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Abstract
The Faculty of Medicine of this University has decided that from now onwards every student shall be provided with the means of not only observing, but of actively participating in, the provision of medical care for patients in their own homes. The task of making the necessary arrangements is the responsibility of the University's General Practice Teaching Unit. It gives me particular pleasure to accept an invitation from the Royal Medical Society to contribute to its journal an article on this Unit, its history, aims, philosophy, and teaching methods.

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FAMILY MEDICINE

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Introduction

The Faculty of Medicine of this University has decided that from now onwards every student shall be provided with the means of not only observing, but of actively participating in, the provision of medical care for patients in their own homes. The task of making the necessary arrangements is the responsibility of the University's General Practice Teaching Unit. It gives me particular pleasure to accept an invitation from the Royal Medical Society to contribute to its journal an article on this Unit, its history, aims, philosophy, and teaching methods.

The Unit has grown out of the nucleus of a practice set up in 1948 in the premises of the Royal Public Dispensary. This, the oldest of the Edinburgh dispensaries for the sick poor, was founded by Andrew Duncan in 1776. The same Andrew Duncan, who ranks amongst the most illustrious of the physician-teachers whom this school has produced, played a leading part in the founding of the Royal Medical Society, and was largely responsible for obtaining for that Society its Royal Charter. Andrew Duncan, like so many of the Edinburgh graduates of his day, pursued his postgraduate studies in the continent of Europe and was profoundly influenced by what he saw and learned in the medical school of Leyden. He returned to Edinburgh deeply imbued with the Boerhaavian enthusiasm for clinical instruction. The lecture theatre and the textbook were inadequate means of training medical students unless reinforced by practical demonstration by the bedside or in the doctor's consulting room. The doctor-patient relationship was no longer merely a subject for academic discourse and disputation, but had become an actual vehicle for the training of the medical student. It is not surprising therefore to learn that from the day of its foundation, under the leadership of Andrew Duncan, the Royal Public Dispensary (and indeed all the Edinburgh dispensaries for the sick poor which were established in the years that followed) served a dual purpose, namely the provision of medical care and the instruction of medical students. The dispensary tradition was a prominent feature of this medical school. In one sense, therefore, there is nothing new in the provision of clinical instruction outside the hospital for all our students. What is new concerns the circumstances under which the patient and the student are introduced to each other.

By the second decade of this century, the service provided at the public dispensaries was beginning to change in many respects. The extension of hospital services—in particular outpatient services—the rapid development of personal services provided by the local authority for school children and for infants and expectant mothers, the provision of medical care by the State for the indigent and for persons suffering from certain categories of illness, e.g. tuberculosis, venereal disease and mental disease, the introduction of National Health Insurance, and the generally increasing prosperity of the 'working classes,' brought profound changes in the kind of patients who used these dispensaries and exerted a specific selective action on the kinds of morbidity which these patients presented. By the 1930s there had come about dramatic changes in the quality and quantity of clinical material

available at these dispensaries for instruction of medical students. In the following decade, the rapid expansion of statutory and voluntary social services and finally the inauguration of the National Health Service rendered the dispensaries completely redundant as a form of medical charity.

It is paradoxical that at a time when the Edinburgh dispensary system was undergoing disuse atrophy, teachers in practically every medical school throughout the country were becoming increasingly preoccupied with the need to bring the student out of the hospital into the community. This desire to provide some practical instruction for the student in a setting outside the hospital came about for a number of reasons. These are inherent in changing trends in the practice of medicine which have become more marked since the introduction of the National Health Service. The changes have come about not so much because of the Health Service. The provision of a National Health Service has merely focused our attention on the nature of these changes.

Changing patterns in medical practice and in the provision of medical care

The post-war era has seen rapid advances in medical science and profound changes in the practice of medicine, both in the hospital and in the community. Each advance in knowledge and every change in the practice of medicine brings its own problem and challenge to the medical teacher. Among current trends the following are singled out because of their particular relevance to undergraduate teaching:

(1) The patterns of morbidity have undergone dramatic change in recent years. One of the most striking features of this change has been the decline of infection as a major cause of morbidity. Degenerative cardiovascular disease and neoplasms dominate the patterns of morbidity seen in hospital where even in the acute teaching hospital the average age of the patient population has risen steeply even during the past decade. Improvements in diagnostic techniques, the greater availability of diagnostic facilities, and in particular dramatic additions to the therapeutic armamentarium of the family doctor, have all contributed to the virtual disappearance from hospital practice of many illnesses which were commonplace a few years ago, and are no longer seen except in the setting of domiciliary medicine. Diseases and syndromes which account for the great bulk of our national morbidity are very sparsely represented in the material available for clinical instruction in the teaching hospital. It is no longer possible to demonstrate to the student in this setting that the common diseases are the common diseases. It may therefore be that these qualitative and quantitative changes in the patterns of morbidity presenting at our teaching hospitals have themselves caused us to consider the possibility of taking the student out of the hospital into the community, in order to give him adequate practical instruction in ordinary clinical medicine.

(2) Alongside this decline is the actual and relative incidence of disease of infective origin, there has come about a relative and actual increase in disease which has its origins in faulty adaptation to the normal stresses and strains in the human social environment. The increasing importance of faulty human relationships in the etiology of disease, the importance of considering the inter-personal relationships of the patient in the management of disease, have led to an increasing preoccupation with what is happening to the patient in the

home, in the family, in the community, and at work. In this way we hope to increase our understanding of the diagnostic and therapeutic problems confronting us at a particular point in time during an episode of illness which has brought about the patient's admission to hospital.

(3) The rapid development of specialisation is probably the most striking single feature of current trends in the practice of medicine in our generation. The increasing tempo of specialisation is bringing about a state of affairs in which the more junior clinical teaching staff of medical schools is largely composed of specialists who of necessity have to concern themselves with a narrowing field of clinical interest. The pressure to specialise early in one's postgraduate years frequently denies to the future teacher the opportunity to gain a substantial personal experience of dealing with patients in their own homes. The specialist by definition must limit his field, and in so doing pre-determines the kind of clinical situation to which he is exposed. His efforts to advance knowledge in his particular field frequently leave him with little opportunity of gaining practical experience of dealing with the ill-differentiated clinical and social problems in diagnosis and management which daily confront the doctor practising medicine in the homes of his patients. One of the by-products of specialisation is that it conditions the doctor to adopt an analytical approach to the professional problems with which he is confronted by his patient. By breaking down the problem into its component parts, he reaches the diagnosis—he advances medical research. As a result the students whom he teaches absorb this philosophy, this attitude of mind, and it is essential that they should do so because this is the essence of the scientific approach. At the same time the practice of medicine and the attitude required of the doctor who is actually treating the patient, is in essence a synthesis—a putting together of the known clinical facts alongside the doctor's knowledge of the patient as a person, as a member of a family, as a member of a community. One of the unfortunate but not inevitable by-products of specialisation is that it can lead to a separation of the teaching of medicine from the practice of medicine. Here again, since many of the factors involved in the provision of integrated comprehensive medical care are concerned with the patient as a member of a community, the specialist working entirely within the walls of the hospital is peculiarly handicapped in the resources available to him for the instruction of students.

(4) The fourth set of circumstances which require special consideration are the changes which have occurred and which are still taking place in the provision of medical and social services for the community on a national basis. Probably the most significant single facet of the National Health Service is that it granted to every citizen in this country access to the services of a personal medical practitioner. It is important to remember that little more than ten years have passed since we began to accumulate experience on a national scale of the professional, educational, administrative and other problems which arise when medicine is exposed to the full pressure of society. The idea that medicine must serve society is not new, but the fact that society in the form of a personal domiciliary medical service has an eloquent means of expressing its needs in respect of compre-

hensive and integrated medical care is something new. The challenge to medical schools is obvious since they must provide the basic training for all doctors who man this service.

Re-orientation of Medical Education

The significance of these trends in the evolution of medicine and of our medical services has been the subject of considerable detailed discussion by teachers in every medical school in this country. The General Medical Council, governmental commissions and committees, the Royal colleges, the British Medical Association, and many other bodies and individuals, have reported on one facet or another of the problems involved. All have emphasised the need for widening our horizons in medical education. Many of these reports have emphasised the need to focus the students' attention on the social and community aspects of health and sickness.

One of the features of this post-war era in medical education has been the expansion which has taken place in many medical schools in the teaching of social and preventive medicine. These departments have often taken the initiative in developing schemes whereby the student is introduced to the medical and social services which exist in the community. Alongside these attempts to introduce the student to the community aspects of health and sickness, there have grown up a great variety of schemes for effecting the personal introduction of the student to the general practitioner. There is now practically no medical school in this country which has not made some arrangement, usually on a voluntary basis, which permits the student to pay visits of observation to a family doctor. These schemes all have one thing in common, in that they provide the student with an opportunity of seeing the patient as a person with his own unique family environment. In some of these schemes the student is introduced to the patient by the family doctor. In others, the student is encouraged to visit the patient's home with the primary objective of making his own appraisal of the social, economic and cultural factors in the patient's environment, which have contributed to the etiology of his disease or which complicate the management of the patient and his illness. In yet other schemes the attention is focused particularly on the medical and social resources available in the community for the care and after-care of the patient seen in the first instance in hospital.

The great variety of teaching schemes which involve the demonstration of the patient in his social habitat leaves one with the impression that there is no single discernible purpose common to all these schemes. In some schools it is the paediatrician who is concerned that his student should have a vivid picture of the importance of the background of the patients whom he is seeing in hospital. In others, the teacher of psychological medicine takes this opportunity to demonstrate the significance of human relationships within the family, at home, in the work situation, or in the community. In at least one school, the interest and enthusiasm of the teacher of bacteriology has led to the development of a scheme whereby the student is encouraged to go out of the hospital into the homes of his patients. In other schools the motivation is less specific and is more directed at broader educational objectives. The Dean of Clinical Studies in some instances is the person primarily responsible for making arrangements of this kind. The great variety of these schemes for sending students to work for varying periods with family doctors suggests that there is more than one cause operating in this educational malady. They do suggest, however, that there has come about a growing awareness of the possibilities of exploiting the family doctor-patient relationship for the purposes of undergraduate teaching.

While therefore there was nothing unique in the educational challenge

with which this medical school was faced in post-war years, and while we were not alone in our appreciation of the potentialities of family medicine as a vehicle for instruction, this school possessed two unique assets which have enabled us to make our own special contribution in this field. The first was the long and intimate association between the medical school and the city's dispensaries for the sick poor. Although the material contribution which these dispensaries could make to our teaching resources was continuing to decrease year by year, the traditional and sentimental attachment of the school to the dispensaries was still probably stronger and more vividly appreciated than in any other medical school. Our second and even more important asset was Professor F. A. E. Crew. Immediately after the war, when we were seeking a new definition of social medicine as an academic discipline, F. A. E. Crew was appointed to the Chair of Public Health and Social Medicine in this medical school. It was the vision of this man which was largely responsible for our setting up a teaching general practice in the premises of the Royal Dispensary with a view to obtaining a field laboratory to be used by the medical school for research and teaching in social and preventive medicine. While Crew's original concept of the function of this unit and the contribution which it could make to medical teaching has been considerably modified, he was undoubtedly the source of inspiration which led to the establishment of this Unit.

The General Practice Teaching Unit

On 5th July 1948, the day on which the National Health Service Acts came into force, Professor Crew prepared the way for the acquisition by the University of a teaching general practice by seconding his senior lecturer, who was given the task of using the premises at the Royal Dispensary as practice premises from which he offered a full-time family doctor service to any patient who chose to register with him as a principal under the terms of the National Health Service Act. In time this doctor was reinforced and as the practice grew the service offered to the patients was provided by a team comprising two family doctors, a nurse, a medical social worker, and a secretary. From the beginning a limited number of senior medical students were permitted to attend on a voluntary basis for practical instruction. By 1951 this practice was able to provide a three months' course of instruction to some 30 students.

By that time the only remaining dispensary in the city, the Livingstone Memorial Dispensary which was used as a training ground by the Edinburgh Medical Missionary Society, was about to wind up its affairs. At this stage the University received a generous grant from the Rockefeller Foundation to enable us to extend our teaching facilities by acquiring a second practice which used as its headquarters the premises of the former Livingstone Dispensary, now known as Livingstone House. The Unit thus became established on an experimental basis in 1951, and consists of two general practices each manned by a family doctor team comprising two doctors, a nurse, a medical social worker, and a secretary. The total patient population being looked after by these two practices was in the region of 5000 persons. By 1956 when we were nearing the end of the period of support from the Rockefeller Foundation, the Unit was offering a course of instruction to some 60 students per annum. It was then that the Faculty of Medicine recommended that the Unit should become an integral part of the medical school and should expand its teaching facilities as rapidly as possible so as to be able to offer instruction to every medical student. We have now reached this goal. Some of the expansion of clinical and teaching facilities has been achieved by recruiting to the part-time staff of the Unit a number

of selected local general practitioners. According to our teaching load, we can now attach up to a maximum of four such part-time colleagues to each of our two practices. This arrangement not only increases the number of students we accept, but it also provides us with an opportunity of arranging for each student to spend part of his time working in the University practices and part of his period of attachment seeing how a family doctor works under conditions which approximate more closely to those which obtain in general practice under the National Health Service. One further development should be mentioned to bring up-to-date this brief account of the evolution of this Unit.

Through the generosity of the Nuffield Provincial Hospitals Trust there has been set up in Edinburgh a Family Doctor Diagnostic Centre providing full range of X-ray diagnostic facilities, laboratory facilities including haematology, biochemistry and a limited amount of bacteriology, and the services for diagnostic purposes of a trained medical social worker. It is the intention that this Family Doctor Centre, which will become the responsibility of the Department of Health for Scotland, shall be open to all family doctors practising in the city of Edinburgh. This Centre is located in the premises of the General Practice Teaching Unit at its headquarters in Livingstone House. To begin with the number of doctors using the Centre will be limited. The services however will be available to the members of staff of the University's General Practice Teaching Unit, and will add considerably to our teaching resources.

Teaching Arrangements

Each student in his Fifth Year is attached to the Unit for one academic term. During that term he is allotted a minimum of two weekly afternoon sessions in the Unit. Each student is attached to a particular doctor, and on a fixed day per week he is the only other person present when the doctor is at work in his surgery attending to whatever patient appears during that consulting period. He also accompanies the doctor on home visits either in response to new calls which have been initated by the patient, or on follow-up visits initiated by the doctor. At the beginning of the term, the role of the student is that of observer, of seeing a family doctor at work. As the term progresses, however, he takes an increasingly active part in the diagnostic assessment of the patient and in working out, under the immediate supervision of the patient's own doctor, the regime of therapy. The student gradually takes over with the patient's consent and under the supervision of the doctor, delegated responsibility for the management of a patient and his family. He thus becomes the doctor's apprentice.

Each student and his doctor attend a weekly tutorial. This tutorial is made up of not more than ten students, half of them working in the Unit and the other half in the practices of our extra-mural colleagues. The students and their doctors come together to discuss and review the work they have been doing during the previous week. The students are reminded that patients have an elementary right of direct access to the doctor of their choice, that the final responsibility for all decisions both major and minor must rest with the doctor, that the consent of the patient must be sought literally on all occasions on which the student is introduced. This means that this teaching mechanism is necessarily costly. While the students can make a worthwhile contribution to the work of the practice, they may not interfere with the establishment and continuing maintenance of a true doctor-patient relationship between the patient and the doctor of his choice. This however means that it is the patient, in the last analysis, who is the teacher. The patient has a family doctor, he knows what a family doctor

is, the kind of work he does, the kind of problems which he is willing and able to tackle. The student does not know, and thus the student is manoeuvred into a situation in which the patient tells him what he must do, what he must know, what kind of things he has to be able to tackle if he hopes to become a family doctor.

Teaching Objectives

Our immediate objective is of course to exploit the opportunities which exist in the setting of family medicine for allowing the student to see and himself take part in, the actual provision of medical care. In doing this we hope to provide the student both with the opportunity and the challenge to integrate all that he has learned so far in his clinical teaching in the hospital. We are not so much concerned with teaching the student anything new as with providing him with an opportunity of assimilating and integrating the knowledge and skills with which he has already been equipped. Although the student will learn a great deal about the nature of general practice, we are not primarily interested in or concerned with vocational training for general practice. The teaching experience to which the student is exposed and the lessons he can learn have just as much relevance for the young man or woman who is not going to enter general practice but is taking up some other branch of medicine. Indeed, rather than emphasise the purely vocational aspects of training for general practice, we are particularly concerned with the necessity of demonstrating to the student that medicine is indivisible. In a practical situation in which the doctor is placed vis-a-vis the patient, there is no such thing as preventive medicine, curative medicine, social medicine, or any other kind of medicine. There is just medicine. We are more concerned therefore with demonstrating an attitude of mind than with the demonstration of techniques or the imparting of information. Among the practical situations which can be exploited in this context for the purpose of teaching are the following:

(1) The patient is the teacher. In the familiar setting of his own home, clad in his working clothes instead of hospital pyjamas, surrounded by the familiar objects of his daily existence instead of the paraphernalia of the hospital, and in the presence of his family, neighbours and friends, the patient is obviously more relaxed, more at ease, more loquacious, better able to express himself and to describe and discuss intimate personal relationships. At a home visit the salient features of his socio-economic circumstance can often be taken in at a glance without recourse to a formal structured social case-taking inventory. The patient takes an active part in the consultation. He talks back to the doctor. He has fewer inhibitions about discussing his problem, about mentioning the trivialities which are often highly significant. He is more likely to ask the simple, direct or sometimes tentative question which might remain frozen on his lips in the unfamiliar setting of the hospital or clinic. Under these circumstances it is not surprising that the student's history, his account of the illness, and his appreciation of the significance of the relative clinical and social factors, is more rounded and complete.

(2) In the consulting room the student sees for himself the wide range of undifferentiated clinical problems which present in rapid succession and in a completely unrehearsed fashion to the family doctor. He sees the trivialities, the acute emergencies, the beginnings of major organic disease, the terminal illness, the incurable, the hopeless. He thus acquires some insight into the significance of the direct access of the public to medical care.

(3) This direct access of the patient to the doctor enables the student to gain some insight, not only into the very wide range of organic and functional disorder which exists in the community, but also introduces him to the notion that there is no strict dividing line between clinical and social pathology. The student is thus introduced to this border land which is the concern both of medicine and of sociology. He discovers that he must concern himself, not only with human anatomy and physiology, but also with the anatomy and physiology of society.

(4) The continuity of care which is inherent in the nature of family medicine lends itself particularly to directing the student's attention to the natural history of disease. In discussion with the patient's family doctor and from consulting the medical notes of the patient and of his family accumulated over a period of years, he can see a disease process in continuity. The family doctor includes among his patients children who have not yet been conceived.

(5) Another major objective is to exploit the opportunities which exist for demonstrating that the care of the patient involves an adequate assessment of the home and family circumstances of the patient, the nature of his personal relationships at home, at school, at work, and in the community. Having been introduced to the idea that it is essential to make a social diagnosis, the student becomes involved in considering how to prescribe the appropriate social therapy. As well as a new drug the patient may require a new house, a new job, a new wife, or a new attitude to his old wife. Although he may be familiar in broad outline with the statutory and voluntary agencies which are available to the doctor for writing the social prescription, these agencies become more meaningful and realistic when discussed against the background of the peculiar needs of a particular patient and his family.

(6) One other facet of medical practice which can be particularly well demonstrated in the setting of family medicine is the need to develop and practice the skills of team work and collaboration. The family doctor has to look more and more to the hospital, to his consultant and specialist colleagues, to obtain for his patients the benefits of modern techniques, both in diagnosis and therapy, but he also has to turn away from the hospital to services which are available in the community to assist him in the care of his patients. He has to be ambivalent. He very often is required to take the lead as an integrator of the medical and social services already existing in the community which require to be harnessed, co-ordinated, and streamlined to meet the peculiar needs of a particular patient. This role of medicine as an integrator—the role of the doctor as a person who co-ordinates the medical and social services on behalf of his patient, who interprets his patient's needs to a medical or social agency, and interprets the agency and its functions to the patient—is one which specially lends itself to practical demonstration in the setting of family medicine.

(7) Finally, it is one of our objectives to introduce the student to the situation where the doctor has to learn to live with his problem and to differentiate between the patient's problem and his own emotional reaction to it. The doctor may have to accept the facts of the patient's socio-economic circumstance without necessarily doing anything about it. The student may have to be shown not only the potentialities but also the limitations of the contribution of scientific medicine. In this setting he can begin to appreciate the significance of the aphorism 'to cure sometimes, to relieve often, to comfort always.'