Repeat prescription issue systems have frequently been criticised for putting too much responsibility on the receptionist. We feel that using this system the responsibility is squarely on the doctor's shoulders, and further, that the patient is safeguarded to a greater extent than he is when no system is in use.

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PERSONAL EXPERIENCE: EDUCATION

The family doctor internship

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THERE ARE FEW MORE EXCITING developments in the field of medical education than the provision of initial and continuing education schemes for general practice.

Although the trainee—general-practitioner education scheme has been in existence since 1948[1], it was not until 1964 that the present facilities were clearly recommended by the Royal College of General Practitioners[2]. These were later developed in detail in a booklet entitled 'Special Vocational Training for General Practice' published by the College[3] and substantially supported by the Royal Commission on Medical Education in 1968. It was reference to this booklet which first set me upon a positive course of training for general practice after graduation. In essence it suggested that three years after graduation should be spent in 'suitable' hospital appointments, in which a variety of subjects are covered in a series of six-month and three-month appointments, followed by a further year in orientating to general practice as a trainee.

Summary of hospital posts most suitable for the future general practitioners[3]*:*

(1) General medicine—six months (possibly with a further six months at a later stage)
(2) General surgery with casualty experience—six months
(3) Obstetrics, with gynaecology—six months
(4) Paediatric medicine, including outpatient experience—at least three, preferably six months
(5) Psychological medicine, especially outpatient experience—at least three, preferably six months

The following subjects are suitable for shorter or combined appointments:

(6) Dermatology
(7) ENT
(8) Ophthalmology
(9) Geriatric medicine
(10) Physical medicine and rheumatology.

Table I lists the relevant clinical disciplines (inasmuch as it is possible to separate them), and compares the percentage of time spent training in each subject before and after graduation, with the respective percentages of the main groups of disease as seen by the general practitioner[4 5].

The Birmingham Regional Hospital Board operates an optional two-year training scheme for general practice, the first year being a 'family doctor internship' at SHO grade based at a general hospital in the region, and the second year an orientation course as trainee. The aim of this paper is to record my experiences as a family doctor intern in the South Birmingham Group of Hospitals, spent chiefly at Selly Oak Hospital, from February 1970 to January 1971.

First a few general comments. The intern's initial task is to select a provisional programme, suggesting the length of time he would like to spend in each department, while the chairman of

the medical staff committee acts as intermediary and co-ordinator with the various departments concerned. Choice of subjects depends on the individual's undergraduate training, his postgraduate experience, the type of general practice which he hopes to enter, and the availability of the departments concerned. I chose the following programme:

1. ENT, opthalmology, and geriatrics: nine weeks each (each spread over 12 weeks to accommodate other subjects running concurrently)
2. Dermatology: nine weeks, to run concurrently throughout the year
3. Obstetrics: six weeks
4. Oral medicine: four weeks
5. Holidays: four weeks
6. The equivalent of about four weeks was subsequently added to the programme, so that short courses in family planning, vernereology, teaching methods, and group psychodynamics could run concurrently, together with two small research projects.

TABLE I

PERCENTAGE OF TIME SPENT IN TRAINING BEFORE AND AFTER GRADUATION

Subject	*A Percentage of formal undergraduate teaching time*	*B Percentage of postgraduate training period*	*C Percentage of total cases*
General medicine	*24*	*12*	} *47—55*
ENT	*5*	*5*	}
General surgery	*10*	*12*	?
Orthopaedics and trauma ..	*5*	*0*	*6—18*
Paediatrics	*8*	*12*	*22—26*
Obstetrics and gynaecology ..	*10*	*18*	*6—17*
Dermatology	*1*	*5*	*6—12*
Geriatrics	*1*	*5*	*10—11*
Psychiatry	*7*	*12*	} *12—19*
Social medicine	*3*	*12*	}
Ophthalmology	*1*	*5*	*1— 3*
Oral medicine	*0*	*2*	?
Para-clinical	*25*	*0*	—

Column A represents the percentage of formal clinical teaching time spent in undergraduate training at present (April 1971) in the last three clinical years at the University of Dundee. The figures given are only rough estimates because of difficulties in computation from the published leaflets.

Column B represents the percentage of my postgraduate training period spent in the respective subjects from August 1967 to August 1971.

Column C is the distribution of the main groups of disease seen by the general practitioner, after Fry 1966[4], Bebbington 1969[5], and Morrell *et al* 1971[7]. Some cases are included in more than one category.

The programme was selected to complement the general medicine, general surgery, paediatrics, psychiatry, obstetrics and gynaecology previously covered at house officer or senior house officer grade.

1. *Ear, nose and throat*

The difficulty of manipulating specula, mirrors and forceps down inaccessible orifices needs to be experienced to be believed. Auriscopy and anterior rhinoscopy can be attempted by the unskilled, but the clumsy placing of a mirror in the oropharynx to view either nasopharynx or larynx is unrewarding to say the least, and often embarrassing. In the outpatient department a glimpse over the examiner's shoulder had to suffice with regard to larynx and pharynx, but it was usually possible to persuade patients to allow examination of their ears for a second time. However, routine pre-operative cases admitted to the ward would usually agree to gentle, brief examination of the whole upper respiratory and alimentary tracts, although confidence can only come from further practice. The diagnosis and management of wax impaction, otitis externa, otitis media and sequelae, Ménière's disease, sinusitis, deviated nasal septum, nasal 'polypi',

pharyngitis, tonsillitis, laryngitis and the occasional carcinoma all made their impact; and there was the need to puzzle over differential diagnosis of pain in the head, ear, face, throat and neck; deafness; aural discharge; vertigo; nasal discharge, obstruction and bleeding; hoarseness; cough; and dysphagia. Time was spent assisting with the emergency duty rota to learn about nasal packs, chemical cautery, and the acute infections of ear, nose and throat. In theatre, common operations were interspersed with aural operations seen through the observer eyepiece of a dissecting microscope. Two visits to a school health service deafness clinic emphasized the importance of early detection of deafness for the normal emotional and intellectual development of a deaf child.

2. *Geriatrics*

The management of the elderly patient is a rapidly developing field in which a knowledge of general medicine is essential. The hospital consultant is concerned with assisting the general practitioner to keep the elderly patient, with her many disease processes, active and independent in the community. Hospital admission is seen as an interim event for acute illness, or medico-social crises. Clinical instruction at ward rounds, physiotherapy rounds, outpatient clinics, day hospitals, day centres, welfare homes and domiciliary consultations provided a unique opportunity of learning the practical management of patients at risk. A typical patient, bedfast, incontinent and ulcerated, after a silent myocardial infarction might develop hypostatic pneumonia, and give more than one reason for her congestive cardiac failure. In addition, painful osteoarthritis, nutritional anaemia, solitariness, upstairs bed and arteriosclerotic dementia may cause an intricate, but by no means uncommon diagnostic problem whose management is far from easy. How much easier it would have been if the constipation (leading eventually to overflow incontinence of faeces and urine) had been relieved earlier; if the pneumonia and congestive heart failure had been treated promptly and joint pain alleviated to prevent complete immobilization; if her diet had been adequate in the past, her bed and toilet put downstairs, with regular visits from friends and relatives. Now, if hospital admission is to be avoided, she will require district nurse, home help, meals on wheels and devoted support from a resident relative, followed later by day hospital rehabilitation and possibly admission to a welfare home. There was an abundance of such clinical material for diagnosis and management, and valuable experience was obtained in this multidisciplinary subject.

3. *Dermatology*

In a topic which many undergraduates find inadequately taught, and which has such a wide representation in general practice, it was refreshing to receive enthusiastic teaching in almost every apsect of clinical dermatology. General medical considerations play a large part in the practice of dermatology, but less expected was the importance of a detailed case history, and a complete examination of the whole skin surface. There are certainly difficulties in applying such an approach to the atmosphere of general practice, but the diagnostic and therapeutic hazards of 'spot diagnosis' in dermatology was illustrated time and time again. Common problems included the differentiation of fungal infections from other scaling disorders such as seborrhoeic dermatitis; the part played by contact allergens, primary irritants and emotional factors in the perpetuation or exacerbation of eczematous dermatitis; and the varying manifestations of scabies and its mistreatment. It was surprising how many patients with skin disorders having long-term implications (such as atopy, seborrhoeic dermatitis or venous stasis leg ulcers) were aware of these implications. Far too many were looking for a rapid and permanent 'cure' instead of being prepared for careful long-term management. Some cases of viral warts had received little or no treatment prior to referral to the outpatient department in spite of numerous prescriptions from their doctor. This confirmed the general impression that patient co-operation is vital to the success of dermatological treatment. Much time was spent in detailing to patients the causes and prevention of their particular skin disorder before prescribing drug treatment. Emotional factors play a large part in dermatological disorders, and the dermatologist receives little or no psychiatric training; indeed, the family doctor is usually in the best position to offer help in this direction. Not surprisingly premarital, marital and occupational problems figured prominently in relation to anxiety and depressive states and the subsequent initiation, perpetuation or exacerbation of disorders such as eczematous dermatitis and psoriasis. As with geriatrics, dermatology undoubtedly requires a multidiscipline approach.

4. *Ophthalmology*

The use of the binocular slit-lamp microscope as a routine diagnostic instrument has largely overshadowed the hand loupe and torch in ophthalmological departments. This is unfortunate since the latter is the only method open to the average general practitioner and requires some skill in its use. However, the vastly superior view offered by the microscope is very satisfying from the student's point of view, and a combination of both methods constitutes an ideal teaching set-up. As with other specialties, the importance of examining the whole organ in its surroundings was emphasized. Whether the complaint was of painful eye, red eye, watery eye, poor vision, headache, squint, the examination was basically the same: for both eyes, direct inspection of lids and periorbital tissues, eye movements and pupil reactions, followed by magnified inspection of fluorescein-stained cornea; aqueous, iris, and lens; then, finally, ophthalmoscopy of lens, vitreous and retina. Further investigations might include refraction, measurement of intraocular pressure, and orthoptic report. By such means the diagnosis of conjunctivitis (infective, seborrhoeic, foreign body), chalazion, refractive errors, glaucoma, uveitis, cataract, senile macular degeneration, arteriosclerotic and diabetic retinopathy, comitant and paralytic squints were all readily detected. The problems raised by blindness in the elderly really required the attachment of a medical social worker, but this was not feasible. A fair proportion of the clinic was devoted to the orthoptic department, which comprised of a number of medical auxiliaries specially trained in the diagnosis and management of squint. The high incidence of squint, and the success of early treatment in eliminating amblyopia, accentuated the importance of early referral. Operating lists, for an unskilled observer, were remarkably uniform: correction of squint, cataract extraction and filtration procedures for glaucoma, but they provided a more leisurely opportunity for study than in undergraduate days. Occasional visits to selected cases at the Birmingham and Midland Eye Hospital enabled me to see uncommon but important conditions such as retinal detachment, and visits with an orthoptist to local welfare clinics offered another aspect of ophthalmology.

5. *Other topics*

A flexible approach to time-table planning enabled time to be spent in subjects which might otherwise have been omitted. For example the small size of the dermatology department in the South Birmingham group necessitated attending 2–3 sessions a week spread throughout the year instead of an intensive three months. Shorter topics covered concurrently with other subjects included teaching methods in general practice: six afternoons spent at Wolverhampton Technical Teachers' Training College on a course specially designed for instructing general practitioners in the latest teaching methods suitable for undergraduate or postgraduate training programmes. A theoretical and practical course was arranged by the Family Planning Association for a fee of £25. Although I missed a course on research methods in general practice, I took part in two unsuccessful small research projects (one investigating the incidence of cervical incompetence after vacuum extraction, the other an attempt to induce labour by tape-recorder as an experiment in suggestion and conditioning).

Eight sessions in the venereal disease clinic, at a hospital outside the group to which I was formally attached, emphasized the importance of accurate diagnosis before treatment. Common conditions included gonorrhoea, trichomonal vaginitis, and non-gonoccal urethritis. Much less common were Reiter's syndrome and syphilis, but I was fortunate to see one primary chancre during my time there. The recent introduction of a medical social worker to the clinic is recognition of the vast emotional and social problems of which venereal disease is but a sign.

The last month of the internship was also spent outside the South Birmingham group, namely at Birmingham Dental Hospital, to gain experience in oral medicine. This topic is frequently omitted from the undergraduate syllabus, although patients with facial pain, facial swelling, and oral ulceration present frequently to their medical general practitioner, particularly following the recent increase in dental charges. The dental hospital staff were more than willing to demonstrate the work of each department. The examination room was visited briefly by all referrals; the periodontal department bristled with cases of oral neglect leading to necrotizing ulcerative gingivitis, caries, loose and migrating teeth and subsequent occlusal problems. Oral hygeine in immigrants presented a special problem. Prosthetics provided a variety of oral ulcerations, muscle-joint pains and cosmetic problems. Under careful supervision I extracted a few teeth, and joined in discussion of more serious surgical problems at oral surgery clinics.

An introductory course to group psychodynamics by Birmingham University extramural department was my first experience of studying the evolution of group atmosphere and relationships. Twelve social workers and myself were allowed spontaneous interaction for ten consecutive meetings, while the senior social work tutor interrupted at appropriate intervals to explain the nature of events which had taken place. The part played by such interactions is of paramount importance to patients in family and occupational situations, as well as to a doctor and his medical and para-medical colleagues.

Comment on internship

Once the excitement of graduating has faded, and the hazards of the pre-registration appointment faced, the young doctor is left with a sinking realization that he is far from achieving a satisfactory standard of medical practice. He still needs to acquire skill in clinical techniques of most subjects in the undergraduate curriculum (and perhaps several more), as well as to become orientated to a more practical viewpoint. House officer appointments fulfil this need to some extent, but cannot be expected to cover the multiplicity of topics necessary for the general practitioner. The flexibility of a rotating internship with short attachments, and little commitment, under the supervision of a paid supportive adviser of studies is essential. Clinical teachers should receive payment for time spent instructing the intern, and excessive clinical commitment reduced. Married accommodation must be made more readily available to minimize the domestic disturbance resulting from attendance in emergency subjects for up to four years in hospital. The temptation to acquire a special interest during the internship should be resisted, as this can be obtained readily by 6 or 12 month senior hospital officer appointments.

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RESEARCH METHOD

The reliability of results obtained from medical questionnaires

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THE METHODOLOGY OF ANY SURVEY of health or morbidity greatly determines the results which will be obtained. It has been shown that significant differences occur when information is obtained from the person concerned compared with that obtained from another member of the