Schedule for medical students in our practice

	Week 1				Week 2				Week 3				Week 4			
	M	T	W	Th	M	T	W	Th	M	T	W	Th	M	T	W	Th
Monday			Dep. of General Practice				Dep. of General Practice				Dep. of General Practice				Dep. of General Practice	
Tuesday			Surgery calls				Surgery calls				Surgery calls				Surgery calls	
Wednesday			Surgery calls				Surgery calls				Surgery calls				Surgery calls	
Thursday			Surgery calls				Surgery calls				Surgery calls				Surgery calls	
Friday			Surgery calls				Surgery calls				Surgery calls				Surgery calls	
Weekend	As appropriate				As appropriate				As appropriate				As appropriate			

M—Morning 9.00-12.30. A—Afternoon 2.00-4.00. E—Evening 4.30-6.30.

patients in hospital, if appropriate, or for reading. These last few days are less structured and provide time for the student to follow a particular interest or to experience some aspect of general practice so far not covered.

The final seminar on the Friday morning is an important part of the entire exercise. The 12 students in the group present a brief account of their experiences with a description of the "host" practice, and are encouraged to be both honest and critical. At the end of the student's attachment to the practice a written confidential assessment of his performance is given to the department that covers such points as attendance, dress, relationship to both patients and staff, application, and enthusiasm. This provides the foundation for his overall assessment in the general practice attachment.

What is gained?

What do the students gain? During the time spent in surgery and on home visits the clinical and sociomedical objectives are hopefully fulfilled. The time spent during tutorials and informal discussions fulfils the vocational objectives. During his undergraduate career the student meets a highly selected patient population, and most of his teaching is centred on this. His time spent in general practice helps to redress the balance and, it is hoped, provides him with a sense of perspective. He is able to see how illness in one member of the family can have a profound effect on other family members. His time spent with other members of the health team gives him an insight into the sort of expertise that is available in the community and enables him to assess what is meant by "community support," including the limitations. By spending time with all the doctors in the practice he can compare different styles of consultation and patient management. His time spent in the front office enables him to

assess the medical records, the advantages and disadvantages of repeat prescribing, the handling of telephone calls, and some of the difficulties in being at the patient practice interface. As in other attachments where he is treated as a house physician or surgeon under supervision, he is offered the chance to run his own surgeries. The patients are not specifically selected, though patients who are obviously inappropriate are seen by the supervising doctor. In these surgeries he sees the patient alone and makes the initial decisions on diagnosis and management. The patient is then seen by the general practitioner along with the student, and any prescriptions or certificates are signed by the doctor. If, however, the student is unwilling or unduly apprehensive or if the patient does not give his consent then the exercise is abandoned.

And what of the patients? The student is always introduced before each patient contact, and the patient is informed at the reception of the student's presence. If the patients wish to be seen alone the doctor is told beforehand. It is rare, however, for the student to be asked to leave the consulting room; indeed, most patients enjoy their presence, which at times may be used to advantage since while explaining a condition or decision about management ostensibly to the student an appreciable "fallout" radiates to the patient.

And what of the doctor? The experience is a dynamic one, and often the doctor learns from the student. The preparation required forces the doctor to think logically about his job and how he hopes to convey his thoughts to the student. This applies to all who are concerned in the teaching programme. The final seminar is always fascinating. The students are sent to many and varied practices and bring back with them a tremendous range of experiences. This always provides for an interesting discussion and no one has been known to pull punches. It can be a very rewarding and a very humbling debate, but it is a valuable and honest one, which all seem to enjoy.

FACTORY LABOUR Before the ingenuity of the mechanic had called into existence those potential instruments of manufacture that bring forth wealth in unbounded profusion, and cast into shade the former humble and unassisted operations of man, the different fabrics of the country were produced in the cottage of the artisan. Then it was that industry was passed in innocent recreation, until the system was so far defaced as to justify the appropriation of its powers, not as a matter of gain, but to qualify it for its part in life. Acknowledging the responsibility of a parent a workman of those days would have spurred the idea of consuming, in its youth, the manhood of his child, or of coming into the world, in its infancy, to be a burden on the condition changed. Machinery was introduced, and it brought forth abundantly. The application of steam was effected, and its mighty energies multiplied the power of man. The cottage was swept away, and a social hearth made desolate. . . . It was soon discovered that, as direct strength was not required, women might be serviceable; and, second-

ly, for this employment they abandoned their household labours. Uniting in the pursuit of wealth, the employer failed not to observe that a child, nay, an infant, (and that without distinction of sex), might supply the place of an adult, and the fields and playgrounds ceased to resound with the noisy hilarity of youth. But the evil ended not here. Individuals, whose thirst for gold was insatiable, gradually extended the period of labour. Exaction began reaction to such an extent, that not only did the term of exertion frightfully increased, but the intervals for refreshment were at first curtailed, and afterwards, in some instances, abrogated altogether, food being taken as the opportunity might offer, and the hours of the day were divided into shifts. It mattered not that this abuse had a local origin: having been commended by a few, others were constrained to follow in their wake, by the coercive fear of competition. (John Maynard Keynes, *On Factory Labour*. (Read before the Westminster Medical Society). *London Medical and Physical Journal* 1833; new series 14:109-20.)

has the opportunity to meet consultants, with all the benefits which follow. Admitting patients to hospital can be a prolonged affair, with ambulances taking about half an hour to arrive—a very long time in an emergency. Since the county ambulance controls were centralised, phone requests have, because of the long distances, become very expensive.

Weekly postgraduate sessions take place at lunchtime at two district hospitals, but attendance at these is out of the question because travelling alone takes one and a half hours. For the same reason, my attendance as a member of the district medical committee became a problem and I had to resign.

The luxury of most weekends off duty enjoyed in some multipartner practices is foreign to us. Being only a two-man partnership and the neighbouring practices too far away for practice cover arrangements, we have no alternative to duty every other weekend. When single-handed I was permanently tied to a telephone and never more than a reasonable distance from the practice. Holidays were a rare luxury in those days.

Locums are hard to find. Hospital junior staff cannot help out because of distance, and a retired practitioner living in the vicinity can be, and in our case is, a godsend. The cost of a full-time locum is daunting, especially for the single-handed practitioner. In rural areas there is the added high motoring cost and perhaps also hotel accommodation to be taken into account. A new locum also presents with the time-consuming problem of acquainting him with the area—often best solved by arranging a stand-by local guide to accompany him on visits.

Dispensing is an important activity in this practice since all patients are on the dispensing list. Although there are no

chemists within 10 miles and no village has a population over 400, we are well aware of the repeated threat by pharmacists to take over all doctor dispensing and firmly support the proposed compensation fund that will come into force when the Clioher recommendations are implemented. The cost of drugs today is so high that a great deal of capital is tied up maintaining a reasonable stock of drugs. It is important therefore to ensure a quick turnover by dealing as we do with a dependable wholesaler who delivers frequently. It is necessary to keep up to date with the latest prices and labelling recommendations, not to mention child-resistant containers and closures. And one really wants to keep up with the latest prices, for example, the *Chemo and Druggist* price list is essential.

Collecting prescription charges is a real chore, especially now that they have exceeded one pound. With so much money being collected, security dictates its regular transfer to our girobank account. After the surgery had been broken into twice we were driven to counter measures, including installing an intruder alarm and extra fittings on windows and doors. Our cabinet of controlled drugs has not been raided since.

Having described some of the problems of rural practice, I would stress that these are far outweighed by the pleasures such a practice brings. First and foremost it is as close to traditional family medicine, with its attendant satisfactions, as it is possible to get these days. One particularly remembers those times when, without help close at hand, one successfully managed a tricky situation. The incomparable beauty of the scenery in all its seasons and particularly the wild life of moor and river are among the things which lighten and enrich the daily round.

Thinking About the Unthinkable

Service committee hearing

ZOË KENYON

When I returned from a winter holiday one Tuesday in January I found the usual list of messages awaiting me. Among these was a suggestion that I should during the week call on a patient whom I had known for several years who had an acute exacerbation of her chronic respiratory disease. My partner had seen her the previous day and prescribed expectorants and antibiotics. On that first morning after my return from holiday the husband of this patient—who was not on our list but was renowned for his eccentricities—came into the surgery to be sure that I would call later that day. He reappeared in an agitated state at midday to say that his wife if not already dead soon would be. Immediately we left together for their flat a few hundred yards from the surgery. On arrival it seemed to me that my patient had been dead for at least an hour. Routine

procedures were completed, sympathetic remarks made, and I continued with my rapidly accumulating work.

About seven weeks later we received from the family practitioner committee a letter of complaint from a stranger living five miles away. She claimed to be concerned about the poor medical care received by acquaintances of her husband.

(Complaints may be made by (i) the patient; (ii) someone authorised by the patient; (iii) someone acting on behalf of a patient who is too old or too ill to make the complaint himself; (iv) anyone, authorised or not, if the patient had died or is under the age of 18 years; (v) the family practitioner committee in matters concerning the administration of medical services provided by the practitioner.)

We were accused of breach of service, having "failed to attend when requested"—the letter having been put through our letter-box at 4 pm on Sunday just under a notice giving directions for emergencies. We had "failed to admit the patient to hospital" when the husband asked—although there was no clinical indication for this—and I had "not responded to a plea for an urgent visit" on the Tuesday morning.

Thus we found ourselves facing many months of time-consuming bureaucratic and antiquated machinery, which dates

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Country Practice

Problems of rural practice

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That the problems of rural and urban practices differ widely is to be expected and quickly became apparent to several vocational trainees who visited this practice. Working in urban training practices, they have been surprised to see the contrast not only in practice organisation but also in clinical content, with noticeably more interesting pathology and much less certification of trivia.

The more important problems peculiar to rural practice arise from relative isolation, difficulties in obtaining off-duty cover, the paucity and cost of locums, and dispensing. This practice, which is as rural as they come, is, I believe, no exception. The practice is a partnership of 200 acres and lies astride the Derbyshire/Staffordshire border in the heart of the Peak District, the terrain ranging from lowland pasture to heather-covered moors. Adjoining the moors is an extensive area of marginal land—boggy and reedy—a "breeding ground" for farmers' lung. We have a very high incidence of this disease and must be constantly aware of the possibility among farming patients.

The weather in winter leaves a great deal to be desired. It is wet, cold, and windy. The Peak District has more than its share of snow, usually with substantial drifting. Motoring can be a real problem in winter, and there are always those rutted pot-holed farm tracks to contend with all the year round. A four-wheel drive vehicle is obviously preferable but can be expensive to run, and even these will not get anywhere. On one memorable occasion my Land-Rover became stuck in a narrow lane full of deep snow, and it took 24 hours to be released. Even a helicopter lift can, and has been, thwarted by severe blizzard conditions.

Because of these difficulties associated with terrain and weather the area in which the practice lies is classified as a "special district," which means that all patients attract an extra payment from the rural practices fund. This is just as well because these conditions, together with the huge number of miles that one has to travel, result in very high motoring expenses—cost of petrol, wear and tear, and a depreciation double that of the average car. Regular changing of cars, essential for reliability, can be a considerable drain on capital resources. Furthermore, it is always necessary to have a second car in reserve.

Convenience of the patients

We have one main surgery and two branches officially designated "outlying consultation facilities." Since they are located in private houses these branches are obviously limiting as far as clinical examinations are concerned. One of these, six miles away, is used four days a week, and we maintain a

stock of the more frequently used drugs there—locked for security reasons in a steel cabinet. Notes about patients seen in the branch surgeries are written in a daybook for later transcription by the practitioner in the main surgery.

Because of the distance many patients have to travel to the surgery it has always been felt that they should have the opportunity of attending whenever convenient. We do not, therefore, have an appointment system, and this of course has the disadvantage of not being able to plan the work load. The rate of visiting is known to be higher in rural areas, and over the past five years the highest proportion of visits per total patient contact was 20%. In three of these years December was the busiest visiting month.

There is no doubt that rural communication would be a great asset in this practice, but many problems arise in such hilly terrain. Until a few years ago the ambulance service was unable to cover every part of Derbyshire, and it was only after erecting many relay masts that it overcame all "blank spots." Unfortunately, the service would not agree to the local medical committee's request to allow general practitioners to use their aerial network. We resort to the age-old method of leaving a list of houses where we may be contacted by phone. Fortunately, telephones are becoming quite commonplace, even in the most rural households.

Professional isolation

Three local "cottage" hospitals, providing casualty facilities and general practitioner beds, lie 10 to 11 miles from the main surgery. Participation in the work of these is precluded by distance, but we do attend confinements in three GP maternity units, believing that having cared for the patient antenatally we should be present at the confinement. These occasions, together with purposeful visits, require much travelling time and can be disrupting during normal working hours.

A satellite laboratory, 11 miles away, receives our pathological specimens, most of which are then forwarded to its parent for investigation by more sophisticated techniques. It is here that we run into difficulties since the majority of specimens have to be sent by post, which rules out investigating those required to be as fresh as possible. Sometimes, however, we or the patients deliver specimens to the laboratory, but this is a haphazard arrangement that cannot be relied upon. The Derbyshire Local Medical Committee has advocated a pathological collection service in response to rural practitioners who felt strongly that such a service was necessary. Our representations met with the usual response, however—the ever-present lack of finance.

The three district hospitals, which we use fairly equally, are located 25 to 28 miles away. One of these provides a very good and varied extension of its outpatient service in one of the local hospitals in addition to excellent open-access radiology facilities, including contrast media x-rays. One of the great disadvantages of an isolated rural practice is that visits to local or district hospitals are inevitably few and far between so that one rarely

from 1911 and is very cumbersome. Only for the most florid breaches does it seem to be a valuable disciplinary tool. For the rest of us it is an added anxiety in our lives, with no rewards for either side.

My reaction

My first reaction on receiving a complaint was of slightly irritated incredulity swelling to complacent self-righteousness. Surely "they" knew that the complaint was unjustified, made against me—law-abiding, "respectable," brought up to keep the rules, to conform, a trained and member of a royal college. How could I be in breach of my terms of service!

I was unfamiliar with this formal and rather pompous approach adopted by the establishment, and when a reply eventually shaped itself in my head it was instantly returned by the far-sighted administrator of our family practitioner committee. I did not realise that all correspondence was passed on unpurged to the complainant, and so my fairly terse and explicit descriptions of the unhappy domestic situation my patient had tolerated for some years were inappropriate. The administrator advised me to consult the secretary of the local medical committee or the defence union, or both.

With sighs of exasperation (for the complaint seemed to be a malicious one brought by a mysterious outsider) I turned to the secretary of the local medical committee, a quiet, thorough, and frighteningly non-partisan figure, while my partner consulted the local medical defence society.

We searched our records and our memories and made copious notes. The secretary of the local medical committee talked adult to my adult when I needed him to talk nurturing parent to my complying child. It was one thing to have the practice team back me up, quite another to hear the reassurances from an objective, informed outsider.

At this stage self-doubt wriggled into my thoughts. Might different pathways have been followed? A patient had died. Was her death avoidable (even though I knew she had multiple chronic pathologies)? Perhaps the bereavement could have been managed more positively. The widower was never a patient of ours, and we always regarded him as eccentric and "difficult," so no positive effect was made by me to console him in the weeks after his wife's death.

In the light of the original complaint (that we failed to visit when requested) we reassessed practice procedure. We examined our notice boards, analysed the management of routine requests for visits, worried about leaving adequate notes when a partner goes on holiday, and thought yet again about our attitudes to the chronic well-criers. It seemed that this was audit, alive and well and nurtured by the complaints procedure.

Effect of the hearing

The process leading to an official hearing is prolonged, routine tasks take up much of our day, and so replies to the family practitioner committee tended to go to the bottom of the "must be done soon" tray. During the time between submitting our "informal" response and hearing there was to be a medical services committee hearing there was an almost imperceptible undercurrent of unrest and even fleeing suspicion. I could no longer offer my old ally at the family practitioner committee by his first name, and who was the mysterious complainant? Did other members of the family know that a complaint had been made? I wondered if other patients (neighbours responsible for leaving the original request for a visit) were deliberately consulting other practitioners with names similar to the complainant or living in her area were viewed with momentary suspicion.

During the prolonged preliminaries a near neighbour had an

infarct that required close contact and support from the practice, but no mention was made of our claim. Did we collect, or was it really of so little importance to them? In retrospect I am sure that they were quite unaware of the magnitude of the wave created by the complainant. Even now, months after the event, I cannot explain the complainant's behaviour. She was a complete outsider in her mid-thirties, neat in appearance, articulate but not highly educated, and had a tendency to misuse our jargon; throughout the hearing she was oblivious to the forbearance and increasing exasperation of some of the committee.

While I ruminated, my partner accurately and quietly stated the facts and got on with her work. The effect on the ancillary staff, however, was not so straightforward. They were quick to defend our system, vociferous in our support, and in fact so fiercely loyal that in other circumstances they might have been accused of "closing ranks." Despite this certainty that we were wrongly accused, the approach of the formal hearing date had an adverse effect on them. Apprehension at having to participate in a formal procedure and unfamiliarity with the surroundings and process contributed to their unease. As they were disturbed and anxious while waiting to be called as witnesses, so I was angry that they should be distressed in any way on our behalf. We all drew considerable strength from the secretary of the local medical committee, who arrived early, explained the procedure in detail, and made most welcome soothing noises.

The hearing was a challenge, something between an interview for a much coveted job, an oral examination, and being called to the head's study for some unspecified sin. Members of the committee were introduced (though we knew most of them), and at last, after 18 months, we were underway. The evidence was given and conclusions drawn.

Although my partner and I both felt confident at the end of the hearing that there was no case to answer, we had to wait another two months for the official decision to pass from one committee to another. During this time it was most difficult for our receptionists to maintain a dignified silence in the neighbourhood, for unlike us they had to shop in the practice area, wait outside local schools for their children, and so on. They were exposed to the ripple of gossip that can hurt the reputation of the practice, and it was hard for them not to leap to our defence in the market place.

There is no way in which we can retaliate, and there is no legal remedy in respect of defamatory statements made by a complainant. (Complaints to family practitioner committees. Medical Defence Union, June 1975.) A notice in the local newspaper proclaiming our innocence would hardly be appropriate. We can only continue to practice as usual and try to be self-critical and aware of our own vulnerability.

During the year 1 April 1981 to 31 March 1982 there were 51 complaints against general practitioners concerning breach of contract made to our local family practitioner committee. Of these, 30 were settled by office procedure, and only 10 went to the medical services committee official hearing (one is still being processed). Ultimately only two were found to be in breach of contract. During this same period 22 inquiries about complaints procedure were made to the local community health council, but only eight complainants contacted the family practitioner committee.

It is interesting to speculate how many patients are dissatisfied with their medical care, and how many would complain if they were familiar with the methods available. Some are deterred from taking any action by the attitudes of first contacts, some are reluctant to become entangled in bureaucracy, others are cynical about the profession closing ranks, and some, even today, are unaware of their rights as users of the National Health Service.

We are unable as individuals to assess the standards of medical care given by other doctors and can only draw conclusions from very subjective patient comments. Certainly standards vary, but how close to a medical service committee hearing do we all come at sometime in our professional lives?

"Let he who is without sin cast the first stone."

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