UNDERGRADUATE TEACHING IN COMPREHENSIVE MEDICINE

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The general practitioner (or the "personal doctor" as Fox (1960) has recently re-styled him) is supposed to treat his patient as a whole person, i.e., to take a comprehensive view of both the somatic and psychical factors within the patient's social setting in contrast to the specialist who deals with a limited aspect of the patient. The study of the psychological component of illness* has lately come much to the fore. Most general practitioners nowadays would agree that patients cannot be dealt with purely from the somatic angle (e.g., Medical World Conference, 1959). Understanding has to go beyond that of the conventional disease processes and must include the psychical forces within the patient and the reciprocal influences between doctor and patient if the pathology of the whole person is to be fully comprehended.

If this is true, then all medical students, whether they become general practitioners or specialists, must, in addition to their ordinary medical learning, be made aware of and be able to understand psychical forces and somato-psychic interaction. The need for this kind of comprehensive medical outlook has been recognized by medical students (British Medical Student's Association, 1958/59), by eminent consultants (e.g., Pickering, 1953), by psychiatrists (e.g., Dicks, 1950; Balint, 1957[a]), by general practitioners (e.g., Model *et al.*, 1957; *Undergraduate Education and the General Practitioner*, 1958), sometimes under different terminology, e.g., holistic medicine (Dicks, 1950), personal medicine (Fox, 1960), psychobiology (Sinclair, 1955), etc.

Unless the medical man has learned during his student days what

*Psychological medicine in the sense in which I use the term in this report embraces psychiatry, normal and abnormal psychology, psychosomatic medicine, and the study of relationships (especially the doctor-patient relationship) and communications (especially between doctor and patient), for which at present we have no short name.

it means to be physician to the whole man, he will have to acquire this knowledge in practice, slowly, unsystematically, painfully, and at his own expense and that of his patients.

Through the award of an Upjohn Travelling Fellowship by the College of General Practitioners I was enabled to study not only how much time in the curriculum was spent on teaching of psychiatry, but to what extent the comprehensive medical outlook described above was taught or conveyed to the student.

I chose for my study three academic institutions: The Radcliffe Infirmary at Oxford, Darbishire House Health Centre at Manchester, and the Edinburgh University General Practice Teaching Unit. These are evidently only a sample of teaching centres, not even randomly chosen, but practice commitments limited the time for my travels. My report gives my impressions and certain conclusions which are biased by my own views on medicine and general practice, and by the fact that I saw only three medical schools at work for short periods.

The Radcliffe Infirmary, Oxford

The Radcliffe Infirmary was opened in 1770 from funds left in trust by Dr John Radcliffe (1650—1714), a Yorkshireman who practised as a physician in Oxford and London. Students in physic and surgery were admitted in 1786, but the number dwindled and it became a complete clinical school only in 1939 (*Radcliffe Infirmary Handbook*, 1949). The Infirmary is now part of the United Oxford Hospitals of which group it is the most important. It has almost 550 beds. With the other hospitals in the group (together over 1,200 beds) it serves a fairly compact community of about one and a half million people.

The centre of the clinical medical school is Osler House, adjoining the Infirmary, where the offices of the Director of Clinical Studies, the administrative offices and the students' common room are situated. The school is small, the annual intake of students is only about 20.

I was able to attend x-ray conferences, medical ward rounds, outpatient sessions and lectures. I am very grateful to all the distinguished consultants for allowing me to sit in with them or take part in their ward rounds and to the medical officers and administrators for spending their valuable time with me. I had, unfortunately, no opportunity to meet the psychiatrists of the United Oxford Hospitals who, owing to circumstances beyond their control, could make no suitable arrangements for such a meeting.

Clinical teaching. I was impressed by the clinical teaching. The x-ray conferences, held jointly by the physician in charge of the patient and the radiologist, were certainly most informative.

The clinical and radiological findings were critically discussed by the consultants, their staff, and students to everyone's benefit, especially the patients'. The ward rounds were very interesting. No effort was spared to elucidate the most refined physical diagnosis of the patient's illness, and the diagnostic statements were supported by extensive biochemical and histo-pathological facts. An almoner was present at one of the ward rounds to take note of any social problems that might arise. The outpatient sessions were particularly interesting in that they reminded me very much of general practice sessions in the way in which stress situations were easily discernible under the picture of organic disease.

So far as psychological medicine in the " comprehensive " sense was concerned, either this did not exist or I missed it. My survey of the practice of medicine in the Radcliffe Infirmary and the teaching there was, of course, rather limited. Yet, in my discussions with the tutors and junior medical officers it was confirmed that student teaching does not include the kind of comprehensiveness of outlook which I thought indispensable for the medical man. The highly specialized physician or surgeon cannot, perhaps, be expected to retain his ability to encompass complicated biochemical and physico-pathological fields and at the same time deal with emotional and medico-social problems. The psychiatrists, even were they willing and able to fill that gap, are physically divorced from the main teaching hospital and are, so I understood, only called to the hospital in cases of psychosis or attempted suicide. My informants thought that the hospital was not the right place to teach such " general practice " or " comprehensive " medicine, but that a general practitioner attachment scheme for students (which at present does not exist) might be able to do this. It would teach students something of the ways and difficulties of general practice (of which they learn nothing at Oxford University Medical School) and impart, perhaps, something of the comprehensive outlook.

Apart from talking to the almoner who accompanied one ward round, I had no contact with the almoner's department. I should think it likely that much medico-social work is done there. It played, however, hardly any part in the clinical teaching that I saw, except perhaps, for a passing remark here and there.

The excellence of the teaching rested mainly on its technical proficiency. It was obvious that the doctor's task was seen in his ability to achieve a refined diagnosis of organic disease and possibly give treatment. If organic disease could not be diagnosed with all the doctor's acumen and the means of highly developed techniques, then " functional disease " was diagnosed, and the patient left at that. That does not mean that patients were not treated with the utmost consideration and sympathy. It was striking to see the

concern of the consultants and junior doctors over severity of illness, or lack of response to treatment, or difficult social circumstances, and the patients felt and responded to this concern. It was likewise striking to note the difference in the intellectual levels of approach between the purely clinico-pathological problems and the emotional or medico-social ones. The pathological problems were dealt with on a truly scientific level. The occasional emotional and medico-social problems were dealt with on a " poor chap " and " he's got some marital trouble " level, as if sexual disturbances, anxieties, repressions, frustrations were not worthy of scientific exploration and had no possible causal connection with the patient's illness.

Of course, in this context it must be accepted that the wards of a rather old-fashioned hospital are not exactly suitable for the detailed elucidation of emotion and social factors. The consultants had to deal with many chronically ill patients, a good number of whom were deeply withdrawn into states where psychological interview techniques would be really difficult to apply. The atmosphere of the ward with the vicinity of other patients, constant movements of doctors and nurses were also not conducive to such investigations.

But, even when opportunities might have arisen to discuss or, at least, mention aspects beyond the purely technical to the students, this was omitted. For example, a girl, 20 weeks old, was presented. She had a hare lip and a cleft palate and was going to be operated upon. The anatomical and surgical aspects of the proposed treatment were fascinatingly and eruditely detailed. At the same time, the little girl had been in hospital for several weeks, separated from her mother; she looked depressed, withdrawn, lifeless. Perhaps I am asking for too much, but I thought that this aspect of the child's pathology ought at least to have been touched in the lecture-demonstration and brought to the notice of the students.

This applies even more to the outpatient clinics where, during my stay, perhaps by coincidence, most patients really and obviously needed dealing with their emotional problems rather than with the apparent organic symptoms. Again it is doubtful whether a study of emotional and stress situations could easily be carried out in outpatients' departments as at present organized. It can certainly not be done if there is a division of medical labour, in that one doctor takes a history, another examines, and perhaps a third writes out a prescription.

Darbishire House Health Centre, Manchester

Darbishire House is the University Health Centre set up in 1954 by agreement between the University authorities concerned with medical care and the City of Manchester. The health centre is run by a board of management under the vice-chancellor. On

the board of management are representatives of the university, Manchester City Council, the general practitioners who work in the centre, two representatives of the Manchester Executive Council, and a representative of the Manchester Local Medical Committee. The staff of the Darbishire House Health Centre consists of four general practitioners, a social worker, nurses, technicians, a secretary, and clerks. The reader in social and preventive medicine in the university gives approximately half his time to the work of the health centre in an advisory capacity, so that the health centre is in a way under the aegis of the Department of Social and Preventive Medicine. (*Annual Report*, 1957-58.) The day-to-day management is in the hands of the four general practitioners.

My own impressions of the work at Darbishire House suffer from the same shortcomings as my impressions of the teaching at the Radcliffe Infirmary. Like any casual visitor I may have missed much, or misunderstood what I saw.

General practice. In 1954 the four general practitioners who were then practising independently in the area agreed to practise from the health centre. Each doctor limited his practice to 2,750 patients. The doctors are paid by the executive council in the usual way but receive in addition payment for the undergraduate teaching they undertake, and payment from local government sources for their work in preventive clinics which are within the centre.

The relationship of the doctors with their "independent" colleagues in Manchester is cordial, and there seem to have been no professional or ethical difficulties through their participation in clinic work.

The patients seem to appreciate the work that is done for them. I happened to take a taxi from my hotel to Darbishire House and, when I gave the taxi-driver my destination, he told me that he was a patient at Darbishire House. He spoke very highly of the services there. He thought that the greatest benefit to him was the fact that investigations such as x-ray examinations and laboratory tests could be carried out on the spot which was time-saving and, so he felt, more satisfactory. He was very much attached to his own practitioner at Darbishire House, and there was certainly no feeling of a dispensary or clinic atmosphere.

The general practitioners are not in true partnership. However, they work together in a kind of group practice where they can relieve each other for holidays and periods of sickness. Each holds a morning and evening surgery in the centre. They each take part in a weekly local authority clinic at the centre. Each acts as a clinical instructor in general practice and has a student in attendance in the mornings for about forty weeks in the year. There is quite a considerable amount of administrative work such

as committee meetings and attending to visitors from Great Britain and abroad. An assistant doctor is employed on a yearly basis to undertake a share of the off-duty rota and to be available as locum.

The entire professional life of the general practitioners is based upon the centre. They have no other surgeries. The centre has its own pathological laboratory and x-ray plant with staff, and its own nursing service. One of the aims and objectives of forming the centre was for it to serve as a demonstration of the integration of preventive and curative services, as represented by the personal health services of the local authority, the general practitioner services, and the hospital specialist services. In addition the centre is meant to put into practice a major concept of the director and the doctors, namely, that of the (domiciliary) medical team (doctors, nurses, midwives, social worker, health visitors, etc.), in which the doctor is supposed to be the leader. (*Annual Report* 1957/58.)

I understand that the practice at Darbishire House has been criticized as being artificial and over-elaborate and thus not representative of general practice. It is situated in a working-class area and the doctors, from what I heard and saw, work in a manner very much like any other general practitioner in an industrial district. The standards of building, equipment and ancillary staff are certainly better than in most general practices, but there are some group practices where similar standards, though perhaps not so high and extensive have been achieved.

The statistical digest attached to the *Annual Report* (1957/58) indicates that the doctors are probably not quite so busy in their surgery sessions as the average general practitioner in an industrial district. The daily average number of patients per doctor was 15 to 30 per surgery session. This is probably due to the ease with which people can approach the different agencies, such as health visitors or social worker, for demands which normally would be dealt with by the doctor, at least preliminarily.

The surgeries were well-equipped and pleasant, and each had its individual character in size, lay-out, and type of equipment. Each surgery had an examination room attached.

I sat in with one of the doctors, who, on that day, had no student with him. It appeared to me (and this is a casual observation which may well be wrong, if generalized) that the vicinity of the social agencies to the surgery and perhaps the all-pervading concept of the medical team made the doctor restrict himself more to the somatic aspects of his patient's case, perhaps in the knowledge that emotional and social problems might be dealt with by the almoner and the health visitors.

After surgery, during coffee break, the doctors, staff, and students met and discussed informally and briefly some of the happenings

of the morning and administrative problems that had arisen. These coffee break meetings were, however, not proper case conferences, but rather social, chatty occasions. One of the deficiencies of the centre, noted also in the *Annual Report* (1957/58) is the lack of or rarity of case conferences in which doctors, ancillaries, and students would take part.

Local authority health services. The local authority health or preventive services consist of a health visitor service, maternity and child welfare clinics, a family welfare service, and a school health service.

Health visiting has been decentralized from Manchester Town Hall to Darbishire House. There are three health visitors based at the centre. The practitioners at the centre refer patients from the surgery to the health visitor and send medical students to them so that these can gain an insight into the health visitor's work.

In the afternoon antenatal and infant welfare sessions are held at the health centre. Two thirds of the mothers attending belong to the list of the health centre practitioners. Two midwives and two health visitors attend at the antenatal clinic. Instruction and relaxation classes are held and a physiotherapist is in attendance.

Once a week a session for the family welfare service is held at the centre by an outside psychiatrist and the social worker. I was not able to attend such a session but I understand that the service is designed to deal with problems of adolescence, home difficulties, and marriage problems. The main sources of referrals are outside general practitioners, health visitors, and the Marriage Guidance Council. A school clinic is also held at the centre with all the advantages of the centre's physiotherapy unit, laboratory, and x-ray department.

Each of the four practitioners of the centre in rotation holds sessions and clinics for the local authority. Urgent cases of accidents and sickness arriving at the clinics are seen and treated by a centre doctor irrespective of the time of day.

Ancillary services. Radiological and laboratory services are, as mentioned above, on the premises. It was thought that the laboratory was not used to its optimum extent. The *Annual Report* (1957/58) says: "But bio-chemistry or bacteriology are not used as much as they might be: possibly indicating that simple tests of blood and urine are of more significance to the general practitioner who seeks to exclude abnormality. Often his aim is to reach a presumptive, rather than, as with the consultant, a definitive diagnosis ".

The radiological facilities have proved of great benefit. A radiologist from Manchester Royal Infirmary reads the plates, but the wet films can be scrutinized by the general practitioners on the spot.

The social worker or almoner has been at Darbishire House since

1955. Her work depends upon referral by the doctors, by health visitors, or by outside sources. Some patients come directly to her without having been referred by anybody else. The almoner's work seems to be largely concerned with social medicine, i.e., the alleviation of social and economic difficulties. This is done either by herself or by other agencies to whom the patient is in turn referred. She works with the health visitors in the centre who do many of the investigations needed. The almoner also carries out some child psychotherapy.

Student teaching. Attendance at the health centre by students is voluntary. The student is expected to spend a fortnight in the centre during his final year. He sits in with the general practitioner in the surgery, meets the other doctors and the staff during coffee break, and goes out with the doctor on home visits. There are also tutorials taken by the director. The staff see the task of their teaching as showing the student how disease can be diagnosed in the earliest stages; making him aware that many patients seek the advice of the general practitioner for emotional rather than physical illness; and demonstrating that the function of the general practitioner, unlike that of the specialist, is often not primarily to diagnose and cure, but to keep watch, to detect early, discern, and palliate handicaps. In addition, the student should gain some understanding of social and preventive medicine, and to see general practice as a scheme of comprehensive care. The *Annual Report* (1967/58) says:

> Darbishire House might be used to teach more about the psychological aspect of family health care, including the emotional relationships of doctor and family, techniques of counselling and listening, and psychotherapy (Scott, Balint, Reader, Silver), but for these purposes much more than a fortnight would be needed. Attempts so far made within the limits of fourteen days, have sometimes tended to confuse and to disturb.

Tutorials. I was able to take part in two tutorial classes. The students reported cases they had seen during their surgery attendances or home visits, and the director tried to teach the principles of general practice on the basis of the case reports. During one of the tutorials I was left alone with the students and spent a most interesting hour with them. Evidently they met with a type of medicine in this general practice course that seemed to them somewhat unscientific; it certainly was very different from the medicine they had learned in hospital. They were greatly interested to hear about the psychological implications of ordinary illness and the psychological problems in general practice, but felt that this was outside the kind of medicine they had been taught. They could not easily connect the two.

A case report. A case as reported by a student showed these difficulties clearly.

> Kevin, aged 9, is a member of an Irish family living in a small, dark, terrace

house in the back streets of Ardwick. He is the eldest child, there are three siblings and his mother is expecting another child.

For the last three years (at least) he has been subject to attacks of bronchitis and asthma. He had fairly severe attacks in the winters 1957 and 1958 and was seen at intervals throughout the whole of 1959. The present exacerbation has kept him away from school for the last five months. He has not responded to medical treatment which has included the administration of benelyn, antistin, penicillin, ephedrine, achromycin, and chloromycetin. In addition he had enlarged tonsils, tonsillitis, and a heavy sinus infection. The tonsils were removed one month ago. As expected, although the infection has cleared up and Kevin has recovered well enough to return to school next week, he still looks very pale and sickly with numerous rhonchi still to be heard in his chest. He is far from well.

After his tonsillectomy, arrangements were made for him to convalesce for a few weeks at Conway, but he refused to go. The matter was pressed no further as his father had promised to take Kevin to Ireland at Easter for a holiday. Kevin now says that he will not go to Ireland and it is difficult to press the matter against the child's wishes for fear of the asthmatic attacks which would certainly be precipitated.

The child admitted that he fears his younger brothers and sisters may usurp his position in his mother's affections if he should ever go away from her. His mother in turn is tense, fusses him, and has a tendency to overprotect him claiming that she gives him " twice as much affection as she does the others ".

Here then is the problem of a jealous child who has reacted with a physical illness to an environment of overprotection and tenseness. It is a problem which the general practitioner is able to recognize through his knowledge of the family as a whole. But even with this knowledge where does one break the vicious circle?

His failure to respond to medical therapy and the admission of his fears regarding his siblings show that the real problem is psychological. For the child to have a chance to improve he has either to be taken away from his environment, or his environment (particularly his mother's attitude towards him) must be changed.

He has already refused to go away. If one insisted on this, in order to prevent his departure his illness would become worse with the possibility that status asthmaticus would be precipitated. Although one would hope for improvement once the break had been made, there is still the strong possibility that, with his lack of independence, he would fret for his mother and show no improvement.

As regards the mother's attitude, the general practitioner may talk to her, look for the basic cause behind her attitude to Kevin, try to understand her problems and then try to show her that she should be less tense and protective towards him. As well as it being doubtful whether the mother would be prepared to, or is capable of, changing her attitude towards him, Kevin is also used to having plenty of affection from her and would see in her changed attitude a lessening of love for him—a change to which he is likely to react by being ill.

In addition to the psychological aspect of the case, the child also has a predisposition to bronchitis. He is almost certain to grow up into a chronic bronchitic with the semi-invalidism and associated miseries which that condition entails. There is little one can do to prevent this. Change of environment would be beneficial but the difficulties involved have already been discussed. Prophylactic antibiotics may help to prevent infection but will not cure the underlying condition.

So a seemingly insoluble problem remains. The social worker, as yet, sees no solution to the psychological problem and the general practitioner is left with the dissatisfaction of an unsolved case knowing that in the near future he will be expected to find the answer to the question " Kevin is still ill, doctor. What do you think should be done now? ".

[Miss Sylvia Manton, medical student].

The report clearly shows considerable understanding on the part of the student of the complexities of family relations and the interaction of social circumstances, emotional, and medical conditions.

It was admitted by the students that they had never experienced the like in their hospital patients. The report also demonstrates the frustrating and puzzling situation in which our young colleague found herself. The discussion took place during one of the occasions (which I was told were rare) when the general practitioner in charge of the case was present. The general practitioner, the director, and a visiting physician from Australia who happened to be there all thought that the only way to deal with Kevin was to change his environment. They suggested sending the whole family back to Ireland. The social worker and the students agreed to that proposal. It was evident that the doctors, social worker, and the students felt quite powerless when confronted with this patient who would not respond to treatment. Removal of the patient, obviously a counsel of despair, seemed the only way out.

Such cases are, of course, not uncommon in general practice. The remedy suggested by the tutorial group is not often applicable. It indicates one of the shortcomings of the teaching at Darbishire House. The central problem in this case is undoubtedly a psychological one. The physician from Australia could not accept this at all. He insisted that this was a clear-cut case of bronchitis on an allergic basis and that treatment ought to be confined to this. He thought that the search for allergens ought to be extended and further refinements of the physical diagnosis sought for. The other members of the tutorial group could see the preponderence of the psychological features, yet accepted it somewhat shame-facedly because it struck them as an unscientific or vague concept, and my insistence on a study of the psycho-dynamics as a bit crazy. Yet, one of the major symptoms of the child's illness was the feeling of helpless despair it engendered in all around him, his parents and the doctors. This feeling and the central problem certainly were not capable of being influenced by environmental changes (i.e., removal). They needed dealing with the inner turbulences of the child. There are psychotherapeutic techniques, even within the orbit of general practice, which could be used to deal with such disturbances. Of course, psychotherapeutic training is required, especially in the use of the doctor-patient relationship as a tool. I was told that the staff are not trained in such techniques and that such training is not available. I had an opportunity to discuss the great and very real obstacles in the way of an extension of this teaching. The staff at Darbishire House are to an extent aware of it, as the previously quoted passage from the *Annual Report* (1957/58)[1] shows.

The medical team. The aim of the teaching at Darbishire House, as it appeared to me, was to inculcate the concept of the domiciliary

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medical team, i.e., the doctor, the social worker, the nurse, and the health visitor, each dealing with a certain aspect of the patient. I shall examine the implications of this in the conclusion of my report, but it struck the observer at once that this team work, by the very impossibility of demarcating the boundaries of each member's task, gives rise to much tension among its members. Each member of the team seemed to feel in turn that the others took on tasks which were really in his sphere. Dr Logan, who as a non-practising doctor was able to stand outside the team, appeared to be placed in the role of an arbiter who had to keep the balance, not exactly an easy task.

The Edinburgh University General Practice Teaching Unit

The Edinburgh University General Practice Teaching Unit is based topographically on the old dispensaries for the sick poor. The attendance of students for clinical instruction at these dispensaries has been a tradition of the Edinburgh medical school. The Royal Dispensary and the Livingstone Dispensary were, after the inception of the National Health Scheme, taken over by the university for the purpose of establishing a University General Practice. Their premises are now used by the unit. They are run as National Health Service group-practices by the doctors practising there. Any citizen in Edinburgh is free to register with one of the doctors in the dispensary practices or to leave the practices under ordinary N.H.S. rules. He is entitled to the usual full range of medical services, and he may, if he wishes, see the doctor at the dispensary alone without a student being present. First emphasis is thus placed on providing the patients of the practices with a true family doctor service. Teaching and research are subordinated to this. In fact, the patients become the teachers through whom the students gain insight into the nature of the family doctor-patient relationship. (Scott, 1956; *Edinburgh University General Practice Teaching Unit*, 1959.)

In each of the two group practices the family doctors are assisted by the services of a trained medical social worker (almoner) and an experienced nurse. Adequate secretarial assistance is also supplied, as full and sufficient record keeping is considered essential. Close liaison with hospital and specialist services, with local health services and social agencies has been developed.

General practice. The general practice teaching unit thus comprises two general practices with administrative headquarters. One practice is located at the Royal Dispensary, the other in Livingstone House. Each practice has about 2,500 patients, and each is staffed by two general practitioners, one almoner, one nurse and one secretary. The general practitioners hold full-time

university appointments, and there are no more than approximately 1,250 patients per doctor. The practices contain a disproportionate number of unskilled labourers, of problem families, and, curiously enough, also of professional families. There are three daily consulting sessions which patients attend without appointment. Calls for home visits are received throughout the 24 hours. Antenatal clinics are run which patients attend by appointment. One of the practices has an infant and child health clinic for its own patients. The other practice has a local authority child welfare clinic on the premises. At the Royal Dispensary a qualified pharmacist dispenses medicines, a memory of the old dispensing days.

The doctors have open access to the clinical services of Edinburgh like any other Edinburgh practitioner. In addition, they can use a Family Doctor Centre (built in 1959) which is a diagnostic centre with a full range of laboratory and radiological facilities. This centre is located at Livingstone House and is most beautifully and sensibly equipped. Certain other local general practitioners can book consulting suites and make use of the services.

I attended a surgery session with one of the doctors. The consulting room I saw was pleasant, not very large but functional, and there was sufficient equipment. The patients were dealt with by the doctor in the way any good general practitioner would deal with his patients. It was evident that the emotional problems of the patients were understood, although they were, in general practitioner fashion, not always dealt with during that particular surgery session. The standard of medicine practised was high in the academic and the general-practitioner sense. I also went with one of the doctors on his house visits to families in some of the slum quarters in Edinburgh, and I also saw some new housing estates. A number of the problem families with whom the practice has to cope were Irish and Roman Catholic, and some of their problems were connected with the question of birth control. The doctors and members of social services evidently had to work under far more difficult conditions than their opposite numbers in the south of England. I was present at a home confinement in extremely poor surroundings where the doctor, the midwife, and her pupil worked under the most difficult circumstances with great devotion and efficiency.

Case conferences. A daily case conference is held at each practice, attended by the doctors, nurse, and almoner of that practice. Local health visitors, midwives, and other para-medical workers may also attend these case conferences. All cases seen by the doctors and staff are reported upon and a situation report provided. Each member of the conference makes his own contribution to the discussion. I have certainly never experienced before such an excellent

way of building up a complete picture of the patient and his family, enabling the staff to take decisions on long-term policy and immediate action and determine who is to take action. They also provide most valuable training for the staff, and integrate the skill of its members.

At one of the conferences which I attended there were present the two principals, a trainee doctor, the almoner, and the nurse. They discussed the cases of the previous night's surgery session (which I had attended) from all angles, medical, social, and emotional. It was most interesting to watch the pooling of the resources and information that came from all the members present. When one doctor gave some information about the patient he had seen, another might add information that was not available to the first, or the almoner or the nurse might have noticed something in the family set-up that had not been mentioned. The initial reports did not come only from the doctors. The nurse, for example, reported on a child to whom she had given an injection and the other members of the conference built up a picture of the background of the child's family. The almoner discussed some patients who had not kept their appointments with her and the meaning of this in relation to crises in the patients' lives.

It was evident that some of the doctors had had little systematic training in psychotherapy. They concerned themselves mainly with medical diagnosis and treatment, and left much of the psychological, emotional aspects to the almoner, though this was a pity, as this led to difficulties in the case conferences and to a restriction of their usefulness. During a conference, for example, one of the doctors reported on a patient who suffered from pneumonia. Other members of the case conference tried to point out to this doctor that his particular way of management of the case was based on the doctor's feeling of disdain for the patient. The doctor's report showed this very obviously, but the doctor was unaware of it and unable to accept it. In fact, he became quite cross over what he thought was an accusation of bad faith. Following this, another case with many emotional and relationship implications was reported and then the interaction between doctor and patient was carefully left out of the discussion, although it would have been of the greatest importance in understanding the problem. Nevertheless, the benefit that both patients and doctors derive from these case conferences must be enormous. They are certainly not lifeless, clinico-pathological case conferences, but evidence of " whole person" medicine such as I have experienced nowhere before.

The almoner. The role of the almoner in the Edinburgh unit is wider than that of the social worker at Darbishire House in

Manchester. She combines functions which one might broadly equate with those of a social and those of a psychiatric social worker. As her approach is one of understanding the emotional drives of the patient which entangled him in his present difficulty, rather than just trying to find the most suitable social agency for his relief, her consulting sessions are very personal, intimate, and confidential. This makes it difficult for her to accept " sitters-in ", and I felt greatly honoured at being allowed to sit in with her. The patients she saw in my presence were on the surface " social problem cases ", but in reality, and that became quickly apparent, what they needed most was dealing with their emotional problems. The almoner handled them and their problems, both diagnostically and therapeutically, very skillfully. The patients had been referred by the doctors. It was evident that the almoner was, to an extent, carrying out "general-practitioner psychotherapy", a task that should have been the doctors'.

Student teaching. At the beginning of each academic term one third of the fifth year medical students (maximum 48 students) is attached to the unit for a period of 3 months. Twenty-four students are allotted to each of the two unit practices. The two family doctor teams are reinforced for teaching purposes by general practitioners who are attached to the unit on a part-time basis. A maximum of three students at a time are allotted to each part-time doctor for a period of one academic term. Of the 24 students attached to each of the units, 12 work in the practice itself, the others in the practice of the part-time doctors. Each student sits in with a doctor on one fixed day per week. The students and their doctors attend a weekly seminar. The maximum number of students attending such a seminar is 12. This training is compulsory for all medical students.

My visit to Edinburgh coincided with the end of the academic term, and the final tutorials or seminars which I attended dealt mainly with the students' comments on their general practice experiences and the teaching they had had. The doctors, almoners, and nurses were invariably present at these tutorials. The students, as in Manchester, impressed me very favourably. They seemed alert and interested, and the teaching had obviously made a deep impression upon them.

One of the points of discussion was the students' attachment to their doctor-tutor. As this was evidently a recurring theme (and the same attachment appeared to be felt by the doctors for their students) this might well have made a useful start for a discussion of transference and counter-transference phenomena between doctor and patient in general practice.

Another point of interest to the students was continuity in general

practice. This seemed to the students the most important aspect of general practice, especially as it never occurred in their hospital teaching. They also felt that they now understood far better than before the difficulties that beset general practice.

I felt that there was too little discussion of the doctor-patient relationship and its meaning in diagnosis and treatment during these seminars. This was not because the staff were not aware of it, but partly because they seemed to be afraid that the emotional aspects might upset the students. This over-protective attitude or fear by the doctors of harming the students which I shall discuss again later in this report was ever present.

The almoners do little teaching of medical students, except that they sit in at tutorials and lecture on the general principles of their work. The students, unfortunately, have no chance to see the important work the almoners do, though they get a second-hand view of it from the lectures and general discussions. No doubt the very nature of this psychotherapeutic work makes the attendance of a third person difficult. After all, it rests solely on the use of the almoner-patient relationship and any disturbance of this relationship and the ensuing psychic forces will upset the therapeutic task. Yet there are general practitioners who carry out psychotherapy and admit a student to their sessions, and are able to handle this situation. I felt that the reluctance to be bold in this respect was due to the feeling on the part of the staff that they had no *formal* or recognized training in psychotherapy. I think that this feeling is quite unwarranted. In any event, so little is known about the psychodynamics of general practice and of the doctor- or almoner-patient-relationship that experimentation, free research, and "trial and error" methods are of much more value than inactivity due to a feeling of insecurity.

Conclusions

Education in somatic medicine. The present-day image of the doctor in Great Britain has its historical origin in three pre-eighteenth century healers: the physician, a widely cultured university graduate; the barber-surgeon, a technically skilled craftsman; and the apothecary, a practical familiar tradesman. These three figures with widely differing social and educational backgrounds and vocational outlooks, eventually merged in the doctor of today, very largely due to the discovery of physical examination (Newman, 1951) in the eighteenth and nineteenth centuries. This diagnostic method which led to the unification of medical education proved to be far more superior in accuracy than the older methods of diagnosis which were either largely unrelated to biological facts or unsystematic. The scientific development of the system of physical

examination in its modern development and its physical and chemical aids enables us now to base many of our diagnoses, forecasts, and treatments on a sure predictable footing in keeping with modern scientific thought.

The training of the medical undergraduate shows clearly the historical roots of today's doctor. His training is designed to make him into a physician, employing all the physician's skill in the use of highly refined methods of physical examination and with perhaps somewhat dimmed memories of the wide cultural and humanistic outlook of the physician of old. He is also trained to become a surgeon, skilled in the use of his tools (his senses and instruments) and the application of practical methods. And he is trained, too, in the apothecary's knowledge of materia medica.

In addition there is his training as a man-midwife, another eighteenth century development, and instruction in those many specialities which have split off the three main disciplines in the nineteenth and twentieth centuries.

Psychological medicine. Psychiatry and psychological medicine have lagged considerably behind physical medicine. As sciences they are only about 60 years old, and they have no scheme of examination or classification comparable with that of somatic medicine. Yet, their scope and importance, both on account of their subject-matter and the very large number of patients involved, are constantly increasing.

Psychological medicine is taught as one of the minor specialities. An investigation by the British Medical Students' Association (1958/59) showed that only six medical schools out of seventeen had chairs of psychiatry, mental health, or psychological medicine. Woodger (1956) noted with surprise the exeedingly small part played by psychology in medical training, compared with the considerable part played by mental illness in contemporary life.

Of course, if psychiatry or psychological medicine were truly only specialities, dealing with certain diseases which we call mental, comparable in scope to, say, ophthalmology, then my report would only be concerned with whether one should add or subtract a few hours from its present allocation of teaching time. But that would take far too narrow a view of the importance of emotional and psychic matters in medicine. In its widest aspects psychological medicine is the science of understanding human emotions, personalities, and relationships in the medical field. There are few branches of medicine that are not deeply affected by emotional and personality factors, and few doctors to whom understanding of relationships does not matter. It certainly plays a major part in general practice. The words of the *Report of the Inter-Departmental Committee on*

Medical Schools (1944)—the Goodenough Report—are still valid:

> Nowadays, there is increasing recognition of the wide incidence of psychological factors in the causation of disorder. This recognition extends not only to the mass of major and minor psychoneuroses which form a large part of every doctor's practice, but also to the important part which these factors play in the progress and treatment of many essentially organic diseases, and in social medicine and the promotion of health. Whether he is dealing with problems of health or sickness, a medical practitioner cannot fully understand his patients and advise and treat them adequately unless he pays due attention to the psychological background. The better the doctor, the more attention he pays to this background without perhaps thinking that he is doing anything "psychologically"; but for the most part, nowadays he has to rely mainly upon natural insight and commonsense, rather than on trained understanding and experience, the reason being that, with few exceptions, the training which the medical schools still provide is based upon the narrow, old view of the scope of psychiatry.

General practice. It is clear from the foregoing that *good* general practice is unthinkable without the general practitioner's ability to understand human emotions and relationships, and without his using this understanding as a therapeutic tool, and this not only instinctively, but with scientific comprehension. Unless this understanding is made a scientific discipline, it can hardly be taught on an academic level.

I saw no evidence that any of this was taught at the Radcliffe Infirmary. At Darbishire House, the subject was mentioned, but not discussed at depth. One could hardly expect so during a fortnight's course. In Edinburgh an effort was certainly made to impart this difficult discipline to the students.

It struck me that the different accents given to the teaching of psychological understanding indicated three divergent views of general practice:

At the Radcliffe Infirmary in Oxford I heard much praise of the general practitioners in the hospital's catchment area by the consultants. The local general practitioners were considered "very good", but "very good" meant largely the ability to arrive at a somatic academic diagnosis of the patient's disease, or in other words, to practise proper hospital medicine.

At Darbishire House in Manchester, the image of the good general practitioner was that of a man technically well trained, with an appreciation of social factors, and the ability to divide the patient's problem into sections (medical, social, nursing, psychiatric) and to use the appropriate member of the medical team for its solution.

At the General Practice Teaching Unit in Edinburgh the nearest approach to medicine of the whole person and the family-group I had seen anywhere was practised and taught. The ideal of the good general practitioner here was a technically apt doctor with appreciation of environmental factors and the ability to under-

stand emotional drives and his relationship with the patient, and to use these therapeutically.

The teachers. It seemed that these different points of view originated largely in the status of their propounders.

At the Radcliffe Infirmary the teaching is in the hands of consultants and specialists. In my description of my experiences at Oxford I have briefly mentioned how difficult it must be for the highly specialized physician or surgeon to go beyond the field of the basic natural sciences. But if these consultants and specialists are the sole teachers of future general practitioners (and doctors in general), then something important is missed. The words of Dicks (1950) might not inappropriately be quoted here:

> In fact these mighty consultants do not teach the general practitioner more than a fraction of what he finds it useful to know. Yet, owing to identification and prestige, he still feels he has learnt " his medicine " and " his surgery " from them and ought to be very grateful. Actually, what he has seen impressively in action has been the full-scale clinicopathological method applied to " good teaching material "—i.e., to patients with well-marked structural or biochemical change, whereby a series of well-judged tests, recorded on charts of many hues, the right diagnosis fell into the team's lap. The image of good doctoring was that of the " great white chief " performing miracles of mechanistic skill on a dramatic, perhaps catastrophic, rare case while the dull sort of case, whose pain did not fit in, was perhaps half jokingly referred to " our psychiatric colleague."

It is perhaps not to be expected in the very nature of things that the consultants and their juniors could teach systematically the kind of psychological understanding we need. It is doubtful, too, whether psychiatrists, as a genus, could do so any better. Sinclair (1953), an academic teacher and consultant, writes about the teaching of " psychobiology ": " It seems to me that the psychiatrist is perhaps not the ideal man to deal with this aspect of the student's education. After all, psychiatrists occupy an ivory tower just like the rest of us, even though their tower is sometimes larger and more luxuriously appointed. . . . ".

On the other hand there have been psychiatrists who were able to teach our kind of psychological medicine to undergraduates, e.g., O'Neill (Davies *et al.* 1958). They are, however, rather the exception than the rule. If such psychiatrists could teach jointly with consultants who are interested in psychological matters, much good work could be done. Such joint work has been carried out (in research, though not in teaching), for example, by Morris and O'Neill (1958).

At Darbishire House in Manchester the *systematic* teaching is in the hands of the adviser to the health centre, a non-practising doctor who is a reader in the University Department of Social and Preventive Medicine. The social worker plays a small part in teaching. The four general practitioners of the centre teach their students apprenticewise, informally and by example. There are a

number of disadvantages in this system. The general practitioners have no academic standing; they lack facilities for critical evaluation of their work (i.e., regular case conferences and seminars with students *and* general practitioners present). The leader of the tutorials is not in general practice, and can therefore deal with cases only second-hand and not from immediate experience. This may well lead to misunderstandings of the role of the general practitioner, as we have seen it recently expressed in the pamphlet *Demand for Medical Care* (Forsyth and Logan, 1960). The Department for Social and Preventive Medicine is responsible for organizing teaching and research at the centre, and this gives to teaching a " social medicine " bias. Social medicine has a good many useful contributions to make to general practice, but it is certainly not the alpha and omega of general practice. In fact, a social medicine bias can be rather a liability, as it is apt to make the student think that medicine is all environmental influence and therapy all environmental changes, as we saw in the case of Kevin.

At the General Practice Teaching Unit in Edinburgh, Dr Richard Scott and his colleagues have taken the bold step of working *and* teaching as full-time general practitioners (may it be said, at great economic sacrifice to themselves). They all work as general practitioners like any other family doctor, except for the restriction in number of their patients. They live in the midst of all the medical, social, emotional, and relationship problems of general practice. They are exposed to mutual criticisms at case conferences and seminars. They teach informally *and* formally from their first-hand experience on the battle-field of general practice, as it were. The unit is independent of any university departments, reports directly to the dean of the medical faculty, and has its own director.

This is no doubt the best way to teach an integrated medicine of the whole person, the instructors being practising family doctors and at the same time full-time academic teachers and research workers. It seems a pity that the highest academic position attainable in the unit is only that of reader, and that there is no chair or professorial unit of general practice in Great Britain, not even in Scotland, a country so advanced in general-practitioner teaching.

The students. The medical students I met on my travels made an excellent impression. They were always greatly interested in general practice and psychological medicine. Brotherston *et al.* (1959) in a paper on the Edinburgh University Unit's teaching as evaluated by its former students confirm that impression.

I have previously remarked on the belief in the vulnerability of the medical student, and the rather paternal-protective attitude of the tutors which I noticed at Manchester and to a lesser degree at

Edinburgh. It was thought that teaching or free discussion of controversial and upsetting matter (such as psychotherapy, doctor-patient relationship) might confuse or disturb the students. I found, on the contrary, that these new ideas gave those students who wanted to think food for reflection. This question of the possible harm caused to the student by emotional problems has been discussed by O'Neill (1955), a psychiatrist who has done much valuable student teaching, by Davies *et al.* (1958), and Balint (1957[a]) who have come to similar conclusions. The anxiety and over-protective attitude of the tutors leads to the establishment of a particular tutor-student relationship which is an obstacle to free discussion and criticism. This was noticeable in the tutorials in Manchester and seminars in Edinburgh.

It might be of great value both to doctor-tutors and students if the teacher-student relationship and its influence on the patient in the general-practitioner teaching centres were freely discussed between doctors and students. Davie (1956), one of the four general practitioners at Darbishire House Health Centre, has mentioned the strong transference reactions between student and doctor-tutor. Little effort has, however, been made to study this subject, although it would be the natural lead to a discussion of the doctor-patient relationship and induct the student in its therapeutic use. This idea admittedly is not easy to carry out, especially in Manchester where the general practitioner course lasts only for a fortnight.

Most of the students to whom I talked would rather have become consultants than general practitioners, although 30-40 per cent in the end become general practitioners (Howitt, 1959; Cartwright, 1960). This desire to be like the Great Consultant who is teacher, prototype, and ideal to the student is understandable. It is more so when one remembers that the student is taught a kind of medicine and a set of medical values in hospital which differ greatly from the kind of medicine and medical values of general practice. For example, whilst refinement of diagnosis is an aim in itself in hospital, a diagnosis in the hospital sense is often not made at all or, at best, presumptive in general practice. The student finds this confusing, and as he tends to overvalue hospital medicine, thinks that general practice is " unscientific " and " vague ". The students have a similar feeling towards psychological medicine which also does not fit into the scheme of things that they were taught (Hill, 1960). As we all have been students once and have gone through our hospital training, most of us carry the feeling that there is one kind of " scientific " (hospital) medicine, and another " intuitive " (general practice) medicine. A report by the B.M.A. on *General Practice and the Training of the General Practitioner* (1950) states

that general practice cannot be taught. It goes on to say rather naively: " It is true that one cannot teach tact, common sense, patience, sympathy, and other such personal qualities which go to the making of a good doctor, but it is possible to give some early direction to their use and practice and to save the young practitioner from any mistakes and pitfalls ".

One may not be able to teach tact and sympathy, but the relationship, emotional, and psychical problems which distinguish general practice from hospital medicine can well be studied and taught.

The College of General Practitioners in a report on *Undergraduate Education and the General Practitioner* (1958) (by a Committee under the chairmanship of Dr Richard Scott) have taken a step forward by stressing the possibility of teaching general-practice medicine, as exemplified at Edinburgh.

The students themselves, in spite of their initial bewilderment and under-valuation of general practice, feel that an important element is missed in their hospital training. The *Report on the Teaching of Psychology and Psychological Medicine in British Medical Schools* by the British Medical Students' Association (1958/59) says, *inter alia:* " The outstanding criticism which the students made . . . was that they felt . . . that . . . as qualified doctors they would not be in a position to appreciate . . . the part which the psyche had to play in the causation of illness ".

The same, somewhat puzzled awareness of the importance of psychological factors in illness is evident in Miss Sylvia Manton's report on Kevin quoted in full on page 235.

There is certainly a wide and receptive field in our medical students for those teachers who are keen to teach medicine as a holistic science. It might be appropriate to say here a few words about training for these teachers themselves. The doctors both at Manchester and Edinburgh showed a considerable degree of insecurity in their dealings with psychical problems which they put down to their lack of training in psychotherapy. Balint (1957[a], 1957[b], 1957[c]) has shown new ways in the successful teaching of psychotherapy and scientific methods of psychological understanding by means of group discussion in seminars. These postgraduate seminars, held at the Tavistock Clinic in London, would probably be the ideal training ground for general practice tutors of medical students.

The role of the almoner. I have already said that I am not particularly keen on the idea of the domiciliary medical team which leads to a parcelling out of the patient away from the integrating function of the family doctor. This is not to say that the almoners have not a very important function to perform. (Paterson, 1950; Dongray, 1958). They are most useful ancillaries with their know-

ledge of and influence with the social agencies and services. More important, if the almoners have psychotherapeutic training, understanding, and aptitude they can in many ways supplement the general practitioner's psychotherapeutic work, even if the general practice tutors have some psychotherapeutic training. Some family doctors with the best of intentions are not particularly suited for such work. All of us have blind spots, patients we cannot deal with, or who upset us, and it will be a great relief even to the psychotherapeutically well-trained general practice tutor to know that he has the almoner available for referrals. There will be patients, too, who will find it easier to go to the almoner with their problems than to the doctor.

Medical students could learn a great deal from the almoners, if they were permitted to sit in with them. Until this is achieved, the almoner will only play a relatively unimportant part in teaching of students.

My own gains. I should lastly like to say a few words about the benefit I myself have gained from my travels.

It is not easy for a busy general practitioner to remove himself from his practice for any length of time. But how important and beneficial is such a break! Professional isolation is one of the drawbacks of general practice. The hospital doctor is always surrounded by his colleagues, able to give and gain in interchanges of ideas and experiences, and exposed to criticism by his professional peers, which constantly puts him on his mettle and refreshes him. The doctor in full-time academic practice has often the benefit of a sabbatical year, spent in foreign medical schools or laboratories where he meets colleagues with different outlooks and thoughts. The general practitioner is only rarely so favourably placed. He has little opportunity for communication between equals where both sides freely give of their accumulated knowledge to each other and where doctors working in the same field can watch each other's work and techniques.

Osler (1905) in his essay *The Student Life*, says that one of the essentials for a medical practitioner is a quinquennial brain-dusting, by which he means an occasional move away from the practice to some place of learning, " for renovation, rehabilitation, rejuvenation, reintegration, resuscitation, etc.".

It was exactly this kind of brain-dusting that my exhausting and yet refreshing journey supplied. It gave me plenty of food for thought and for collection of my own ideas on general practice, psychological medicine, and teaching. And furthermore, it gave me an opportunity, not easily otherwise found, of meeting such men as Dr Richard Scott and his fellow-workers, Dr R. Logan and his

colleagues, and doctors of distinction and sincerity at Oxford.

That I did not always agree with their views, outlook, and teaching methods does not necessarily mean that they are wrong and that I am right. We can all learn from opinions that differ from our own.

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I should like also to thank my partner, Dr S. Ginsborg, M.R.C.S., for constructive criticism of style and contents of this report.

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A COMMONWEALTH OF MEDICINE

(From an address given by Dr John McMichael, M.D., at a Clinical Meeting of the British Medical Association, Canterbury, 14 April, 1961. *Brit. med J.*, 1961, **1**, 1126.)

" . . . We have achieved in this country, by a very substantial expenditure, a high standard of health and life expectancy. It costs less than 5 per cent of our national income, or about £12 per head per annum. We must approach with sympathy and understanding the problems of the poorer countries in which the expenditure may hardly be as many shillings per head, and where obviously it will be many decades before they can apply our standards widely. We must be sympathetic to their efforts to adapt to the new knowledge. We must show them how to translate the results of research (which they themselves may not yet be able to pursue) into effective practical action. The sustained British tradition of shrewd and detailed bedside history-taking and clinical examination, backed by appropriately selected laboratory checks, is our greatest strength in transmitting " know-how ", for we can frequently demonstrate that, by precise and accurate clinical observation, costly and extensive laboratory investigations may be merely confirmatory and often unnecessary for practical decisions. These working rules of bedside practice which we discern by careful study and research are available for the guidance of all. . . . "