MEDICAL PRACTICE

Clinics in General Practice

A case of a twisted ankle

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The trainee's problem

The patient is 40 and a rather highly strung qualified school-teacher who left her job to buy an antique business. She is intermittently separated from her husband (who is not a patient of the practice) and the basic reasons for her marital difficulties are complex and sensitive. Although this may seem rather irrelevant to her present story, it explains why establishing a working doctor-patient relationship has been difficult.

The story is that the patient "went over" on her ankle three weeks ago while on a country walk. Her ankle was painful and slightly swollen at the time, and a nurse, who is a neighbour of the patient, applied an Elastoplast strapping. Ability to walk quickly returned, but the top of her foot is still hurting her, and she thinks there is an abnormal bony lump there. Her friend has again applied a strapping and told her she requires an x-ray examination. In addition the nurse—who has worked in the local casualty unit—has told the patient that between five and six is the best time to go, and also advised her to "get your doctor to give you a line."

When I examined the foot there was no evidence whatever to suggest that radiography was necessary. No local tenderness was present, there was no swelling, and there was a good, though not yet complete, range of pain-free movement. The dilemma is simple: the patient wants an x-ray examination; her friend who is "experienced" in casualty work has advised her to have one and how to get this done. I am sure she does not need one (physically) but do not want to fall out with her, especially

when she has been courteous enough to consult the practice first. What should I have done?

General practitioner's comments

When one is consulted about an apparently minor injury that occurred some days or weeks ago, and when spontaneous recovery is almost complete, there is seldom any need for an x-ray examination. One can afford to explain, reassure, and wait. There are some important exceptions—for instance, a suspected scaphoid fracture or "something in the eye" after exposure to high speed metallic particles—but for most minor injuries simple explanation is all that is needed from the established general practitioner with a patient who knows him well and trusts him. For yourself, as a trainee faced with this patient it would be more difficult. Therefore there is much to be said for referring her to casualty with an explanatory note, saving time and energy for subsequent patients. I believe this is the advice that would be given by medicolegal experts. Nevertheless, the story is well chosen because it illustrates several features of many consultations that are worth examining more closely.

Firstly, there is the special importance attached to x-ray examinations. Sometimes it seems a request for these is based on a vague belief that they will have direct therapeutic, as well as diagnostic, value. Perhaps it is confusion with radiotherapy, but more often it almost seems there is a belief that radiography has a magical curative quality. At all events, undoubtedly "failure to x-ray" ranks high among complaints against doctors. Oddly enough, failure to listen, which is generally a greater form of negligence, is a rare accusation by comparison. One must recognise, therefore, a certain limited need for radiography not strictly indicated on clinical grounds for what are called, rather pretentiously, psychosocial reasons.

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MARITAL DIFFICULTIES

Perhaps, however, she did not really come about her ankle. She is said to have complex and sensitive reasons for marital

difficulties, suggesting she may be presenting an injured ankle as an acceptable conventional reason for consultation when she is really driven to see you by her emotional problems. Mainly through the teaching of the late Dr Michael Balint¹ such cases are now widely recognised, and we should be more sensitive than we were 20 years ago to the existence of hidden problems behind apparently trivial complaints. Quite often, in such circumstances, the patient claims to have come on the advice of someone else. Take, for instance, the common opening statement: "I didn't want to trouble you myself doctor but my wife/husband made the appointment and insisted I came." It seldom rings true but one should always recognise the genuine anxiety in the statement as well as the attempt to disguise it. Although this patient claims to have been advised to come by a neighbour it may well be she is telling the literal truth. Moreover, a 40-year-old ex-schoolteacher who has gone into the antique business on her own is much more likely to be eloquent than tongue-tied. I suspect that if she wanted to discuss her emotional problems it would be harder to stop her than to start her off.

No: the more I look at the story, the more I suspect there is no more to it than meets the eye. Moreover, she came to see you conveying a ready-made line of action suggested to her by someone else—a nurse. You were told what to do, and the demand did not even come directly but was sent through the patient. Few of us are so cool and detached that we would not experience a spasm of irritation at this, although it lessens with time. The important thing to remember is not to reject a suggestion (or demand) made by a patient simply because it is presented in an irritating manner. To do so is to court disaster as the suggestion may be right. But the paramount reason for never, if possible, allowing oneself to be annoyed by a patient who is unreasonably demanding or irritating is simply that the *next* patient, who is probably the essence of courtesy and consideration, is the most likely person to suffer.

COURTESY

There is, however, one sentence in your story that intrigues me. It is that she "has been courteous enough to consult the practice first." Is it a matter of courtesy? British medicine is based on the principle of referral, but the principle is not always appropriate at casualty departments. Major road-accidents, for instance, should be transferred direct to casualty departments, and illness, certainly minor illness, should not be the concern of casualty departments, although it quite often is in urban areas.

What about minor accidents? Undoubtedly the tendency for patients to go direct to casualty departments is increasing. Between 1959 and 1971 the number of new outpatient attendances rose by 15%, but the number of new attendances at accident and emergency departments rose by 52%.² Work carried out in Newcastle^{3,4} showed that a large majority (78%) of patients who suffered minor injuries went directly to accident and emergency departments believing that "illness is for the doctor, accidents for the hospital." In small towns, equipped with a GP hospital and a considerable distance from the nearest casualty department, the general practitioners usually deal with most minor accidents themselves. They may form a large part of their work, and it is possible to gain considerable experience in and satisfaction from their management. In urban areas some general practitioners also undertake the care of minor accidents; others believe that all accidents are better dealt with in casualty departments and encourage patients to go there directly when injured or refer them if they come to the surgery or health centre. The Newcastle study showed that many patients knew (or at any rate believed) that if they went to their general practitioner with a minor injury they would simply be sent to casualty, so why not go there directly? Going directly to casualty—self-referral—is not necessarily a discourtesy, but it is a growing habit.

What should be done about it? I think more information is

needed about the amount of self-referral, the willingness of general practitioners to undertake the care of minor accidents and injuries, and the extent to which both of these vary between different areas. Then it might be possible for the directors of accident services to work out with general practitioners in their area a jointly agreed policy. If the work load of casualty departments continues to increase probably some definite policy to meet the need will be necessary; but it will not be easy to reverse the trend of increasing self-referral. Perhaps the Royal Commission should consider this.

By the way: if my assessment of this patient is correct I think I would have referred her for radiography—for "psychosocial" reasons.

Consultant's comments

Outside the casualty department of the hospital where I work there is a notice stating that the department is for people in urgent need of treatment for injury or sudden illness. Our patient with the twisted ankle might very properly have presented herself for treatment immediately after the injury but, instead, in a commendable attempt at self-sufficiency, she has been looking after it herself with the aid of the nurse, her friendly neighbour. She can now no longer be represented as in urgent need of treatment for her injury, and it would be inappropriate for her to go on her own initiative to an accident and emergency department.

Most orthopaedic surgeons provide, for good reasons, two standards of service. Immediate advice and treatment are available for patients with injuries through the casualty departments and their related fracture clinics. In contrast, routine orthopaedic clinics, often swamped by the problems of backache and arthritis, offer the patient an appointment usually only after a long delay, certainly of several weeks and often of several months.

If our patient with the twisted ankle is no longer eligible for treatment by the emergency service then also her problem is not ideally one that can be postponed to the next available orthopaedic outpatient appointment. In a case such as this where the patient has missed the bus for emergency treatment the general practitioner's role may be crucial. Patients present with innumerable aches and pains that they attribute to some injury or other. The injury is often quite irrelevant and even when responsible it may have simply provoked the onset of symptoms from, for example, degenerative joint disease. It would defeat the purpose of any accident service if the casualty department was flooded with such patients. Enough arrive already on their own initiative without more being referred by general practitioners. Where, however, the original violence was considerable and is clearly remembered by the patient, although presenting late for medical advice, she may still well be suitable for referral with a note of introduction to the local casualty department. This advice applies even when the effects of the injury appear trivial. For the sake of picking up and treating promptly potentially disabling injuries the accident service has to sift through many minor injuries, most of which may well have recovered without expert care. Where the services of an accident department are readily available the general practitioner in my view need have no hesitation in referring for further advice any patient he thinks may have suffered a fracture or disabling joint injury. I do not think our trainee general practitioner need feel embarrassed by doing as his patient wishes and giving her a note to the local casualty unit.

PLANNED VISIT

Although most casualty departments provide a 24-hour service the patient with a non-urgent complaint is not usually welcome outside ordinary working hours. In the evenings, at nights, and at the weekends staffing levels are reduced to those

needed to cope with new emergencies only. A planned visit to the department as this patient intends should whenever possible be made during office hours though one may have sympathy for the patient who turns up in the evening so as to avoid missing work or because of home ties with children during the day. Nevertheless, if the department is busy with an acute emergency when they arrive they may well have to wait until those patients with more urgent conditions have received attention.

A partial tear of the lateral ligament of the ankle is best treated by immediate steps to limit swelling—an elastic supporting bandage or cold compresses. Continued use of the foot is to be urged. If mismanaged, immobility and excessive exudation cause a diffuse deposition of fibrous tissue in the neighbourhood of the injury and painful limitation of movement. Deliberate exercises are then needed that many patients can do successfully themselves, although for others the encouragement and supervision of a physiotherapist are desirable. In the late stages manipulation under anaesthesia can be dramatically helpful.

Instead of tearing perhaps a few fibres of the anterior talo-fibular ligament, the ligament under tension may pull off a small piece of bone from the lateral malleolus or from the neck of the talus. Such a flake fracture is of no more clinical importance than the uncomplicated ligament tear. The detection of the fracture by radiography might even occasionally act against the patient's best interests if those responsible for treatment are overimpressed by the finding and equate "fracture" with "plaster", and thereby overtreat the injury. The malleoli are easily palpated. If there is no major tenderness or swelling over either of these bones there can be no major malleolar fracture. I am sure there is no physical indication for radiography of this injured ankle.

We do not, however, treat injuries, we treat patients. It is all too easy for an over-anxious patient to misinterpret bland reassurance by the doctor as unwillingness to take her complaint seriously or to go to any real trouble. It may be far more economical to put on an impressive show of strength at the first consultation and satisfy the patient in one move than to hastily attempt reassurance and have her repeatedly and unhappily returning in the future. I would have no hesitation in asking for the radiographs she expects so that she will have full confidence in my eventually spoken opinion that the injury is not serious. And it is, of course, just possible that the investigation will reveal something quite surprising and relevant.

Postscript to the problem

This patient was referred for radiography—which gave, as predicted, normal results. The consultation with the trainee, however, had lasted a very long time, and the next patient had complained to the receptionist about the delay. The potential for a tense morning was obviously developing; fortunately the trainee had the ability—essential for the budding general practitioner—to keep a cool head, and all settled down amicably.

References

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- ⁴ Holohan, Ann, M, Newell, D J, and Walker, J H, *The Hospital and Services Review, 1975*, **71**, 80.

Medical Education

On training tomorrow's doctors: the Newcastle curriculum revised and reconstructed*

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In an era when knowledge is ever increasing and patterns of postgraduate training and medical practice are constantly changing the responsibility of medical educators has never been greater. Certainly the medical schools and licensing bodies are no longer required to produce on graduation a "safe doctor"; but they should provide a training on which the clinical experience of the preregistration year and the fruits of subsequent vocational training can be superimposed.¹ Nevertheless, for those intimately concerned in curriculum planning at a time

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of financial constraint, the problems of providing a medical training that is balanced yet comprehensive, scientifically adequate yet clinically relevant, and intellectually challenging without stifling initiative presents increasing problems. Fortunately, the British medical schools, despite current unease in the National Health Service, continue to receive far more applications from academically outstanding and well-motivated young men and women than they can possibly accept. Without question those students who are admitted usually have the intellectual capacity, application, and dedication to enable them to cope with whatever course we offer them, however demanding it may be. This paper aims to show how medical education in Newcastle has been shaped in the last 15 years and to describe some recent changes.

Growth in the medical school

In 1971, when I was appointed dean of medicine, we accepted 100 students a year into the second year of medical curriculum, 95 usually being admitted direct from school and five coming from