

able to stay with their cousins for a while. My biggest problem was the home.

The home had to continue to be run. I was lucky because the general help was able to increase her hours to keep the home clean and tidy, and the mother-in-law of one of my partners had been recently widowed and needed something to do. She agreed to look after the children from the end of school and cook supper, staying until I was home. This worked very well during the week, but the children and their emotional problems became very testing for her. However, we survived. The weekends were more of a problem. I had a day weekend rota of one-in-one-out. When I had a full weekend my brother and his family kindly came over and looked after us. Once this arrangement had started I had to employ an answering service with one of the ancillary staff for my evening on call. The house became organised, but there was an obvious absence—no mother and no wife.

The life of the general practitioner continues unabated, and the problems have to be dealt with. Each patient still expects your complete attention, and this was difficult at times. I went through the motions of life for about three or four months. The divorce proceedings were going along as smoothly as is possible. It was eventually heard on my terms, and I was divorced seven months after the marriage broke up. The divorce was made absolute, but the financial settlement was deferred as the children still needed a home—a costly mistake on my part.

I had become a single parent again and suddenly realised that we lived in a paired society—despite the statistics. At dinner parties I was always the odd one out or hopelessly "paired" with a woman in a similar situation. Gradually I tried to build up some sort of life of my own, but I was still intensely lonely. The children, particularly the youngest one, were emotionally confused. I was granted a custody order for the children with a reasonable access clause. I had no wish to restrict them seeing their mother, even though it was hurtful to me. She was able to spoil them, tell them all sorts of things, and then let me pick up the pieces when they returned home. I had to try and restore their security at home with me. Luckily I have had very little interference in their management.

Diary of Urban Marks: 1880-1949

It was at the commencement of that session at St Mary's that I met a man called Harold Cruickshank Lees, who hailed from Stockport. I cannot remember how it came about but Lees and I chummed up together and went to live at 23 Delamere Terrace, Bayswater. The house was kept by Mrs Crawford and faced the Grand Regent Canal. There were three lots of students here. Lees and I occupied a sitting room on the ground floor. My bedroom was behind this while Lees slept on the second floor. We paid 30 shillings each for full board. Lees used to go to Hays Middlebury a week or two to see his sweetheart. I used to go home by the Sunday League excursions at a cost of 3/6. But when we were away we deduced separate for breakfast, the same for lunch and one shilling for dinner. So that on a Sunday when I went home the total cost was 2/3. But often my father would give me the fare so that on my return I was in pocket. From the time I went to London up to my 21st birthday I had to send Mrs Crawford's bills, together with the washing account, to my father every four weeks. I was allowed 7/6 weekly for pocket money and out of that I had to find tea, which cost four pence in the student's club.

We thought we were leading a gay life on a Saturday night we dined at Lyon's Popular Cafe, which had just then opened, for 2/6 and then went to a show for 1/-, winding up by having a couple of lagers in the Cafe Europe in Leicester Square for 8d. It does not sound exciting now, but at that time it seemed to us that we were "seeing life" and were men of the world. But youth can get a bit out of anything. It was the scene of enjoyment to most of the students in London in the cinema gaily and later in the Europe, which during all my residence in London was the centre where students festered. If on any particular night one wished to find a particular

man the Europe was the place to find him. If he were not there someone who knew him was sure to be.

On one of these Saturday nights Lees went out with the full intention of getting drunk. He said that he wanted to have the experience once so that he could inform his future patients of the effects of alcohol. To get drunk on lager beer was almost an impossibility. He did not like whisky, and as he had not tasted any liquors except Chateau he elected to get drunk quickly on this. He started off with a Chateau and went on to sample the others as they came on the wine list. We had previously been to a theatre, and the drinking bout did not commence until about 11.15 pm. By 12.30 am he was incapable. He could just stagger up the stairs and unfortunately put his elbow into a female's face. She began to abuse him, and he retaliated. She began to scream and the commissioner simply picked him up by the collar and slung him into the street. I called a hansom and assisted him in it. I had a new bowler hat on my head and he seemed to destroy it. He smashed it to bits. Going up Regent Street and Oxford Street he waved his arms about wildly, shouting at the top of his voice. I got on, with the assistance of the cabbie, into my bedroom and partially undressed him. I laid down beside him, and he appeared to be going to sleep. In a few minutes he sat up and let off howl after howl of maniacal laughter. I pushed him down and sat on him. He became quiet again and dozed off. I was nearly asleep when suddenly he sat up again and began to laugh so loudly that Mrs Crawford was aroused and came to inquire if Mr Lees were ill. I assured her all was well, and then we all went to sleep. In the morning Lees could not remember a single thing that occurred after the second liqueur had been taken, but he remembered how he was trying to get up. I had kept the remnants of my new hat, but in fairness to Lees I must say that he replaced it for me. He never got drunk again.

The legal process of settlement of the marital home had been deferred because of the children requiring a home. I discovered, however, that the actual settlement depended on the values at the time of the settlement, not at the time of the marriage breakdown. House prices were very inflationary then, and this cost me dearly. We were faced with a large settlement and had four choices: a loan, a second mortgage, a move, or a period abroad. The cost of this loan and second mortgage were prohibitive with an enlarged family. Moving to a smaller house in the same district would have been difficult. Working abroad seemed unfair on the new marriage, and my wife having to live alone with the teenagers would have been difficult. At this time there was a vacancy for a single-handed rural practitioner and I was successful, so we decided we would sell up, move house, remortgage, and start again. We were then able to settle the outstanding debt and not have to worry; we were broke but happy.

This all happened some time ago, and I have been married again for six years and in my new practice for three years. The children have matured through their difficulties. How about my second marriage? Love, trust, and communication are probably the most important factors in marriage. I think and hope that we have all of these. I know that we are both more aware of impending difficulties and much more willing to resolve them.

I feel that I have emerged from this experience with more understanding of human problems, particularly marital breakdown and loneliness. I hope that I am better able to help my patients than I was before.

mentor, some areas have to be approached delicately. Although the primary care team and consultation techniques are covered in lectures and seminars, they are much more meaningful to students when related directly and immediately to practice during the students' attachment to us. There is the risk of reducing the students' experience of family practice and replacing it with more formal—almost one-to-one—tutoring, so a happy medium must be struck. I have developed several topics, such as the contrast between primary care and most hospital care, which at relevant points during the fortnight I present on a direct teaching basis as informally as possible. I have had in the main to abandon attempts to draw the required thoughts from the student, largely because of the time this takes, especially when in some cases the thoughts are relatively sparse. Other topics crop up that require exposure as well as example, and a fortnight rarely claps without the need to discuss, for example, administration, personal stresses and strains on the GP, and the correct use of the ophthalmoscope. There is a strong temptation to bludge the post-graduate students with supposed knowledge and perception. It is therefore salutary to admit frankly defects of practice organisation, of teaching, of knowledge and abilities, and moreover to ask them for constructive criticism. After all, it is no great shakes if an experienced doctor on his own territory can impress a student in his first clinical year.

Island Practice

Prepared for the unpredictable

ALISTER D GRASSIE

As I write this article there is a force nine gale forecast for Mullin, and I can hear its rumblings starting already. Almost without reaching a conscious level of thoughts and calculations enter my head concerning contingency plans for all sorts of medical problems that may or may not happen. This is not a feeling of apprehension, but more an awakening state of readiness. I used to experience a similar feeling when, as a young casualty officer, I would arrive on duty to discover that there was a big football match on that evening. Then the chances were strongly in favour of a busy night ahead with rather predictable types of problems; tonight anything could happen, but probably won't. I am a single-handed dispensing general practitioner, with a list of just under 1000 patients, and work from my combined house and surgery on the west coast of Arann. This island has a population of about 4000. There is no doubt that my daily practice work differs little from that of any other general practitioner, but it does offer its own problems and rewards. Working in a remote area with my wife, who practises part time, attending clinical meetings and the usual information markets is a hardship that I feel more and more with time spent here. Fortunately, this is offset somewhat by our locality

Shiksha, Isle of Arran
ALISTER D GRASSIE, MB, FRCS, general practitioner

It is fair to point out that there are real problems in meeting our objectives. Apart from financial difficulties tied up with the national economy, problems for the student that are perhaps more immediately soluble include their ridiculously short exposure to general practice (roughly eight mornings in the third year), and the restricted range of exposure—no "out-of-hours" emergencies, no evening work, no on-call and little administrative experience. For the tutor, a major problem is finding time out from his practice to maintain good contact with the department, despite the enthusiasm of most tutors to be more involved. Problems for patients are not only obvious ones, such as hesitancy to give the full story in the presence of a third person, but less obvious ones, such as the families with a child with congenital heart disease being asked too frequently to serve as subjects for students' home projects—a case in point.

Given my primary aim of allowing the students to gain experience in my practice rather than teach them about it, I am convinced that I can best serve their interests by first setting my own house in order. If I am part of a practice and primary care team which is reasonably up-to-date, with a programme of reassessment and self-renewal and can still provide the traditional personal relationship of family doctor with the patient and the patient's family, then I have indeed something positive to offer my students.

I have 227 patients over the age of 65. This is almost one in four of my list and about twice the national average. Almost half of these patients are over the age of 75. Many doctors not familiar with this type of practice have a tendency to regard a job like mine as a bit of a sinecure, but these figures show the heavy burdens that our elderly population puts on my work load. Heavy responsibilities are thrust uninvited on many general practitioners in similar circumstances, and all we can do is try our best.

I have met many patients over the age of 65. This is almost one in four of my list and about twice the national average. Almost half of these patients are over the age of 75. Many doctors not familiar with this type of practice have a tendency to regard a job like mine as a bit of a sinecure, but these figures show the heavy burdens that our elderly population puts on my work load. Heavy responsibilities are thrust uninvited on many general practitioners in similar circumstances, and all we can do is try our best.

Highlands and lowlands

The geography of Arann is best described as that of Scotland in miniature, with the highlands in the north and the lowlands in the south. As in many rural areas in Britain, the weather causes problems on the roads in the winter and the visitors produce their own hazards in the summer months. Off the main roads only a few tracks are surfaced, and access has to be gained on foot in some places. My practice is centred on a coastal strip 3/8 miles long, and a single home visit to either end can take up a whole morning. It has been accurately calculated that my practice work load increases by 30% in the summer months.

Our hospital is in idyllic surroundings, overlooking Lamlash Bay, 15 miles from my home and practice centre. All the general practitioners have access to the 25 beds, which include four

The GP and the Medical Student

Students from Manchester

ROBERT ASTON

Third year medical students from Manchester University come to my practice for two weeks each. Most mornings they spend about five hours in the practice. On two mornings they attend the department of general practice at the university, and they spend one morning with our district nurse or health visitor. One of the two mornings at the department of general practice is spent in a simulated patient teaching session, using professional actors and a TV video-recorder; the other morning is spent in a small group seminar led by department staff or by GP teachers. The seminar includes social workers, nursing staff, and other members of the teaching team. The medical student's attachment to general practice is interpolated into the medical curriculum so that students continue to attend lectures during the afternoons.

The department of general practice in the University of Manchester, headed by Professor David Metcalfe, is made up of the academic department and several general practitioners who teach medical students mainly in their practices. The practices are divided geographically and functionally into "inner-ring" and "outer-ring": medical students are attached to "inner-ring" doctors during the third year (the first clinical year) and to "outer-ring" doctors during the fourth year of their course. I am an inner-ring teacher.

The academic staff in Manchester take a great interest in the fate of their students once they are farmed out to teaching practices. Tutors are made aware of the views and policies of the whole teaching team, and a detailed record of the clinical ground already covered by the students in other departments is provided. Feedback from both student and tutor is ensured by questionnaires and reports that are completed at the end of each attachment. Interaction between the teachers and the students and between academics and inner-ring tutors is provided by the small group discussions. Finally, tutors are encouraged to attend quarterly departmental meetings and regular research and clinical meetings.

The "Source Book for General Practitioner Teachers" gives clearly and concisely the overall policy of the department, suggests the best ways to educate students about general practice, and gives the aims and objectives of teaching medical students some logistic problems that may arise. In this 52-page manual are briefing notes for students concerning primary care and the various projects to be undertaken and copies of the questionnaires. It gives an unambiguous statement of what the academic staff expect of GP teachers, and what they want them to teach, and how they want them to teach it. For example, patient-centred learning is clearly contrasted with doctor-centred learning, and this is especially important because nearly all the other teaching that students receive is doctor-centred.

I imagine that most of us accept the guidelines, not least because when we began as teachers they taught us a considerable

amount about ourselves and our approach to our work in general. That the source book is intended to be an educational aid for teachers and not a statement of departmental dogma is, however, made clear, yet it is the basis on which I organise my teaching programme. It seems to me that the only way to ensure that our undergraduates are given a comprehensive and constructive introduction to general practice is if the whole department acts as a unit, and that all the teaching staff are at least loosely in agreement as to what we are trying to do, and how we propose to do it. The manual is a means to this end.

Essential to building an effective and unified educational system is the willingness of the GP teachers to take their ideas from their colleagues in general practice rather than from each other. At least initially, GPs are individualists in the main, and surely one of the reasons why we want our colleagues to be in an academic department is to provide a focus of unity and a consensus of opinion informed by continuing research and study. Without such guidance it is too easy for the tutor to teach doctor-centred medicine: "Look how well I know my patients; look how carefully I examine them; look what a lot I can do for them; look how much they like me and are grateful to me." This is perhaps not too surprising in view of the inferiority complex bequeathed to so many of us by our specialist teachers in medical school—and from my own experience of only two or three years is a particular temptation for the novice teacher. After all, think of the years before you had a student, when you weren't able to show off to anybody.

I believe that formal teaching is scarcely required and that far and away the most important aspect for the student is experiential, not didactic. If our students can observe the interaction of doctor and patient in personal relationship at a level that is approached by no other discipline, and receive with an overall tone of patient-oriented, problem-solving co-operation between patient and primary care team in the patients' own environment, then they will have an eye-opening experience, leading them to a radical reassessment of what general practice is all about.

Teaching about failure

It is, however, just as important for our students to see how much we fall short of realising our ambitions; perhaps even more important, for in which other discipline are we so successful in failure as well as success? And yet to admit our failures to the students frankly, to demonstrate how to accept failures as inevitable, and to learn from them is to teach an important aspect of our lives as doctors; for, while not wanting to turn doctoring into a "clanger club", to be able to admit "I made a mess of that" is surely an essential milestone on the road to medical maturity. Students seem to recognise the goals we strive for, see our successes as well as our failures, and happily most of them seem to find the prospect of general practice as a career much more attractive at the end of their attachment than at the beginning.

Despite the need for the tutor to serve as example rather than

obstetric beds. Absolutely every medical emergency passes through its doors, including those that are destined to require the skills and technology of a mainland unit. There is a modern well equipped casualty room, x-ray room, operating theatre, physiotherapy department, and even a "pathology come mortuary unit," where four cold stores are provided and post-mortem dissection can be carried out when necessary. This last unit also houses a library-in-embryo and a simple bench top "laboratory" for side-room techniques.

The obstetric unit is on a separate level and has a ward with four beds for antenatal and postnatal patients. There is a separate delivery room, where it is a positive pleasure to attend a woman in labour. In addition to the hospital there is a home for elderly people with 30 beds, provided under part of the Social Work Act by the local authority. With three general practitioner colleagues, a part time surgeon, and a part time anaesthetist, we staff all of these services. Visiting consultants do clinics in obstetrics and gynaecology, general medicine, ear, nose, and throat diseases, and ophthalmology, and a consultant anaesthetist provides a regular session about every six weeks. The core of the primary care team in my practice consists of one triple duty nurse, one district nurse midwife, and a social worker. They are not attached to the practice and are shared by two neighbouring practices. I also have a receptionist and a secretary, who are both part time. It is impossible for us all to sit down for a discussion over coffee every morning, but we manage somehow to communicate regularly by telephone, car radio, and bush telegraph. Communication outside the practice and with colleagues in similar set ups is far more difficult.

Last year's meeting of the Scottish Inducement Payment Practitioner Association was well attended. I find these meetings extremely valuable. Most of the general practitioners who attend work in very remote areas. Since the association concerns itself mainly with practice administration attendance at meetings is not recognised under section 63. It is therefore all the more remarkable that so many GPs turn up from far and wide at considerable personal expense. The real attraction, of course, is in discussing one's work in congenial surroundings with kindred spirits. Few of us can attend postgraduate meetings and lectures. The Scottish Association of General Practitioner Hospitals promises to provide an extremely valuable meeting point for those working in them. It is a unique opportunity to bring together practitioners from remote and urban areas alike, whose common link will be their commitment to the hospital.

Getting to a meeting

I was asked by a colleague to accompany a seriously ill patient in a helicopter flight to the mainland on my way to the first annual meeting of the Scottish Association of General Practitioner Hospitals. The helicopter was a small, single-engine aircraft, a road accident and appeared to have transversed his cord at a lower dorsal level. In addition, he had severe injuries to the face and jaw. We were storm bound, with no ferries running at all. I was caught in a very uncomfortable position, as I was engaged for my wife and another colleague to cover the practice. Having made some frantic last minute changes of plan, I was soon crouching in the back of an aircraft, receiving a severe buffeting by a heavy storm in the Firth of Clyde.

In the cramped conditions in the back of this aircraft and in poor light it would have been impossible to do very much at all if the patient had vomited. I had all the equipment necessary to deal with such a situation, but it would have been useless in the circumstances. I have no idea how the poor patient felt, but I know that I was feeling very unwell with air sickness. Providence

was on our side, however, and thanks to the expertise of the helicopter crew from HMS Gannet we were able to land our patient safely in central Glasgow on what could only be described as a filthy night. My contribution to this man's well being was therefore nominal, and full credit to his safety must go to my colleagues, who dealt with the problem from the scene of the accident to the door of the helicopter. Many doctors throughout Britain must be able to quote similar stories. It was refreshing to be able to talk to some of them at the meeting, which, of course, I could not have attended without the helicopter trip!

The "state of readiness" that I mentioned earlier is borne from an experience of problems quite unfamiliar to most general practitioners. As a dispensing doctor I am required to provide a complete range of services in a remote area, and I am required to provide a complete range of services in a remote area, and I am required to provide a complete range of services in a remote area. The "state of readiness" that I mentioned earlier is borne from an experience of problems quite unfamiliar to most general practitioners. As a dispensing doctor I am required to provide a complete range of services in a remote area, and I am required to provide a complete range of services in a remote area. The "state of readiness" that I mentioned earlier is borne from an experience of problems quite unfamiliar to most general practitioners. As a dispensing doctor I am required to provide a complete range of services in a remote area, and I am required to provide a complete range of services in a remote area.

Many practitioners, particularly in the city, are struggling for facilities to perform the kind of work that we are obliged to do here. There is a fund of research material which, with a few exceptions, remains untapped—but this is beginning to change. The difficulty of access to libraries, statisticians, royal colleges, and postgraduate centres is a big hurdle for anyone who contemplates doing research in a remote area. Clearly, more frequent contact has to be made. In the past we have had to do most of the running, but now some of our colleagues are meeting us half way by combining a visit with a holiday. Hopefully, more frequent exchanges will take place in the future, with undoubted benefit to our patients. The pharmaceutical industry is very aware of the costs of visiting a practice such as ours. I have been visited twice by representatives in the past five years. There is immense value in their visits, but our work here, and though stressful at times, the stress is not a destructive element. It is one of the many reasons we choose to remain here. Rural life is very pleasant, but inextricably bound to our work and family life. We are rarely drawn by the call of Marks and Spencer, but when we are we arrange a locum and assuage our appetite. I am convinced that we have closer relationships with our patients, but this is a claim made by many practitioners, and it is an element that is impossible to measure. When we are old GPs I trust that we will be able to write this last paragraph with the same degree of conviction.

Manchester 20
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