PRACTICE OBSERVED

Practice Research

Newcastle vocational trainees 1976-80: are they doing the work they wanted?

NEWCASTLE BRANCH OF WOMEN IN MEDICINE*

We are a group of women who are concerned with the problems that women may have in finding posts in general practice. As the number of women vocational trainees grows these problems are going to occur more frequently. We think that assumptions are made by career advisers and by general practitioners who are looking for partners about the kind of work women doctors want and are able to do. These assumptions affect the choices that are open to women and the decisions they make. We decided to find out what the women who were in the Newcastle vocational training scheme from 1976 to 1980 were doing now.

We have found only one similar study, which was done before the Vocational Training Act was introduced. In 1978 Dr John Hasler surveyed 40 women and 40 men who had completed a training year in general practice between 1976 and 1978. Ninety per cent of the men who had wanted to enter general practice as principals had done so, and none was unemployed. Only 45% of the women who had wanted to enter general practice as principals had done so, and more than half of these were part time; 25% of the women were unemployed. These doctors were at various stages in their training, and not all were members of a formal vocational training scheme.

We devised a questionnaire to find out how many women who had completed the Newcastle general practitioner training scheme had had difficulties in obtaining the work they wanted, what these difficulties were, and the solutions they found. To compare women's experiences with men's we sent the questionnaire to all the vocational trainees whom we could trace who had completed the Newcastle scheme between 1976 and 1980 (125 out of 133 doctors). Of the 125 questionnaires sent, 101 (81%) were returned; 70 (69%) by men and 31 (31%) by women. This compares with 73·7% men and 26·3% women who had completed the vocational training scheme in the five years studied. Table I gives details of the doctors' marital state, number with children, and type of work they were doing.

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Expectations on leaving the scheme compared with present work

We asked doctors what had been their ideal choice of work immediately on leaving the scheme and what work they were now doing (table II). Ninety seven per cent (68) of the men were doing the kind of work that they had wanted to do on leaving the scheme: 91% (64) were working in full time practice. Of the six not in full time general practice, four were in other full time medical work, and the other two had not found the kind of work that they had wanted.

Sixty five per cent (20) of the women were doing the kind of work that they had wanted on leaving the scheme. This included full time general practice, part time general practice, and childrearing. Eleven were full time, five were part time, three were childrearing whole time, and one was working abroad.

Doctors who were not doing the work they had wanted

Two men were not doing the work they had wanted. One was working as a locum in general practice abroad, and the other was a locum in general practice in Britain. Eleven women were not doing the work they had wanted. We tried to analyse the reasons for this by asking whether (*a*) their circumstances had changed, (*b*) they had changed their minds about what they wanted, or (*c*) they could not get the kind of job they wanted.

or if they were clear, were easily put off by lack of success. Obviously it could be argued that it is hard to plan when pregnancies cannot be perfectly timed, attitudes may change after having children, and the needs of spouses may also change. It seems likely, however, that at least some of these women would benefit from discussion with an adviser who has personal experience of these problems (*a*) to clarify for themselves their own aims in general practice in the short and long term; (*b*) to sort out their own particular views and feelings about having children and the best way to care for them; and (*c*) to be encouraged to persist in pursuing what they want, in the knowledge that many women obtain it.

Other factors

Geographical area—The results of our survey showed, as expected, that women are much more often influenced by their spouses' employment when considering where they will work than men are (table IV). This obviously limits their own scope when looking for work and makes it harder to find the job they want.

TABLE IV—*Number of doctors influenced by spouse or other member of household in choice of geographical area*

	No (%) of men	No (%) of women
Yes	18 (26)	22 (71)
No	49 (70)	7 (23)
No answer	3 (4)	2 (6)

Satisfaction with working hours—It is accepted that women have conflicts between domestic commitments and work outside the home; we wished to find out whether this is also true of men. We asked how satisfied doctors were with their current working hours (table V), and what other demands there were on their time. We found that nearly half the men would have preferred to work fewer hours. Of these, most were full time GPs. The reasons they gave were to spend more time with their children and on hobbies. Duties out of hours were frequently mentioned as burdensome. Only two men, however, were prepared to be called part timers (table VI), suggesting that there is some stigma attached to the label "part time."

Satisfaction with present practice and hopes for the future—This section showed a quite important difference between men and women in their level of job satisfaction as measured by their willingness to stay in the job for life (table VII). Eighty three per cent (58/70) of men and only 35% (11/31) of women were sufficiently satisfied to remain in their current post for the rest of their working lives. From the comments made by the women, this reflects not only their changing requirements with changing domestic commitments but also the quality of practices that they were working in. Four of the full time women did not want to continue for life in their present practices—three because they felt that the practices were unsatisfactory—though they did want to continue in full time work. Three of the 11 women (27%) in full time general practice were in teaching practices (either undergraduate or postgraduate) compared to 35/64 men (55%). Seven out of 12 women (58%) in part time general practice were in teaching practices.

TABLE V—*Satisfaction with present working hours*

Would prefer:	No (%) of men	No (%) of women
More hours	2 (3)	1 (3)
Fewer hours	30 (43)	3 (10)
Same	36 (51)	22 (71)
No answer	2 (3)	5 (16)

TABLE VI—*Ideal work 10-15 years from now*

Ideal work 10–15 years from now	No (%) of men	No (%) of women	Current work of women: FT	PTP	PTA	OMW	CR
Full time principal (FT)	65 (93)	12 (39)	6	4	1	1	
Part time principal (PTP)	2 (3)	14 (45)	2	5	1	4	2
Part time assistant (PTA)		1 (3)	1				
Other medical work (OMW)	2 (3)	3 (10)	1	1			1
Childrearing (CR)							
No answer	1 (1)	1 (3)	1				

TABLE VII—*Number of doctors wanting to remain in present work for life*

	No (%) of men	No (%) of women	Current work of women: Full time principal	Part time principal	Part time assistant	Other medical work	Child-rearing
Yes	58 (83)	11 (35)	6	5			
No	11 (16)	19 (61)	4	5	2	5	3
No answer	1 (1)	1 (4)	1				

Ideal work 10-15 years from now—With one exception, all of the women who are not working as principals in general practice hope to be working as principals in future, two full time and seven part time. The general trend, therefore, is for women to want to move back into posts as general practitioner principals and work more in future (table VI).

Conclusion

We did this survey to find out the sort of problems that women encounter in obtaining work after completing the Newcastle vocational training scheme. We felt that there were commonly held misconceptions about what women are doing and what they actually want to do, and we wanted to clarify this.

Most women who completed the vocational training scheme intended to work as principals in general practice. At the time of the survey all the women were working either in medical work or full time childrearing (10%). It is commonly supposed that women want to have part time work if they have children. Our survey showed that women with children are as likely to want to work full time as part time. In fact, as many mothers work full time successfully as part time. Nearly half (8/17) of the women with children wanted to work full time, and nearly half (5/11) of the women working full time had children.

From this it is obvious that there is no one solution to the problem of combining work and family life for women. Some women would wish to work full time while their children are young; others would prefer to be at home for some or all of that time. Changing personal circumstances may lead to changes in job requirements, but this is not inevitable.

The results of our survey showed that it seems to be difficult for women to get the kind of jobs they want. Only 65% of women in our sample were doing the work that they originally wanted compared to 97% of the men. There are many pressures on women to compromise and accept less than they had hoped for. This is reflected in the fact that the women made fewer applications for jobs than the men and took jobs with which they were not fully satisfied. The pressures include geographical limitations, the needs of spouses and children, the tendency for the husband's job to take precedence over that of the wife, and the attitudes prevalent in society towards women and work. This last point is exemplified both by general practitioner trainers and by established practices looking for partners, who

Neither of the men had been able to get the kind of job that they wanted. Of the women, four said that they could not get the kind of job that they wanted, and seven said that their circumstances had changed. In this latter group it seems that the discrepancy between original intention and current work was due to compromise with circumstances rather than a positive decision to change direction. None of the women gave a change of mind as the only reason for not doing the work they had originally wanted.

Looking at the 11 women more closely, seven had wanted full time work and were not doing it at the time of the survey. Two of these said that this was because they could not get the kind of job they wanted, and the other five because of changes in personal circumstances. Only two of these five had children. For the other three marriage alone seems to have been the reason for settling for part time work.

The remaining women had originally wanted part time posts as general practitioner principals. Two could not get the job they wanted, and the other two gave changes in circumstances; in fact both had decided to have children and decided that part time work was too much. It should be noted that although these women may have changed their expectations due to personal circumstances this occurred before they entered a post, and there is no evidence that they changed their commitment once they had started a job.

Nobody wanted to work as a clinical medical officer in family planning or child health. Four women were doing this in addition to childrearing as an alternative to the general practice posts they had hoped for.

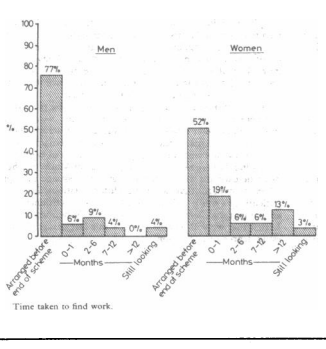
TABLE I—*Details of doctors who were trainees in Newcastle 1976-80: marital state and number with children*

Type of work	Women: Married: No with children	Women: Married: None	Women: Single: No with children	Women: Single: None	Men: Married: No with children	Men: Married: None	Men: Single: No with children	Men: Single: None
Full time principal in general practice	5	2		4	47	11		6
Part time principal in general practice	4	4		2				
Part time assistant in general practice	1	1						
Other medical work	4	1			3			3
Non-medical work, including childrearing	3							

TABLE II—*Comparison of work wanted on leaving the Newcastle training scheme with present work*

Type of work	No (%) of men: Wanted	No (%) of men: Doing	No (%) of women: Wanted	No (%) of women: Doing
Full time principal in general practice	64* (91)	64* (91)	18 (58)	11 (36)
Part time principal in general practice			8 (26)	10 (32)
Part time assistant in general practice			1 (3)	2 (6)
Other medical work	6* (9)	6* (9)	1 (3)	5 (16)
Non-medical work, including childrearing			3 (10)	3 (10)
Comparison of women and men doing their original choice of work				
Full time principal in general practice		64		11
Part time principal in general practice		0		5
Part time assistant in general practice		0		0
Other medical work		4		1
Non-medical work, including childrearing		0		3

*The figures do not represent exactly the same men.



Time taken to find jobs and number of applications made

Seventy seven per cent of men (54/70) had arranged their jobs before their training ended. This compared with 52% (16/31) of the women, which included the three women who were childrearing full time and had decided to do this before leaving the scheme. The figure shows how long it took to find work. Similar proportions of men and women got jobs after fewer than five applications had been made. For most of the men these seemed to be the jobs that they wanted. This was only true of 59% of the women (13/22), of whom six were full time principals, six part time principals, and one was working abroad (table III).

TABLE III—*Number of job applications made*

No of applications	No (%) of men	No (%) of women
≤5	55 (79)	22 (71)
5-15	8 (11)	4 (13)
>15	7 (10)	1 (3)
Not applicable	0	4* (13)

*These included the three women childrearing full time.

Only one of the 11 women not doing the work they originally wanted had made more than five applications. Of the four who gave not being able to get a job as the reason that they were not doing the work they originally wanted, none had made more than five applications. In contrast, of the two men who could not get the jobs they wanted, one had made 30 and the other 90 applications.

These 11 women seem to form a group who were not absolutely clear what they wanted in the short term on leaving the scheme,

tend to have narrow views about what are the right jobs for women. It is imperative that careers advisers and future GP colleagues do not have preconceived ideas about the kind of work women want and are capable of doing. Should medical unemployment become a reality it is clear that these discriminatory views will adversely affect job opportunities for women. There is no evidence that training practices are setting an example in taking on full time women partners or putting them forward as trainers. Indeed, the results of our survey suggest that the opposite is the case.

Perhaps the point of greatest practical value to women starting a career in general practice is that their aims can be achieved. This is made easier by having a clear idea at the start of what these aims are and requires perseverance in the face of lack of early success. Women should be helped by sympathetic and supportive careers advice at all stages of their training from women who have had practical experience of the problems likely to be encountered.

We have concentrated on the problems women have in finding work, but the results of the survey have also raised some other points. Men also require greater flexibility at work and would often like to work less and spend more time with their families. They, too, are constrained by expectations of a man's role at work and their traditional family roles. Investigation of these areas will probably provide the major contribution to improving job satisfaction for both men and women.

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Thinking About the Unthinkable

Divorce

The incidence of divorce has reached about one in three marriages, and medical marriages are no exception. Divorce, by definition, is disruptive, the amount of disruption varying according to circumstances. To a general practitioner this can create many problems, both practical and emotional. The general practitioner is concerned in human relationships and interactions; counselling is becoming a more important part of medicine. He tries to remain objective in his management and hopes that his advice will be heeded, but he may still fail in his own relationships. Is this because he becomes too involved in his work that he does not see the problems at home? Is he too objective in his attitudes so that the subjective problems are not recognised? Does the fact that he has a very busy professional life mean that he loses tolerance at home?

Marriage is a partnership, two people committing themselves to each other to share all the joys and difficulties of life. It is a total commitment and still largely given on a religious basis. Life is never smooth, but a married couple should learn to cope with the problems together. Probably the most important factor is trust. It is extremely difficult to maintain a marriage on suspicion, and abusing such trust is a dangerous pastime in any relationship.

When any relationship breaks there are always personal traumas, and mine was no different. The emotional involvement in marriage is deep and trusting, and this cannot readily be cast aside, particularly if your wife rejects you. There is a marked difference in the emotional reaction between the breakdown of a marriage and death. In death there is a finality and it occurs when there is still love and happiness in the marriage; in marriage breakdown animosity and hatred can, and usually does, replace love.

When my wife first left me for another man I felt rejected, humiliated, and a social outcast. As in many other marriage breakdowns, my wife preferred the company of a good friend of ours. Deceit had built up in the final weeks of our marriage without my realising it. However, as I still loved and trusted her, I was unaware of the true motivation.

I was suddenly told that she was leaving me to go to her mother's "to think things over" and would leave me to look after the children. As this was timed for the beginning of the school holidays and a very busy time in the practice, it did not help me in a very difficult emotional period. It was only later that I discovered that there was a large bouquet of flowers awaiting her arrival at her mother's from the boyfriend. I also learned that they would be setting up home together, after he had left his wife. In the middle of this mix up I had a son and he had two sons who would have to continue to go to a small school together and work closely with each other, yet their parents were in an emotional turmoil and had lost their own security.

I think that the rejection was hardest to accept. What had I done wrong? What had the other fellow got that I had not? What was it about me that she no longer loved? What was the future to be? What would I do without that person I loved and was the mother of my children? How would the children cope with this new situation? Where would their loyalties lie? How could I get her back? Did I want her back? These are just some of the questions that went through my mind at that time. This all produced a lack of self-confidence and need for some thinking. It was very tempting to resort to pharmacological products, but I did not—only increased that delicate Scottish fluid with a large nightcap.

Once rejected it takes time to regain self-confidence. The value of true friendship appears. True friends will allow endless talking and discussion, probing the cause and searching for a solution, which must have bored them endlessly. Friends of the previous marriage are placed in a difficult situation with divided loyalties often aggravated by one-sided stories, so that inevitably I have gained a few good friends and lost some. Suddenly I felt that my role as a GP and listener had become reversed, and I was grateful for it.

Having emerged from the initial shock, I realised that self-pity did not cure anything. I was unable to see any future, however. I met my wife about a week later to discuss reconciliation, but it was obviously in vain; she wanted a divorce and set the process going shortly afterwards. Life continued to develop, and I could not opt out. I had a home, children, and a practice to run. The practice was the easiest, since I was in a large partnership and my partners were willing to be co-operative until I had things organised, though I could not abuse their kindness. The children were a problem, but since it was the school holidays they were

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 duty weekend rota of one-in-three. 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 absentee—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 person again and suddenly realised that we lived in a puritan society—despite the statistics. At dinner parties I was always the odd one out or hopefully "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.

Within a few months I met my second wife through some friends. We very soon realised that this was no ordinary friendship, and later we married. She had had the same unfortunate experience and had two children of similar ages to mine. We then put four teenagers together, who after a honeymoon period decided they did not like each other, and yet we asked them to become a family. The years afterwards were very difficult, yet I think they have all learnt something from it and with the passage of time are now good friends. I could write another article on this particular problem.

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.

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 Hayes in Middlesex many a weekend to see his sweetheart. I used to go home by the Sunday League excursions at a cost of 3/9. But when we were away we deducted sixpence 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 if 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 l'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 bite out of anything. It was the acme of enjoyment to meet all the students in London in the cinema gallery and later at the Europe, which during all my residence in London was the centre where students foregathered. 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 liqueurs except Chartreuse he elected to get drunk quickly on these. He started off with a Chartreuse 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 scrag him, and the commissionaire simply picked him up by the collar and slung him into the street. I called a hansom and assisted him into it. I had a new bowler hat on my head and this seemed to attract Lees. 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 him, with the assistance of the cabby, 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 his aching head for many a long day. 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.

mentor, some areas have to be approached didactically. Although the primary care team and consultation techniques are covered in lectures and seminars, they are much more meaningful to the 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—albeit one-to-one—tuition, so a happy medium has to 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 exposition as well as example, and a fortnight rarely elapses 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 blind the poor students with one's 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.

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 off 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.

Island Practice

Prepared for the unpredictable

ALISTER D GRASSIE

As I write this article there is a force nine gale forecast for Mallin, and I can hear its rumblings starting already. Almost without reaching a conscious level 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 Arran. 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 general practitioner hospital, where we can discuss problems with our colleagues.

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.

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

Highlands and lowlands

The geography of Arran 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 38 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 regularly 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 and some logistic problems that may occur. In this 62-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, of 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 get is disease-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 broadly 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 academic colleagues 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 nowhere else in their course and with an overall tone of patient-orientated, 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 students instructed in *failure* as well as success? And yet to admit one's 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

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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 4 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 the practitioners in 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 patient had received a spinal injury in a road accident and appeared to have transected 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, though I was unaware of this at the time and had arranged 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 in most general practices. A totally unknown pregnant woman on holiday arrives at the cottage hospital in established labour in the middle of the night. She is at 32 weeks' gestation and tells me she has a grade 4 placenta praevia; how does one solve this one? A day tripping gentleman on a waiting list for a heart transplant finds himself storm bound on the island, having brought only a day's supply of his 12 different drugs with him; he asks for a prescription for them to tide him over until he can get back to his car on the mainland. As a dispensing doctor I am required to provide his exotic polypharmacy at an instant's notice. A young woman, armed with a knife, incarcerates herself in a local hotel room: she is clearly suffering from a serious psychotic illness and needs urgent psychiatric referral. I am compelled to resort to an emergency section when she is unable to comprehend my offers of help. This decision to section her sets in motion another train of thought. The whole operation has to be timed accurately to the arrival of a ferry. Will she run away? What is the weather forecast? Are the ferries running normally? The simple answer when storm bound is to request help from the helicopter at HMS *Gannet*. This service is not always the most suitable for transporting critically ill people. For example, what happens if the pregnant woman bleeds during the flight, and how does one safely restrain a schizophrenic patient in a cramped aircraft without authorised professional help? These problems are repeatedly cropping up, and the only feature which makes them unusual, if not in some ways unique, is that they happen on an island. These emergencies are obviously dramatic examples of how geography dictates the management, but it colours every aspect of our work.

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 formal 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 job satisfaction in 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.