GUIDANCE FOR STUDENTS VISITING A GENERAL PRACTITIONER

A Memorandum by the Northern Home Counties Faculty*

Great changes have occurred in medical practice in the last twenty years, including the inception of a National Health Service.

Although these changes have brought many improvements in the medical care of the individual, they have imposed strains on the medical profession. The detailed knowledge required by the modern consultant leads to specialization from early in his professional life, so that few of the contemporary consultants and teachers in the medical schools have any first hand knowledge of general practice. Simultaneously, the increased public demand for medical care and the rapid advances in modern medicine have greatly extended the task of the family doctor. The result has been that these two branches of the profession have grown apart.

This is not a healthy state of affairs, for never before has it been more important for the general practitioner and specialist to work in the closest harmony. Advances in therapy necessitate greater diagnostic accuracy by the general practitioner, not only to enable him to treat many conditions which previously required hospital care, but also to ensure that he will put the appropriate specialist's skill at the disposal of the patient at the right time.

The opportunities and responsibilities of both family doctor and specialist cannot be fully appreciated by a student until he has studied medicine in the setting of general practice. It is essential that those who are being prepared for a life in general practice should see it as a high ideal worth working for early in their careers; and for those destined to enter consultant practice, the insight acquired

*The preparation of this memorandum was suggested by the students' representative of the Undergraduate Education Committee of this Faculty Board.

The views expressed are those of the Faculty Board and do not necessarily represent those of the Council of the College of General Practitioners.

It is a guide for students who contemplate taking part in the attachment scheme. It is intended to prepare them for the situations which they will encounter in general practice, so that they may be in a better position to obtain the maximum benefit and enjoyment from this experience.

into the problems peculiar to the family doctor will greatly facilitate an harmonious relationship with their colleagues in the future.

The Student in General Practice

There are several ways in which a student may be attached to a general practitioner. He may reside in the practice for one or two weeks living either with the doctor or in " digs" provided locally, or he may visit a practice daily or once weekly, while in some medical schools a student is attached to a practitioner throughout his clinical course, calling on him for advice and spending a few days with him at intervals during this time.

Whichever method is adopted, most of the time in the practice will be spent in company with the doctor in his surgery and on his rounds. Some of the time the student will simply watch and listen, but he will find that practitioners who undertake this work will encourage him to examine patients, and discuss diagnostic and therapeutic problems.

The relationship between practitioner, student, and patient is an intimate one. The patient plays a big role, the student brings new ideas, and his keenness is an inspiration for the doctor. The student will be suitably introduced to the patients and his presence will usually be readily accepted. He is encouraged to ask questions, and time may be spent in discussion.

The Setting of General Practice

General practices vary a great deal, and are influenced both by the doctor in the practice and the situation of the practice.

Some doctors see in medicine a very high ideal, calling for the highest moral, intellectual, and physical standards; others regard it as little more than a means of earning a living. Some doctors pass almost immediately from medical school into practice, while others spend many years gaining postgraduate hospital experience, and acquire special experience and skills which influence their methods of practice.

The situation of a practice plays a large part in deciding the role of the general practitioner; the size of the community in which he works, the type of people, and the location, size, and scope of the hospital services.

Nowadays, many doctors practice in partnership. This facilitates the organization of time for leisure and postgraduate study, and brings together doctors with differing postgraduate experience. In a partnership, the student enjoys the advantage of studying the

methods of more than one doctor.

The relationship which exists with the local hospital has an important bearing on general practice. In a small community, the family doctor and consultants are well acquainted and fully aware of each others idiosyncrasies. The consultant treats the practitioner's seriously ill and surgical patients in his wards, and advises him from the outpatient department, at domiciliary consultations, and by informal discussion. He may also arrange lectures and discussions to help him keep up to date. In return, the consultant is not asked to look after patients who should properly be treated at home, and can depend on the practitioner to supervise the care of those discharged from hospital. This is an ideal in which consultant and practitioner inspire each other to maintain the highest standards.

Around the teaching hospitals, the situation is for many reasons more difficult, and contact between the general practitioners and the hospital staff may be much less intimate. The patient often becomes detached from his family doctor, and not uncommonly attendance at the outpatient department continues for years without mutual communication. Unfortunately, some practitioners abuse the casualty and outpatient departments of teaching hospitals rather than take a proper history or carry out an examination of their patients, and this is sometimes the type of general practice to which the student is introduced. This is why many students qualify with no concept of the responsibilities of the family doctor, and why most receive a pleasant surprise from their attachment to a good general practitioner.

The Patients in General Practice

Accustomed to hospital medicine where every patient has been referred on account of suspected organic disease, many students experience some difficulty in attuning their minds to medicine as practised by the family doctor. Before joining a general practitioner, it is therefore important for them to appreciate some of the factors influencing the doctor, the patient, and his disease, which differ in general and hospital practice.

Knowing the patient. The patient who attends a hospital consultant requires a full history and examination, not only to discover what is wrong with him, but also to determine what sort of person he is. The family doctor, on the other hand, knows his patients, and the present symptom is fitted by the doctor into the moving picture which represents that patient's life. Some lives are full of up and downs, which occur at the slightest provocations, whilst others pursue a steady course only disrupted by major catastrophes. He learns from experience how the individual responds to the vagaries of life, and this helps him to assess the significance of new

symptoms. The doctor's approach may therefore, vary considerably between two patients complaining of the same symptoms.

Reasons for consultation. A patient attends hospital because his medical adviser believes that he is suffering from a disease requiring hospital investigation or treatment. He visits his family doctor for an infinite variety of reasons, including certificates, dressings, prescriptions, and numerous medical and social problems. The conduct of the doctor's surgery is therefore very variable and the stereotyped pattern observed in hospital is absent.

Significance of symptoms. Symptoms such as cough or abdominal pain when encountered in hospital frequently indicate well-defined, organic disease. The same symptoms met with in general practice can only in a minority of cases be attributed to a well-defined, pathological process demonstrable by examination or investigation. For instance, the proportion of patients who complain to their family doctor of dyspepsia and have a peptic ulcer, is very small, compared to the number who have less serious disease.

Significance of disease. Not only does the significance of symptoms differ in hospital and general practice, but also the significance of disease. The student's conception of pneumonia or pyelitis is of a patient seriously ill. In general practice, he will see these diseases much earlier in their natural history, and the patient will not usually be desperately ill. They are in fact regarded almost as minor infections by the general practitioner who, seeing them early, is able to " nip them in the bud ".

Examination of patients. The hospital doctor knows when he enters his consulting room, how many patients he will see, and time will be allotted to give each a full clinical examination. The demands on the general practitioner are much less predictable. His problems cover the entire field of medicine, and vary from the very trivial which may be dismissed in a minute to complex medical and social problems requiring time and careful examination. To examine every patient is unnecessary and time consuming, but to detect which patients require full history-taking and examination and to be well organized to deal with these, is one of the marks of a good general practitioner.

Knowledge of the individual patient in health and disease, good records describing the patient's previous response to ill health, and appreciation of the significance of symptoms in general practice as a whole, and in the individual patients in particular, guide the practitoner in his selective approach to surgery consultations.

Some doctors like to deal completely with each problem as it occurs, while others prefer to arrange for patients requiring a lot

of time to attend on a separate occasion.

In dealing with minor conditions the family doctor frequently prescribes simple remedies, telling the patient to return in a few days, when more thorough investigation may be necessary if he is no better. In spite of this however, a big effort is made to make a positive diagnosis particularly in minor infective and emotional disorders, and the method of diagnosis by exclusion, e.g. " His chest x-ray is normal, his urine is sterile, and he has a normal white cell count, so he must have influenza ", is avoided. Not only is a positive diagnosis less time consuming, but it makes the management of the patient and his family more satisfactory, and by seeing the patient frequently, the doctor can keep his diagnosis constantly under review in the light of subsequent events.

Disease in General Practice

Students preparing for final examinations become obsessed with physical signs, so that they have constantly to remind themselves that " a good heart ", or " a good chest ", belong to a person. It is therefore to be expected that they will want to know what " cases " will be seen in general practice. Appended below is a brief summary of some of the problems which may be particularly well studied in general practice.

1. *Normal people.* The importance of being acquainted with the wide variations of normal cannot be overstated. The normal child, his progress during the first years of life, how he walks, the shape of his chest, abdomen, and feet; the normal tympanic membrane, nose, and throat; and the normal processes of ageing will all be seen.

2. *Acute infections.* These include the infectious fevers, and infections of the ear, nose, throat, eye, skin, and respiratory, alimentary, and genito-urinary tracts.

3. *Early sign of disease.* In general practice, many diseases seen in hospital at an advanced stage may be seen in their infancy. The early diagnosis of such diseases as chronic bronchitis, rheumatoid arthritis, cancer, and depression, produce numerous problems which demonstrate the gradual transition from normal to abnormal.

4. *The management of chronic disorders.* The correct attitude and responsibility of the general practitioner for patients suffering from such disorders as diabetes, epilepsy, cardiac failure, and bronchiectasis may be considered, and the student will have the opportunity to see such diseases as peptic ulcer, asthma, and eczema, against the family and environmental background.

5. *The influence of mind over matter.* The importance of minor abnormalities in emotional reactions in the production of physical symptoms, and the reverse effect of physical disease on mental health, is often underestimated. In the intimate relationship between family doctor and patient, these two aspects of medicine can be well displayed.

6. *The extremes of life.* At the extremes of life where the division between normal and abnormal is so delicate, the general practitioner's experience is unique.

7. *Prophylaxis.* Progressively more emphasis is being placed on this problem, which is not just a question of immunization procedures. It includes early diagnosis, the correct treatment of trauma and minor infections, the management of the individual and the family at times of stress and disease, and antenatal, postnatal, and infant welfare work.

8. *Obstetrics.* Domiciliary obstetrics rarely forms part of undergradute teaching at the present time. The student may therefore be surprised to find that in many practices the home is still considered the ideal place for a normal confinement. The emphasis here is on normality, and he will be able to study the methods adopted by the practitioner to achieve this ideal, and the close liaison which he maintains with the midwives and the local obstetric consultant. He may also get some insight into the importance of this function of the family doctor in the establishment of a sound doctor-patient relationship.

Early Diagnosis

The general practitioner is expected to be proficient in the early diagnosis of disease. It may therefore help the student to appreciate in advance some of the problems involved in making an early diagnosis.

The most important person is the patient, for it is he who must make the first move by diagnosing at least some form of ill-health sufficient to compel him to consult his doctor. The strength of stimulus necessary to bring about a consultation depends on several factors. Some people are unable to tolerate even the slightest deviation from normal, and attend the doctor with all manner of trivial complaints. Others are real stoics and are usually in an advanced stage of disease by the time they attend. It is the family doctor's job to encourage a happy medium in this respect by a rather subtle form of health education.

The doctor is also an important factor in deciding when a patient will attend. If he is patient and understanding, the patient is far more likely to consult him early. If, on the other hand, he is brusque, the patient may be easily put off. Fear is one of the most potent barriers to early diagnosis, and this includes fear, not only of the diagnosis, but also of the doctor. It is therefore important for him to encourage his patients to approach him without apprehension. He must also be very sensitive to the mood of his patients. Often an apparently trivial complaint is presented, while the real reason for the consultation is kept hidden, sometimes being casually mentioned as the patient leaves the consulting room. An appreciation of this situation by the student is important, because being accustomed to the scientific approach to medicine adopted in the teaching hospitals, it is easy for him to forget that it is not this or that test applied at an early stage which results in early diagnosis, but the easy personal relationship between patient and family doctor.

Having established a patient-doctor relationship, the technical ability of the doctor comes into the picture. Here again, the student

will notice certain features which differ from hospital practice. Frequently a diagnosis must be made in the absence of certain symptoms and physical signs which he will have learnt as pathognomonic of a disease. For instance, pneumonia in a child may be diagnosed on the character and rate of respirations without the classical signs of consolidation, or the same disease diagnosed in an old person without pyrexia. This is not to decry the classical description of disease as taught to the student, and it is important for him to realize that this is early diagnosis in practice, and not necessarily the answer to an examination question. Examples of this sort are numerous, e.g. the early diagnosis of myxoedema, depression, peptic ulcer, and many forms of cancer.

The General Practitioner, the Hospital, and the Local Authority

The general practitioner asks for help from the hospital, either to make or confirm a diagnosis, or to provide treatment requiring skill or facilities which he does not possess. The student in general practice will see the various steps which lead the patient to the hospital, including the way the practitioner selects his consultants, and the type of letter he writes to them. The patient's experiences thereafter are known to the student until the point where he leaves the hospital, consoled by the words, " I will be writing to your doctor ".

In general practice, the student may take up the story once more at this point. Very wisely most consultants leave the practitioner to explain to the patient the diagnosis and the treatment required. From this follows immediately the prognosis, and the family doctor must develop a high degree of prognostic accuracy. Patients want to know " Is it serious? ", " When will I be back at work? ", " How long has he got to live? ", etc., and the student will be able to appreciate the impact of disease on the individual and his family, and the responsibility of the doctor in nursing them through both physically and mentally.

In some cases, the doctor will organize the numerous services which may be employed in rehabilitation and the home care of sick people. The district nurse, health visitor, home help service, meals on wheels, and a variety of other organizations may be employed in certain circumstances. Here the student will see the inter-relationship between the hospital, general practitioner, and local authority services in the care of the individual patient.

The Advantages of the Student Attachment Scheme

The object of this scheme is to introduce the student to medicine as it is practised by the family doctor. It is hoped by this scheme to

show him that good general practice is an ideal well worth working for, from his earliest days. It is also seen as an opportunity for the student to see many of the acute conditions, and the early stages of the more chronic disabilities which he sees only in their later or more severe forms in hospital practice. Finally, it provides him with some insight into the effect of environment on health and disease.

The benefits of the scheme flow in both directions. There is no better stimulus to the doctor in practice than the presence of a young and criticial mind. In time it is hoped that the student will become a means of bringing together more closely the family doctor and the teaching hospital staff, which cannot but bring great mutual benefit and, as such, benefit medicine as a whole.

"I attended in a chemist's shop, in order that I might gain some knowledge of the Materia Medica, and the making up of prescriptions. The shop was at the corner of Little Newport Street, and the proprietor of it was Mr Clifton, who also practised as an apothecary, exercising his art among the tradesmen of the neighbourhood. He was an apothecary of the old school, having no science in the ordinary sense of the word; yet, I have no doubt, a useful and successful practitioner. I come to this conclusion because, although there was nothing prepossessing in either his manner or appearance, his practice gradually increased, until at last he was able to give up his shop and live in a large house near Leicester Square, where he dispensed medicines only to his own patients. It is usual in these days to regard this class of practitioners with little respect; but the fact is, that they were very useful persons, and, having no very ambitious aspirations, they were within the reach of the poorer orders of society, which is not much the case with the better educated surgeon-apothecaries, or, as they are called, general practitioners of the present day, who have expended a considerable sum of money in order to obtain a license to practise. Mr Clifton's treatment of disease seemed to be very simple. He had in his shop five large bottles, which were labelled *Mistura Salina*, *Mistura Cathartica*, *Mistura Astringens*, *Mistura Cinchonae*, and another, of which I forget the name, but it was some kind of white emulsion for coughs; and it seemed to me that out of these five bottles he prescribed for two-thirds of his patients. I do not, however, set this down to his discredit; for I have observed that while young members of the medical profession generally deal in a variety of remedies, they generally discard the greater number of them as they grow older, until at last their treatment of diseases becomes almost as simple as that of the Aesculapius of Little Newport Street. There are some, indeed, who form an exception to this general rule, who, even to the last, seem to think that they have, or ought to have, a specific for everything, and are always making experiments with new remedies. The consequence is that they do not cure the patients, which the patients at last find out, and then they have no patients left."

An Autobiography of the Late Sir Benjamin Brodie, Bart.
London, 1865, pp. 37-39.