed doors but if possible it should be part of a continuing dialogue between all who are engaged in the education of general practitioners or research in general practice.

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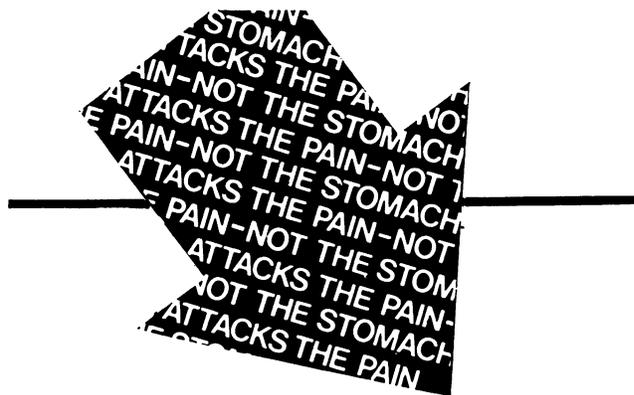
Closure of the ductus arteriosus in premature infants by inhibition of prostaglandin synthesis

Inhibition of prostaglandin synthesis constricts the ductus arteriosus in fetal lambs *in utero*. We administered the inhibitors, aspirin or indomethacin, to 18 premature infants with patent ductus arteriosus, and assessed the effects clinically and by echocardiography (left atrial/aortic-root ratio). After aspirin (20 mg per kg, every six hours for four doses) the ductus closed permanently in one infant within 24 hours; in another, constriction occurred with clinical improvement, and the third did not respond.

In five infants given 0.3 mg per kg of indomethacin, complete closure occurred within one day; two of them, who received three doses, had an elevated serum creatinine for one week. In one infant the ductus reopened, requiring a second dose of indomethacin 11 days after the first. Ten infants received 0.1 mg per kg of indomethacin, and closure occurred within 24 to 30 hours in eight. One had a soft murmur for four days, and one did not respond to two doses of indomethacin. A murmur reappeared after three to seven days in three infants but only one required further treatment. In infants receiving a single dose of 0.3 mg per kg, or one or more doses of 0.1 mg per kg, renal function was unaltered.

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