

## Correspondence

### Teaching general practice

Sir,

The problem of teaching general practice is one which our profession must inevitably face, and therefore the more this is debated the clearer will become our educational aims.

It is a truism that academically general practice has lagged behind. There is no corpus of knowledge, and although this is being rectified we have a long way to go. This is largely because traditionally general practice has been an empiricist rather than a rational discipline. Decisions were confined to the immediate needs of the moment; if a treatment worked it was used without bothering too much about the rationale for using it. This again was tied up with general practice as first and foremost a means of livelihood, so that as many patients as possible were seen in the time available, and quality of care was sacrificed to quantity.

In contrast to this, hospital medicine was rationalized and subject to strict rules which were then taught from one generation to another. This led to a rigid formal discipline surrounding the varieties of human disease, and was of great value in teaching, and the rational appraisal of observational research.

Today, general practice is searching for just such a set of rules to contain its plastic and variable content. It seeks gradually to promote more thought and time to the patient in need, if this means also delegating some routine work to ancillaries.

It seeks, in other words to rationalize and thence to develop, an academic discipline. However, whereas general practice is seeking for rationality, the specialist services have unreservedly thrown in their lot with empiricism, as exemplified by experimental and technological science.

The medical philosophies of the two groups have therefore perceptibly shifted, although their rôles remain the same.

The need for a rigid formal set of rules to delineate the content of general practice, and for a dogmatic approach to teaching is brought out by the comments of the under-

graduates in Dr Byrne's paper. They asked for:

(1) More time and facilities to examine patients, so as to apply their formal clinical yardsticks.

(2) More understanding of teaching methods in conveying unfamiliar ideas to the students.

By this they mean that what is now being done intuitively by the practitioners, must first be rationalized and then dogmatized. Bearing this in mind we can now look at Byrne's eight points which are considered essential for teaching students.

Clearly point 1, which is to teach that the practitioner is a generalist clinician, is unexceptionable, although the reference to good record keeping is a little obscure here. There is, however, no indication if this teaching will differ from the standard teaching methods used in hospital, and if so how and why. Points 2 to 8 are either (a) pure community medicine *e.g.* "To stress the wide spectrum of morbidity in the community and invite comparison with that of the hospital" (point 2), or (b) should be included under point 1 *e.g.* "To demonstrate early diagnosis, the natural history of disease, and interventive (sic) medicine" (point 5), or (c) come under practice administration *e.g.* to demonstrate patient management which includes the use of the 'health team', relationships with the hospital and other bodies (point 6).

I am not here attempting to decry the validity of these eight points, which must be of the greatest practical help in charting a course into the unknown. But are they really what the student wants? Byrne, at a later stage in his lecture, rightly draws the distinction between community medicine, and general practice. I am left slightly confused here over the boundaries between these two, as described in theory, and as it is suggested should be taught in practice.

Indeed, there are social factors in disease as there are psychological but they should be kept in their proper place, which is as an aid to diagnosis, and to subsequent management of the individual patient. They will doubtless

be considered at greater length during another part of the students' career.

Men going into general practice seem to me to be over-ridingly interested in patients as people, and in the forms of human behaviour with which they present. The undergraduate who is going to make the best general practitioner has an interest primarily in persons, secondarily in their diseases, and thirdly in their environment. Indeed, Byrne makes this point when he says "we are clinicians first and last".

If, therefore, we take clinical medicine and human behaviour as our content for teaching purposes, then it would be rational to erect our formal teaching structure around these two modalities. Human behaviour is so diverse that attempts to analyse it experimentally appear doomed to failure. Sociologists have made no impact at all on general practice, which remains opposed to the 'rat box' experimentalists. The only natural laws seen in active practice are those of historicity or experience. Mr X should do this under given circumstances because he has done so before. Usually he runs true to form but unaccountably he may do something else. It is important therefore to remember that we are trying to teach a subject which is both a science and an art. Of course we must be scientific, not least because this makes us a strong branch of medicine. But in so far as medicine is also an art it will move us away from a technological tyranny. If we make human behaviour one basis for teaching then, by definition, we should not be too narrow in our terms of reference. Initially, the net should be cast wide, even to include such great observers of human nature as Chekhov (his Ivanov in particular), Montaigne, Balsac and Maugham.

History taking and clinical examination should be altered to make the former take precedence in length and importance, and the latter curtailed to the essentials. For example, the relevance of work and play and special interests might be gone into as aspects of behaviour. The family structure and sibling relationships are of the greatest importance, but must always have the patient as the central point. Our terms should be worked out and defined, and then taught dogmatically.

Clinically we should concentrate on the common diseases; obesity, depression, bronchitis, duodenal ulcer etc., but relate these to patterns of behaviour and heredity, when they will be seen from a different viewpoint.

Teaching at the periphery would be informal

and flexible with the advantage of being one to one. This too should be rationalized, but only to an extent dogmatized, as the student must here learn to apply techniques already acquired, to compress or expand his approach according to the needs of the moment, but still keeping within his rational framework and thus avoiding empiricism.

I would agree with Byrne when he says there are many things we do intuitively which should be rethought. For example what is our train of thought when we are faced with a patient with an acute back condition? What are the priorities which admit of one probability? How does our knowledge of the patient's behaviour influence our decision? How do we assess progress in common infections? What decides us whether to keep a coronary thrombosis at home or send him to hospital?

I do not know the answers to these questions without sitting down and working them out. This, I am sure, is what we must do.

Crewkerne.

L. E. WEAR.

#### REFERENCES

Byrne, P. S. 1969. *J. roy. Coll. gen. Practit.* 17, 69.

#### Undergraduate teaching in general practice

Sir,

This article by Dr Gaskell earns some adverse comment; firstly because it makes a gratuitous attack upon 'medical schools'—secondly because the attack is apparently based on an ignorance of fact.

At a time of so much movement in medical education it seems quite wrong that an article should be published in March 1969 which contains no reference later than 1966 and which does not even refer to the College's Evidence to the Royal Commission. The references to Darbishire House in Manchester come from material published in 1961. The present state of this institution bears no relationship to that described at that time. Much has been written about undergraduate education in the last two years—a full picture of what was happening in 1966 was described in the *Lancet* in 1968 (R. J. C. Pearson, T. S. Eimerl, P. S. Byrne). I cannot blame Dr Gaskell for not referring to my Gale Memorial Lecture, published in the *College Journal* in February this year, nor to the Upjohn Report of C. M. Harris, which was published last