ue.[1,2] There are only a few published surveys on patients' attitudes regarding contact with medical students and these have been hospital based.[3-5] We carried out a survey to assess patients' willingness to be involved in medical student education when they visit the practice.

A postal questionnaire was sent to all patients over the age of 16 years registered with one general practitioner (N O) in a five partner health centre based practice in Cambridge. Patients were asked about past encounters with medical students within the practice and willingness to be involved with medical student training in the future. Responses were anonymous and there was no follow up of non-respondents.

A total of 1133 questionnaires were sent out and 578 (51.0%) returned. There was a statistically significant ($P<0.001$) response bias — the mean age of respondents was 52.9 years compared with 44.6 years for all those to whom the questionnaire was sent (including respondents).

Of the 578 respondents, 379 (65.6%) reported having previously had a medical student present during a consultation with their general practitioner and 262 of these reported the student to have played an active role, that is taken a history or performed an examination. Of the 368 patients who answered the question, 317 (86.1%) reported that having the student present made no difference to the consultation, 15 (4.1%) felt the consultation was easier and 36 (9.8%) that it was more difficult.

Patients were asked whether they would be prepared to have a medical student involved during future consultations with their general practitioner (Table 2). There was no significant difference in the responses of those patients who had had previous experience of medical students and those who had not. Analysis by seven 10-year age bands showed younger patients were less likely to report a future willingness to have a medical student present during their consultation than older patients ($P<0.05$, chi square test with 12 degrees of freedom).

This survey has demonstrated that a large majority of respondents would be prepared to have a medical student present when they visit the surgery. We conclude that patients' attitudes are unlikely to present a significant barrier to an increased proportion of medical student training taking place in general practice in the UK.

STEVE JONES
NIGEL OSWALD

East Barnwell Health Centre
Ditton Lane
Cambridge CB5 8SP

Table 2. Patients willingness to participate in medical student education in a primary care setting.

	% of patients responding:		
	Yes	Sometimes	Never
In future would you allow a medical student to be present when you see your doctor? (n = 578)	*69.7*	*26.8*	*3.5*
Would you be prepared to see a medical student alone before seeing the doctor? (n = 576)	*47.0*	*27.6*	*25.3*
Would you be prepared to let your child see a medical student as well as seeing the doctor? (n = 196)	*71.9*	*18.9*	*9.2*

n = total number of respondents to question.

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Out of hours treatment centres

Sir,

Recent reports in the national press suggest that the government is planning to introduce primary care out of hours treatment centres (*Sunday Express*, 21 November 1993).

A retrospective review of all out of hours, face to face, doctor–patient contacts over the period August 1992 to August 1993 was made for those patients registered at the four practices covered by me when I am on call. I keep a separate card fo each patient seen out of hours and information was obtained from these. A questionnaire was also sent to all 10 local practices which would be in the likely catchment area for an out of hours centre, if such a centre were to operate from my own or one of the neighbouring towns.

Of the 214 out of hours consultations 81% were for patients living four miles or more from the surgery. A total of 133 patients were seen at the surgery and 81 were visited at home. Of patients seen 62% were therefore willing and well enough to attend the surgery. Only 18 of all the patients seen (8%) required admission to hospital. Of the 214 consultations 14% were accounted for by minor injuries that could have been dealt with equally well in a hospital accident and emergency department. In the 194 patients whose duration of symptoms could be estimated, 32% had had symptoms for 24 hours or less when seen by the doctor. The other 68% had had symptoms for more than 24 hours; 43% of patients had had symptoms for more than 48 hours.

In reply to the questionnaire, 10 doctors indicated that they would be interested and four doctors said they would not be interested in decreasing their out of hours workload by 60%. Five doctors would be happy and eight would not, for their patients to contact a primary care centre directly (one doctor did not know). Seven doctors would prefer their patients to contact the practice/out of hours rota first while four doctors would not and three did not know. Two doctors would be willing to pay a small fee for their patients seen in the centre, seven would not be willing and five did not know. Three doctors would be interested in working in the centre, seven would not be and four did not know. Three would be interested in using the service if it became available, six would not be, and five did not know.

That 62% of patients were able to come to the surgery suggests that these consultations were for minor illnesses. Only 8% of patients needed hospital admission. In Walker's study of out of hours visits to children, only 5% required hospital admission.[1] A recent study showed no difference in doctor defined serious health problems between children seen frequently out of hours and a control group who were not seen frequently.[2] As two thirds of symptoms had been present for more than 24 hours, it is likely that the illnesses had started during normal working hours. Out-of-hours consultations could be reduced by better patient education and

more thoughtful use of primary care services. It is likely that an out of hours centre open between 19.00 hours and 22.00 hours could cover an area with a radius of five miles or more and reduce the out of hours workload of general practitioners in the area by about 60%.

Many of the doctors who were not sure about primary care out of hours treatment centres could become more positive if they were more familiar with the idea, and if they knew that funding was available. However, it is clear that not all general practitioners see this as the solution to the problems of 24-hour general practitioner cover.

DAVID HINDMARSH

The Crane Surgery
Rectory Fields, Cranbrook
Kent TN17 3JB

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Treatment of drug misusers

Sir,

Research can change that which it purports to be studying. That described in the paper by Tantum and colleagues (November *Journal,* p.470) did exactly that; their work undermined rather than supported traditional patterns of general practitioner behaviour.

I write from Rochdale district. I suspect Rochdale is the mill town described in the paper. I have had drug misusers on my list ever since I started practice 20 years ago. Several times in their paper the authors describe intensive promotion of the project among doctors. At the sharp end I am certain that they worked hard and saw mountains of paper disappear from their office. However, at the coalface I was vaguely aware that something was afoot at the nearby tertiary care regional centre. I did receive a pad of their multi-coloured forms which were of no direct benefit to me or my patients. Always willing to help, I filled them in, probably more assiduously at first than later. This tail-off phenomenon is well known and documented.[1] I do not believe that it corresponded with any tail off in treating patients.

I can confirm that our local psychiatrists suddenly developed heightened sensitivity to patients with problems of drug misuse, following contact with the tertiary care centre. Similarly, I received a protocol for the treatment of drug addicts. Top down dissemination of protocols is notoriously inadequate.[2] This protocol was for uncompromising withdrawal and was unsatisfactory as it failed the acid test of usefulness.

The matter was further complicated by the inception of drug teams. They had closer links to the regional centre, greater resources, and were willing to supply greater amounts of methadone than was customary among general practitioners. This served to undermine general practitioners' confidence at the very time this piece of research was taking place.

I believe the Rochdale drug team has the following composition: a manager, a social worker, a psychiatric nurse, a child care worker, a probation worker and sessional input from two local general practitioners. I understand that they have a load of between 80 and 100 clients. In my own single-handed practice of 2700 patients in adjacent Heywood I have 18 registered opiate addicts who I treat with maintenance/withdrawal therapy. The money I received for a drug dependency health promotion clinic has now been withdrawn.

MICHAEL TAYLOR

40 Market Street
Heywood OL10 4LY

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Teaching the art of medicine

Sir,

Bruce Charlton (November *Journal,* p.475) is to be applauded in his discussion of humane medicine, both for his consideration of the philosophy of medical education and for his comment on the science of medicine.

To most doctors medicine is seen as a science both in its frame of reference and in its practice, and to many it now assumes a commercial dimension. In many ways, however, it is appropriately classed with the arts, considering its background and expression, and this is seldom recognized either in training or in practice. The result often breeds a pseudo-science which is compelled to analyse everything with familiar 'scientific method' even when this may be inappropriate,[1,2] and which rejects innovations not conforming to these constricting regulations.[3]

Science is concerned with the discovery and exploitation of data on repeatable patterns in isolated units with maximum precision.[4] Medicine (certainly general practice) has to consider disease (which is different in each case) in patients (who vary infinitely) in physical, psychological, social and spiritual contexts, by different doctors (who have the same variability as patients); and each variable and the response to it differs with time. Without the recognition of this we would not have made much of the progress which the Royal College of General Practitioners has helped to foster in recent years. Although each of these variables may be measured scientifically, the whole may not.

While we may base our practice on the soundest scientific principles we can find, it is often valid to look to the arts to help us to function optimally. Like medicine, the arts are concerned with the uniqueness of the individual and of an individual's responses.[4] We should already be aware of books, poems, films or paintings which have helped us to form our responses to experiences our patients have had but we have not. Much of Plato's philosophy is based on the premise that art is a search for the recovery of perfection or wholeness;[5] the same could and should be applied to the active process of healing[6] ('heal' is derived from the Old English meaning 'whole').

The *British Medical Journal* recently published an article by a schoolgirl, a prospective medical student, on her experience shadowing a house officer.[7] In it she described her reaction on witnessing death: 'I think it could be hard to remember that each death can never happen again and that each person's grief is different and cannot just be given a prepackaged response.' An artist has no difficulty with this, nor have most doctors. But science could only provide a 'prepackaged response', and most of us have been guilty of considering death only in scientific, statistical, or even commercial terms. I hope the writer of this article will not lose her insight as a result of scientific training at medical school.

A shift from purely scientific towards a more artistic medical training (or education[8]) would demand a philosophical sea change. At the very least it is important that doctors realize the proportion of their profession which is art rather than science.

BLAIR H SMITH

Department of General Practice
University of Aberdeen
Foresterhill Health Centre
Westburn Road
Aberdeen AB9 2AY