REPORT OF A CLINICAL CLERKSHIP WITH A GENERAL PRACTITIONER IN SCOTLAND

Dieter Wenzel, Cand.med., Stud.phil.

CLINICAL CLERKSHIPS IN GENERAL PRACTICE seem to become more and more popular among German students during their last few years. There may be different reasons; first, there is the discussion in the medical press about the introduction of a speciality in general practice, and, secondly, the addition of clinical lectures in this subject to the university curriculum in German universities. And there is also the urgent need to counteract the decreasing numbers of general practitioners compared with the specialists, so as to give the patient the best possible care outside as well as in the hospital. Besides these more universal arguments for doing a clinical clerkship abroad with a general practitioner, there are also personal aspects which count; a direct contact and an exchange of views with the doctor, because the student stays and lives in the same house, a complete insight into the everyday work of a general practitioner with all the advantages and disadvantages of a free profession; a wide selection of patients on whom he can try his skill in making a provisional diagnosis; and, last but not least, an opportunity to become acquainted with a foreign country and thus gain a better understanding of the mentality of the people. Indeed, one gets a far better insight than just as a tourist.

The international federation of national students' associations puts a time limit of two weeks with one doctor on clinical clerkship abroad. This limitation may show you, from the start, that this clinical clerkship is not so much intended to perfect some techniques of physical examination of patients as to gain the ability to use the undisputable doctor-patient relationship to its best advantage.

If the student prefers to take temperatures or blood pressures, to load dozens of syringes daily and—if fortunate—even give the injection, to join a ward round as a more or less supernumerary spectator as in German university clinics, then he might submit to this traditional form of clinical clerkship. But if he is interested in personal contact with the patient (and this should be, I think, every physician's attitude whether general practitioner or other specialist) and wants to know more about the social and family circumstances of the patient and learn about the treatment of all kinds of disease—therapeutic and psychotherapeutic—in other words wants to cultivate the true art of being a doctor, then he should spend a part of his free time between terms in taking a clinical clerkship with a general practitioner.

I should like to say at once that my clerkships in Scotland were full of valuable impressions. Each time I found a well-known doctor who helped me in a generous manner concerning all my interests. They introduced me to their colleagues who allowed me to attend postgraduate medical meetings and undergraduate medical lectures at the university. As a result of this I could also go to all social functions. I was able to observe the diverse social service departments of the National Health Service such as the school for the deaf, a day nursery for the children of working parents, a home for children from disrupted home backgrounds and a welfare home for the care of old people. I joined one general practitioner in his part-time work at a psychiatric hospital. I also worked in the casualty department of the local hospital and, apart from that, was asked to scrub up and be assistant to the surgeon at a major operation in the operating theatre of that hospital.

This kind of work while doing a clinical clerkship with a general practitioner was unexpected. The reason is that in Great Britain the general practitioner is in far closer contact with the local hospital and its doctors than his counterpart in Germany. Although the social structure of the medical care in Great Britain is more regulated through the National Health Service than it is in Germany, there remains nevertheless the same pure medical work of a general practitioner. In this respect it seems justifiable to equate the British and German situations.

Each day we saw about 30-40 patients in the consulting room and between 10-20 patients

needed a home visit. Many of these patients were already well-known to the doctor either because of previous disease or because of a chronic disease such as hypertension, asthma, chronic bronchitis, diabetes or depression. I was allowed to make the necessary diagnostic examinations, as far as I was able, such as examination of the cardiac function, respiratory system, reflexes and whatever else was required. We discussed the differential diagnosis and this discussion—when doctor and student talked on the same professional level—encouraged my confidence. The general practitioner knew by heart and from his records the history, the social and family difficulties of almost every patient, and could tell me at once the important features. He emphasized especially the personal contact with the patient and showed all the time a positive empathy, probably because of his rich experience in family medicine. We discussed the treatment of the disease and the necessary prophylactic advice. I thus gained a good insight into the condition of the patient.

I think that this kind of clerkship is a good way for a student to acquire fresh knowledge and to observe the clinical methods of an experienced practitioner.

Based on my experiences, which I gained in several general practices, I feel there should be a certain modification in the vast field of general-practitioner work and this would be desirable; namely—stop the trend towards the mechanical treatment of disease, which has unfortunately become necessary due to the overloading of the doctor in single practice, and concentrate again on the personal care of each individual, based on a positive doctor–patient relationship.

This requires a deep interest in and understanding of human beings, rather than of disease process, on the part of the newly-qualified doctor.

Acknowledgements

With grateful thanks to Dr Marjory C. Hogg and Dr R. A. B. Rorie, Dundee, for their kind hospitality and their profound interest in my clinical clerkship in Scotland.

Correspondence

The educational needs of the future general practitioner

Sir,

Council published a statement on this subject in this *Journal* in December last (*Journal of the Royal College of General Practitioners*, 1969, **18**, 358). This contained a short summary of the content of general practice for educational purposes.

The working party which produced this short report is writing a more detailed report on the content of general practice (and other aspects of vocational training) for the use of trainees, trainers and organizers of schemes of training.

It is already clear that some details need altering.

It would help greatly in this work if members and associates would send in criticisms of last December's short statement to the secretary of the working party, **Dr Conrad Harris, at 14 Princes Gate, Hyde Park, London, S.W.7.**

Here is the part of the report on which we need your comments:

The content of the general practitioner's educational needs falls into five areas. Clinical medicine is the largest and most important.

AREA I—Clinical medicine

Appropriate expertise in traditional specialties, emphasizing general medicine, and with special reference to:

(a) The range of the 'normal'.
(b) The patterns of illness.
(c) The natural history of diseases.
(d) Prevention.
(e) Early diagnosis.
(f) Diagnostic methods and techniques.
(g) Management and treatment.

In the next three areas older doctors had little or no grounding as undergraduates. They do form part of undergraduate medical education today but their relevance to general practice warrants further study.

AREA II—Human development

(a) Genetics.
(b) Foetal development.
(c) Physical development in childhood, maturity and ageing.
(d) Intellectual development in childhood, maturity and ageing.
(e) Emotional development in childhood, mat-