WHAT THE GENERAL PRACTITIONER SEES

A comparison of cases seen in a Canadian and a Scottish practice

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THE more one does of general practice, the more one realises how varied and fascinating it can be. The problems change from day to day and the answers will not always be found in a medical textbook. The actual clinical work is not quite what the young doctor, fresh from hospital practice, might expect; in fact, I have often thought that the medical training could have equipped better the future doctor to deal with the problems of general practice if the emphasis on the various specialities of medicine had been a little different; for example, I feel that I should have been able to devote much more time to the study of psychiatry.

There does not appear to be much in the literature on what a general practitioner sees in his practice. Drs Richard Scott and D. H. McVie (1962) have analyzed home visits made over a year in their practice. Dr Keith Hodgkin (1956) has written an interesting article on " Hospital training as preparation for general practice ".

Whilst working in general practice in Canada last year, I thought that it might be interesting to compare the types of cases seen in the two countries over a short period and this article attempts to do this.

Types of practices

The Canadian practice was in Swift Current, Saskatchewan; it was mainly farming but with trade and business elements. The Scottish practice is at Dalkeith, Midlothian; it is mainly mining and also with trade and business elements.

Material and classification

The numbers of new patients seen in both practices during 30 consecutive days (i.e. during June 1962 in the Canadian practice and from 10 August until 8 September 1962 in Midlothian) have been noted and whether seen at home or in the surgery. Follow-up consultations are not included.

Clinical diagnoses of each new patient seen were made and these have been classified under medical sub-groups. In making this classification the patient's main complaint was considered in each case; thus, a patient who came to the surgery with a cut hand which required dressing and asked also for a further prescription for his ' blood pressure tablets ' was put in the ' injury ' group, and not in the ' cardiovascular ' one. The ages of the patients were noted. Patients referred for hospital outpatient investigations or for consultant opinions were listed.

Results and discussion

During the same period, 471 new patients were seen in the Scottish practice and 277 in Canada (table I). It is my impression that the numbers of hours spent doing clinical work in each practice were similar but, in Canada, more time was available to examine each patient; thus 15 minute surgery appointments were given routinely in Saskatchewan but only for five minutes in Midlothian. This extra time did much to eliminate the " rush against the clock " which one is often conscious of in this country.

TABLE I
TOTAL NUMBERS SEEN IN EACH SERIES

Place	*Seen at surgery*	*Seen at home*	*Total*
Dalkeith	320 (i.e. 68 per cent)	151 (i.e. 32 per cent)	471
Swift Current	235 (i.e. 85 per cent)	42 (i.e. 15 per cent)	277

Another interesting difference between conditions of practice is the ratio of surgery to home consultations. In Canada only 15 per cent of the new patients were seen at home whilst 32 per cent of the new cases in Midlothian were attended in the home. In Saskatchewan patients were actively encouraged to visit the ' office '.

One cannot really dogmatize about this; it would seem to depend on the views of the individual doctor on how he can give the best service to his patients.

The classification of diseases into sub-groups (tables IIA and IIB) is remarkably similar in both practices. The relatively high percentage of 'injuries' in the Dalkeith series is probably due to the fact that this is partly a mining practice. There are several interesting

TABLE IIA

CLASSIFICATION OF DISEASES IN DALKEITH

Frequency	*Medical sub-group*	*Percentage of total*
1st	Injuries	13·0
2nd	Respiratory diseases	12·5
3rd	Dermatology	11·0
4th	Psychiatry (psychosis; neurosis; emotional problems, etc.)	9·6
5th	Diseases of ear, nose and throat	8·5
6th	Cardiovascular diseases	7·6
7th	Diseases of the alimentary tract	7·4
8th	Rheumatic diseases (arthritis; 'fibrositis', etc.)	7·0
9th	Obstetrics	5·0
10th =	Blood diseases (the anaemias, etc.)	3·8
10th =	Inoculations and vaccinations	3·8
12th	Endocrine diseases (diabetes, obesity, etc.)	3·0
13th =	Gynaecology	1·7
13th =	Diseases of the eye	1·7
15th =	Neurology	1·2
15th =	'Clinical examination'	1·2
17th	Genito-urinary diseases	1·1
18th	Malignant diseases	0·8

TABLE IIB
CLASSIFICATION OF DISEASES IN SWIFT CURRENT

Frequency	*Medical sub-groups*	*Percentage of total*
1st	Respiratory diseases	14·7
2nd	Injuries	10·4
3rd	Dermatology	10·3
4th	Psychiatry (psychosis; neurosis; emotional problems, etc.)	9·7
5th	Cardiovascular diseases	8·2
6th =	Diseases of the ear, nose and throat	7·5
6th =	' Clinical examination '	7·5
8th	Diseases of the alimentary tract	6·1
9th	Endocrine diseases (diabetes, obesity, etc.)	5·7
10th	Rheumatic diseases (arthritis, ' fibrositis ', etc.)	5·3
11th	Obstetrics	3·9
12th	Blood diseases (the anaemias, etc.)	3·5
13th	Neurology	2·7
14th	Gynaecology	2·1
15th	Genito-urinary system	1·2
16th	Diseases of the eye	0·8
17th	Malignant diseases	0·5

observations which may be made from these figures concerning the type of clinical cases that a general practitioner might expect to see and his ability and competence to deal with them. Thinking back to one's student days, it would seem that more time should have been given to dermatology and psychiatry which are the third and fourth most common conditions in each series. I am glad that I did a casualty surgery house job although possibly could have devoted less time to anatomy and general surgical studies. Diseases of the ear, nose and throat are seen more than obstetrical cases and rheumatic diseases are more than twice as common as gynaecological

ones although I think that the emphasis of these conditions was reversed in my student days; I did no abnormal obstetrics nor operative gynaecology and this is probably so with most family doctors in this country and many in Canada. Diseases of the alimentary tract, respiratory and cardiovascular diseases, and dis-

TABLE III

CASES REFERRED FOR INVESTIGATIONS AND SURGICAL TREATMENT

	Swift Current	*Dalkeith*
1. *Referred for surgical treatment*	In-growing toe nail Prolapsed inter-vertebral disc Skin biopsy (2 cases) Abdominal hernia	Ganglions (3 cases) Amputation of toe Appendicectomy Removal of cyst Mitral stenosis
2. *Investigations*		
Barium meal x-rays	7	3
Chest x rays	1	2
Cholecystogram	1	—
Radiological (for injuries)	3	11
Other radiological	1	2
E.C.G.	1	1
Blood examination	1	2
3. *Consultant opinion*		
Medical	1	2
Eye	—	4
Dental	2	—
Gynaecological	1	3
Endocrine	—	1

TABLE IV

AGE INCIDENCES OF CASES SEEN

Age in years	*Dalkeith*	*Swift Current*	*Age in years*	*Dalkeith*	*Swift Current*
0— 5	7·2	8·0	30—44	33·0	16·4
5—14	12·1	10·7	45—59	20·0	18·0
15—29	17·4	26·4	Over 60	11·0	21·0

eases of the eye would seem to be given relatively adequate time to the student. Malignant diseases are fortunately at the foot of each list.

It will be noted that 'clinical examination' is sixth equal in the Canadian series. These cases were patients who came, without a presenting symptom, but requesting a 'check up'. This kind of patient was new to me and I was, perhaps, a trifle suspicious of this request; however I must admit to having become converted to the occasional use of this type of examination. The reassurance to the patient is immediately apparent when he is informed that all appears to be well; apart from this the early diabetic or pulmonary lesion may sometimes be found; in the future a routine 'papanicoleau smear" (which is part of this examination in some North American clinics) may discover the 'stage O' cervical carcinoma when curative treatment is apparently possible. I have attempted to introduce this 'check up' examination in a small and modified way since coming home but lack of time is the main problem.

The numbers of cases referred for hospital outpatient investigation (table III) are similar in each series and call for no especial comment; nor do the age incidences (table IV). The numbers of cases requiring surgical treatment were five (i.e. 1.8 per cent) in the Swift Current series and seven (i.e. 1.5 per cent) in the Dalkeith series, reminding one that only a relatively few of the patients seen by the family doctor require referral for surgical treatment.

Summary

New cases seen during thirty consecutive days in a Canadian and a Scottish general practice are described and compared.

It is suggested that the family doctor might be better equipped to deal with modern general practice if the emphasis of the subject matter taught to him as a medical student was altered slightly.

The possible value of the 'check up' examination is mentioned.

The relatively small number of general surgical cases seen is noted.

REFERENCES

1. Hodgkin, K. (1956). *Lancet* **2**, 372.
2. Scott, Richard and McVie, D. H. (1962). *J. Coll. gen. Practit.* **5**, 72.