PRACTICE OBSERVED

Interesting GPs of the Past

Arthur Randell Jackson: 1877-1944

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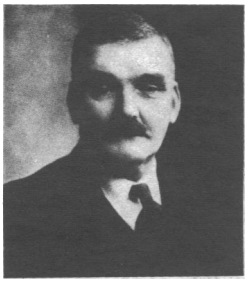
From time to time our childhood faith in the existence of giants is restored when we meet with those of towering attainments in whose shadows we mere men can only "peep about." Such a one was Arthur Randell Jackson, MC, DSC, MD, general practitioner of Chester.

It was while reading light heartedly about spiders (and who does not?) that I first came across the name of Arthur Jackson. In a chapter in Theodore H Savory's *Introduction to Arachnology* on great names of the past he was referred to as "the leading British authority of his day in arachnology," and, to paraphrase Goldsmith, "the more I read the more my wonder grew" that this man, who in Chester was known mainly as a busy general practitioner, should have had the necessary time and energy to parallel his medical career with another, which on its own would have been beyond the scope of most people.

Born in Southport in 1877, Jackson graduated first in zoology and then in medicine from Liverpool University, getting higher degrees in both. The reasons for this change of direction are not recorded. Whether it was because of altruism or the hopes of a better living, or both, or some other cause we do not know, but he certainly seems to have fitted two careers into one lifetime, being still remembered in Chester by a surviving few for his character and devotion to his patients and in the world of zoology as "one of the fathers of British arachnology."

Before settling in Chester in 1905 Dr Jackson practised medicine in the Rhondda Valley and Hexham. During the first world war he served in the Royal Army Medical Corps and was awarded the Military Cross in 1917. He was at one time president of the Chester and North Wales Medical Society, and was given the highest award of the Chester Society of Natural Science, the Charles Kingsley Medal, for his scientific work.



Genius and ungrudging help

Arthur Jackson followed in the tradition of a line of amateur scientists, many of them doctors, clergymen, or teachers, all of whom contributed greatly to scientific knowledge during the last century or two, and tributes to his skill are to be found in most of the important books on arachnology. G H Lockett and A F Millidge dedicated their two volume work *British Spiders* to the memory of Dr Arthur Randell Jackson "whose teaching, help, and encouragement in the past years has enabled us to write this book." They say that his brilliance in diagnosis and care in identification has never been surpassed. "His flair for this kind of work amounted almost to genius."

A further idea of his ability can be got from this extract from Savory's book on arachnida, where he says "The study of spiders quickly became the chief occupation of his leisure. He had many of the ideal qualifications for an arachnologist, a scientific training, a keen eye for important detail, a gift for identification, and the energy of a successful collector. Undoubtedly, his greatest service to the science was the ungrudging help that he gave to all who appealed to him for assistance. This generosity had its tragic side, for it absorbed the time that might otherwise have been given to the writing of the badly needed book on the spiders of Britain. Yet it found its reward later in the work of those to whom he had passed on his knowledge and technique: the writings of Bristowe, Locket, and Millidge may, in effect, be regarded both as his memorial and the source of the widespread interest in arachnida in Britain today."

On a holiday in Scotland, during which Jackson admitted to spending much of the time admiring the scenery, he nevertheless collected over 150 specimens, of which 20 were new to Scotland and two new to science. During his life he wrote 38 papers, 37 of which were "valuable additions to knowledge." He gave a large and valuable collection of spiders to the British Museum, and overall he added 47 species to the British list, of which nine were new to science.

He had an honorary appointment to the department of zoology at Oxford, where he gave informal lectures to students before their holiday expeditions. They sent him spiders collected during their trips which he classified and reported on. His knowledge of spiders of Iceland, Greenland, and the Arctic regions was detailed and he corresponded regularly for many years with authorities on the continent.

Jackson was in no way a narrow specialist. He loved literature and poetry, especially that of Thomas Hardy, and he occasionally wrote light verse for relaxation which was said to have been popular with the 9th Seaforth Highlanders as they pilloried well known regimental figures. He was a keen gardener, his garden being notable for asters, delphiniums, lupins, and lilies.

He was also a collector of etchings, water colour drawings, and furniture, and haunted antique shops where he bought many first editions. He bequeathed a collection of mid-eighteenth century drinking glasses to the Atkinson Museum in Southport dedicated to the memory of his son, Flying Officer Philip Carfield Jackson, who was killed in action in the second world war. This collection is now on display in Southport and recognised as a valuable bequest. It illustrates well the development of techniques in glassmaking in the early and mid-eighteenth century and demonstrates Jackson's discerning knowledge in his choice of pieces. Also in the Southport Museum is a fine collection of prints given by Jackson, which includes a Whistler and a Rembrandt, as well as several by prominent academicians.

Cycling and walking were favourite pastimes that he could combine with his spider hunting, bird watching, and more general interests in natural history. An old Chester practitioner recalls the striking figure of Jackson cycling round the city to visit his patients. He was said to be rugged and strong in appearance, with a misleading manner of toughness and cynicism as he was by nature both sensitive and sentimental. He never spared himself, and both patients and acolytes seem to have appreciated fully his kindliness of heart and depth of human understanding. It would be sad if the name of a man of such outstanding talents should be unknown to succeeding generations of Cestrian practitioners.

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The GP and the Medical Student

Students from Oxford

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I have been teaching medical students from Oxford University since 1979, when tutors in general practice were first appointed and a tutor group was formed by the department of community medicine and general practice. Until this year there were 10 tutors, but three have been added to our group because of the increased number of medical students at Oxford. Students have one month in general practice: a fortnight in their first clinical year after the introductory course, and a fortnight during their final year.

Attitudes of students

The contrast of attitudes in these two groups of students is both interesting and stimulating. The first year clinical students are so keen, sensitive, and open minded about their attachment. Because the experience is so new they feel strongly about both the attitude of their tutor towards his or her patient and the patient's illness. Many of them are deeply moved by the conditions that we expose them to.

Our tutor group has suggested that students in their first attachment should see a mother and newly delivered baby and a parent with a handicapped child or a patient with a chronic disease or possibly an elderly patient at home or in part 3 accommodation (residential home). Visiting a bereaved patient or one with a terminal illness has also been suggested. I, however, reserve the last two for only special conditions, because the doctor:patient relationship should be very close for that to be effective. The intrusion of a third person is not always advisable. Nevertheless, I try to balance the awareness and maturity of the student against that of the patient before deciding whether the student should visit such a patient with me.

In the final year attachment I find that the students are more mature and knowledgeable, having been exposed to several years of hospital practice and attitude. The student's own attitude varies depending on his or her personality and hospital experience and choice of future specialty. The students who preferred general practice seem to be more caring and more willing to be concerned with the patients and our staff. It supports my view that general practitioners are born and not made, although they can be made to improve.

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Our practice

In my practice there are two other full time men partners, one part time woman doctor, and one man trainee. All the partners train vocational trainees and are willing to help with the students in both attachments. I find that the students benefit by being with keen, willing practitioners and it makes my relationship and tuition easier.

The first year clinical students come to the practice for one fortnight a year, whereas final year students are around for between 14 and 16 weeks a year. Occasionally a tutor will miss a fortnight's attachment if the student:tutor ratio is low. The first year students work with my partners early on to expose them to the different attitudes, patients, and conditions that present to them (table I).

They work with the primary health care team, and I benefit from the feedback from them as to what is being said and done to and for my patients. Our practice has an immigrant population of 30%, 15% West Indian and 15%, Indian or Pakistani, with a smattering of Yugoslav and Polish patients. Caucasians fall mainly into social classes IV and V. Thus the students are exposed to various environments, language and its difficulties, and diseases, and I can relate my practice to the two aims of the first year attachment: to show the influence of the social, emotional, and environmental factors on the patient and his disease and to understand the role of the general practitioner on the primary health care team. As table I shows, I list the names of the team members so that the student may know who is doing what. The rota of the final year students (table II) shows the attachment to the doctors in my practice.

TABLE I—*First year clinical attachment*

Morning	Lunchtime	Afternoon	Evening	Names of primary health care team
		Monday		
1st week	*1st week*	*1st week*	*1st week*	Health visitors
Dr A surgery and visits	Dr A lunchtime meeting or discussion	Dr C	Dr B surgery	1
2nd week	*2nd week*	*2nd week*	*2nd week*	2
9 00-10 00 treatment room 10 00-11 00 Dr A surgery and calls	Dr A lunchtime meeting or discussion	Dr C	Dr B surgery	
		Tuesday		
1st week			*1st week*	
Dr A	Dr A lunchtime	Attachment to district nurse 2 00-3 30	Dr A	District nurses 1 2
2nd week			*2nd week*	
Dr A	Dr A discussion	Visit to "selected" patient	Dr B	3
		Wednesday		
1st week				Administrative staff
Reception 9-9 30 District nurse	Dr A lunchtime	Dr A antenatal clinic	Dr A	1 2
2nd week				
Attached to midwife	Dr A discussion	Visit to "selected" patient	Dr A	3 4 5 6
		Thursday		Midwives
1st week				
Health visitor attachment 9 00-12 30	Dr C lunchtime	Dr C antenatal clinic	Dr B	1 2
2nd week	Dr C discussion	Free activity	Dr B	
		Friday		
1st week				Treatment room sisters
Health visitor attachment	Dr A discussion over lunch	Dr D well baby clinic		1
2nd week				2
Social worker attachment 9 00-12 30				3
		Seminar 12 30-4 00 pm		

TABLE II—*Final year students*

Morning	Lunchtime 12 30-2 00 pm	Afternoon 2 00-4 00 pm	Evening 4 00-6 00 pm
		Monday	
1st week	Introduction		
2nd week			
Dr A Surgery and visits	Meeting or discussion	Dr C Surgery	Dr B surgery
		Tuesday	
Dr A surgery and visits	Dr A	Discussion	Dr A Surgery
		Wednesday	
Dr E surgery and visits	Meetings on obstetrics, therapeutics, paediatrics	Dr A antenatal clinic	Dr A surgery
		Thursday	
1st week			
Dr C surgery and visits		Dr C antenatal clinic	Dr C surgery
2nd week			
Treatment room 9 00-11 00 then visits with Dr C	Lunch		
		Friday	
		1st week	*1st week*
Dr A surgery and visits	Lunch (usually drug company)	Dr D well baby clinic	Dr A surgery
		2nd week	
		Assessment	Debriefing

Consultation

My views and approach to the consultation differ in some ways from most of the other tutors. Last year I did a survey to find out whether we all had notices in our waiting rooms telling patients that a student was sitting in—eight out of 10 had no notice—and whether the receptionist told the patient before the consultation—eight receptionists out of 10 did. I inquired about how the student was introduced to the patient, and, of course, everyone did this, but introductions varied from "We have a medical student with us today" to "We have a doctor with us today" and "We have two options for you." One doctor thought that this was unnecessary as "patients were already primed." So various introductions are possible, and I wonder if some standardisation might be worth considering.

The biggest differences between me and the other tutors were where I sat my student in relation to the patient and the extent of participation in the consultation that the student had. Most tutors sat the student on a triangle with the patient facing the student and doctor. I sit my student facing me just behind the patient's field of vision, because I think that the student should be observing the consultation and the doctor/patient relationship. If he wishes to be more concerned with patients as a general practitioner he will become a vocational trainee. During the consultation he will take part as physical signs are elicited and described and perhaps when medical points are raised that I cannot answer—especially with a final year student. Sometimes patients will turn to the student and more participation is inevitable. I largely encourage the student to be an observer and a satellite in the movement of the patient/doctor planetarium, and to have a pen and pencil to make notes on points not understood or drugs used or not used. Discussion may then take place later.

Most of my colleagues let students participate more fully, and one or two ask students to take surgery while they sit in. When asked, students usually say that they enjoy the experience, but I think it is inappropriate at this time. I do, however, encourage final year students to see patients on their own in the last few days of the attachment. The amount of encouragement and the number of patients seen depends on the student's attitude and keenness as well as on the patient's desire for this.

Video

In our practice we have a video recorder, which I have used often recently. The problem with video, however, is that it takes time to view the film, and there are so many other subjects to discuss that only a good and willing student is appropriate. This year we have chosen to look at the consultation. We have had the advice, guidance, and direction of David Pendleton, Stuart Fellow of the Royal College of General Practitioners. I have used the Stott Davies model and David Pendleton's consultation map (figure), which is used with a rating scale (not included here).

Consultation map

1	Nature and history of problems	
2	Aetiology of problems	
3	Patients' ideas, concerns and expectations	
4	Effects of problems: physical, social, and psychological	
5	Continuing problems	
6	At risk factors	
7	Action taken	
8	Sharing understanding	
9	Involving in management	

Special topic

We have studied diabetes this year with the final year students and asked the students to look at 10 patient records to see if entries have been made of blood sugar concentration, weight, and the results of urine analysis, taking blood pressure and peripheral pulses, and examination of the retinas. We have also used a questionnaire to find out the patient's understanding of the disease and its severity in relation to cancer and blood pressure. This was difficult to complete because patients were not always available during the fortnight, there was little time, and sometimes the student's motivation was lacking, especially in the last half of the attachment when finals were on the horizon. We now have a list of complications and treatment of diabetes to use for discussion.

Tutor group

Tutors meet every month, and I find this meeting beneficial for exchanging ideas and formulating new aims for the students. The tutors are still learning from each other and also from the students. The variety is interesting—several are young doctors who have recently entered general practice, several have been in practice over 20 years, and there are a few in between—so that the range of experience and knowledge is good. Last year we had Professor John Fry attached to us. He visited each practice and attended each meeting of tutors. It helped to clarify my ideas on teaching and improved my academic approach to it. From Professor Fry's attachment as Jephcott Professor for one year we planned handbooks for both final and first year students. The first, now being issued to the students, outlines the history of the National Health Service, gives some epidemiological data about disease in general practice, and lists medical and administrative topics to be discussed.

Research

Some tutors are doing research into the incidence and treatment of diabetes, and into the treatment of cystitis in general practice. Dr Godfrey Fowler and Dr Muir Gray from the department of community medicine and general practice are studying the factors causing ischaemic heart disease in general practice. We have participated and use the age-sex register and a morbidity register. I am studying the care that our geriatric patients receive with a view to attaching a geriatric health visitor.

Assessment

At the end of the fortnight attachment I help first year students to assess their experiences in general practice. The variety of characters who are exposed to real patients for the first time provides an experience for all. When a sensitive student almost tearfully describes his concern for a family with a handicapped child or for a chronically ill elderly person living on her own it shows that sensitivity in our medical students still exists. There is also the critical, unmoved student who has been in a practice where partners do not communicate with each other or where one doctor takes four minutes for a consultation and another 20 minutes, all of which adds to discussions about consultation techniques.

In the final year with a colleague I assess a two week attachment once in a term. This assessment is a deeper analysis because students have more medical knowledge and are therefore more critical. This year diabetes was discussed, and the use of video encouraged, using the consultation as a subject. Students are not so highly motivated in the last year, especially to analyse the consultation. I think that reasons for this are, firstly, that they do not see it as particularly relevant to finals; secondly, that more than half of them will not take up general practice as a career; and thirdly, that if they do they know that their trainee year will give them an opportunity to study the consultation in more depth. Students and tutors complete a questionnaire which is used to assess our teaching and not us or them.

Conclusion

I thoroughly enjoy my attachment with students because of mixing young people with different personalities and intellectual abilities with my patients, my practice colleagues, and my staff. Our knowledge is kept up to date. My staff also like having a new face around. Our contact with students is not just for the fortnight. Some have kept in touch with the practice and are invited to sit in surgeries occasionally. Some work in local hospitals and it is reassuring to admit a patient knowing the person at the hospital.

I thank Dr Godfrey Fowler, clinical reader in general practice in the department of community medicine and general practice, Oxford University, for help with this paper.