Congres 1960 voor het eerst uitgereikt, nadat de jury, bestaande uit Prof. Prakken, Prof. Van Deen en Frese, hierover een eenstemmig oordeel had uitgesproken, aan Dr G. J. Bos te Vlaardingen. Ook dit jaar zal deze prijs weer worden uitgereikt.
Slechts tweemaal belegde het bestuur een vergadering met de gezamenlijke adviescommissies en de besturen van de landelijke studiegroepen en van de centra. De eerste maal in maart 1960, waarbij de vraag werd besproken, in welk opzicht de adviescommissies en de landelijke studiegroepen van nut zouden kunnen zijn voor de centra. Het bleek, dat dit nut wederkerig zou kunnen zijn, en de praktische uitvoering hiervan werd besproken. De tweede bijeenkomst werd belegd in september 1960 en was gewijd aan de opleiding van de huisarts en werd al eerder in dit verslag aangeduid. Deze bijeenkomsten zijn bijzonder nuttig en het plan bestaat in het voorjaar weer een dergelijke bijeenkomst te beleggen.

Het is mij een groot genoegen geweest, dit overzicht, deze terugblik te hebben mogen opstellen. Dit overzicht munt echter niet uit door volledigheid, kán dit ook niet. Daardoor leeft het Genootschap, gelukkig, te intensief. Ik hoop er niettemin in geslaagd te zijn een indruk te hebben gegeven van het enthousiasme van de leden, van de activiteiten in het Genootschap zowel naar binnen, als ook naar buiten, van de vele bereikte resultaten en van de tekortkomingen, kortom, van alles, waaruit blijkt dat ons jonge Genootschap springlevend is en voldoet aan de verwachtingen, die men er bij de oprichting van had. En ook — en dit mag toch een goede graadmeter worden genoemd — van de toenemende waardering, die het N.H.G. van buiten af gewordt. Ik moge dan eindigen met het uitspreken van de hoop, dat ons Nederlands Huisartsen Genootschap tot in lengte van jaren vervuld mag blijven van jong, bruisend leven, ter vergroting van de prestaties en vermeerdering van de arbeidsvreugde van de huisartsen en dus tot heil van het ganse Nederlandse volk.

*Experiences of teaching in general practice**

BY RICHARD SCOTT, M.D.I.P.H., EDINBURGH, SCOTLAND

First of all, will you permit me to express my very sincere thanks for the honour you have done me and my colleague, Miss Paterson, in inviting us to join you at this conference. I have been looking forward with very great pleasure and anticipation to this visit to Nijmegen. I cannot think of a more congenial company for this conference which is largely composed of family doctors and teachers and others with a particular interest in the field of social and preventive medicine. This is the second occasion on which I have attended a medical meeting in the Netherlands, and in a sense these two meetings have been complementary to each other. On the first occasion I took part in an international meeting of doctors and teachers who were specially interested in the subject of social and preventive medicine — a most successful conference in the preparation of which Professor Querido played a particularly active and effective role. In those days I was myself in the ranks of the social mediciners, and was happy to meet so many colleagues with similar interests, some of whom are with us to-day. On this second occasion it gives me very special pleasure to have been invited as a family doctor by the Netherlands College of General Practitioners. My colleagues in the United Kingdom think very highly of the work which your College has already accomplished in its short existence. Both you in the Netherlands and we in Britain are convinced that in the post-war era, just as Nijmegen has been rebuilt, so also there has been a veritable renaissance in family medicine and our two Colleges are playing a not insignificant part in the post-war reconstruction and rebuilding of general practice in our respective countries.
I do not think we can claim that the renaissance was due to the inception of our Colleges, but certainly in their own special ways both Colleges are contributing substantially to the growing points in this renaissance. I certainly cannot conceive that such a conference could have been called and that I would have been here to-day, discussing with you the possible role of the family doctor in the training of the medical student, had it not been for the enthusiasm and drive of certain individuals which has found an eloquent means of expressing itself within the framework of our two new Colleges.
There is a very real danger to me surrounded as I am with people sharing so much in common in our point of view and interest that I will be merely preaching to the converted. I hope therefore that what I have to say will not sound too commonplace, and that I will not cause you to regret your generosity in inviting me to address you.
Medical education is the main theme as I understand it of this session, and perhaps before I begin you will permit me to give you a third and personal reason for my accepting your invitation with such alacrity. As a graduate of Edinburgh University and an individual particularly interested as most of us are in the training of medical students, it gives me particular pleasure to visit your country again and

* Voordracht, gehouden op de huisartsencursus „Maatschappelijke facetten van gezondheid en ziekte" te Nijmegen, april 1961.

to pay my respects to one of the most distinguished and venerable of the ancient seats of learning in Europe. I am referring of course to the University of Leiden to which Edinburgh owes so much, because it was the teaching of Boerhaave which inspired the professors of my own medical school to carry their teaching to the bedside, and to embrace the idea, which was so novel in its time, that it is the practice of medicine on real patients which is the most effective of all vehicles for the instruction and training of our future doctors. We in Edinburgh are very conscious of the debt that we owe to the Boerhaavian school, and indeed in many ways some of the activities in which I and my colleagues are engaged consist essentially of a re-application of these principles.

Before presenting some of my experiences and views concerning the role of the family doctor in the training of the medical student, I am tempted to pose the question: Why should students be introduced to general practice in their undergraduate years? I am going to assume however from a cursory glance at the programme for this conference and bearing in mind that we are composed primarily of general practitioners and academic pedagogues and research workers in and around the field of social and preventive medicine that the answer to this question can be taken for granted. Nevertheless a very brief analysis of the question may help to put into prospective some of the things that I would like to say a little about, later.

If we exclude cross infection, iatro-genic disease and some other hazards to the patient of hospitalisation, it would be fair to claim that most illness has its origin outside the walls of the teaching hospital and special clinic. The majority of patients are seen and at least partially investigated and treated by a general practitioner, before they ever come in contact with the hospital. In this day and age most patients leave the hospital alive, but many patients leaving hospital still require a substantial amount of medical and social care and surveillance by the family doctor, with or without the continuing assistance of his specialist colleagues. The sojourn in hospital therefore, or even a continuing period of attendance at an outpatient clinic, in the vast majority of cases represents but one phase in an episode of an illness — one part of a continuum which makes up the natural history of disease. The clinical and social problems associated with the complete rehabilitation of the patient, his re-introduction to his family, to the community, and to gainful employment, constitute an important facet of medical care which does not always lend itself to practical demonstration in the selected material which is available for clinical instruction in the teaching hospital. Then there are the failures, the pathological processes and clinical syndromes for which the hospital and its clinics has little to offer — the incurable, the hopeless, and the dying. These too represent an important facet of the work of the doctor which again cannot always be readily demonstrated in the hospital setting. And finally by the same token there is a wide range of clinical, social and psychological problems which are diagnosed and treated by the family doctor so effectively that the patients never reach the hospital at all, so that if the student is not introduced into the milieu of family medicine he is unlikely to gain any practical experience or insight into the nature of these challenges to which he will certainly be later exposed. This is one of the consequences of specialisation. Specialisation of knowledge must inevitably lead to specialisation of function, and as a subject advances by a process of dichotomy, for instance radiology becomes radio-diagnosis or radiotherapy, so more specialities and more specialist doctors come into being. I do not decry specialisation. Indeed in my opinion we do not have enough specialists, but it is important to bear in mind that specialisation can work in another direction. A subject not only advances by splitting into two separate subjects, but frequently the advance consists of narrowing the field of specialised interest, and perching out much of its content into the undifferentiated field of general practice, so that what is hospital and specialist practice to-day, indeed becomes within the competence and daily experience of the general practitioner to-morrow. This process of sloughing off inevitably means that the clientele of the teaching hospital clinic must itself become more and more differentiated, selected and specialized as medicine advances, so that we are approaching an era where some of the illnesses and clinical syndromes which contribute very substantially to our total national morbidity, are very inadequately represented in the clientele of the hospital.

In my own country, and I have no reason to believe that the picture here is substantially different, among the major challenges to our health services are the problems of providing for the chronic sick, the aged and the whole field of mental illhealth. One of the characteristics of these groups of diseases is their multifactorial etiology. Another is that social, economic and particularly human relationship factors in the environment of the patient, contribute substantially to the etiology of the disease and present particularly urgent and complex problems in the management of the patient.

It has been said that compared with a generation ago we are much less preoccupied with the bacterium and the physical features of the patient's environment, and more and more we find it necessary to focus our attention on human relationships, human customs, practices institutions, and the contribution which they make to our national illhealth. Creeds are now much more pathogenic than cocci. It is not surprising therefore that in almost every country that I know of, in most medical schools there is a growing awareness of the need to take the student out into the community, to take the student to the patient rather than take the patient to the student — to remind the student that the proper study of mankind is man, and man in his natural

setting, in the family, at home, at work, or in the community.

These I suggest are some of the reasons which have led to a variety of different kinds of attempts to enable the student to visit the patient in his own home.

It is interesting to note that experiment in teaching along these lines is not the exclusive concern of any one academic discipline. In some medical schools for instance the paediatrician in the course of his clinical teaching has encouraged the students to visit children and particularly the parents and families of children, in their own homes, and to discuss with the family doctor, the visiting psychiatric or social worker, and the paediatrician concerned, the significance of the human component of the patient's environment. And in yet other schools the psychiatrist and the teacher of psychological medicine has taken the initiative. Perhaps the teachers who have been most active in this field are the professors of public health, preventive medicine and social medicine. In at least one other school that I know of, the professor of bacteriology has taken his students out with him on these domiciliary expeditions. In yet other schools the initiative has been taken by the professor of medicine or internal medicine who wishes his students to become familiar with the diagnostic and therapeutic challenges presented by patients with clinical problems which are inadequately represented in the teaching material which is normally available to him. In yet other instances, pressure has come from students themselves who have asked the Dean of a medical school to provide them with opportunities for practical experience in family medicine.

The point that I wish to make briefly is that although a common pattern of intention can be deduced from all these varying attempts to get the student into the milieu of family medicine, the object of the exercise varies considerably with the academic interests and the educational drive and motivation of the teacher concerned. The actual degree of participation by the general practitioner, the extent to which he is invited or encouraged to join as a colleague in these exercises, also varies enormously from school to school, and according to the interest, views or attitudes of the teacher who has taken this kind of initiative. On the whole, in my own country at least, it is fair to state that while some teachers might think it a good thing for the students to see something of general practice and the general practitioner, with a few notable exceptions the family doctor as such does not take a particularly prominent part in determining how the programme will go, what shall be taught, and by whom. A cynical general practitioner might be forgiven for commenting that while he welcomes these schemes which bring the student into contact with the family doctor in his own milieu, in some instances at least, it would appear that the medical teacher has done the right thing for the wrong reason.

I have perhaps spent too long in this introduction of the subject in so far as I have been specially asked to comment on the teaching of the student by general practitioners as distinct from the teaching of the student in the setting of general practice, but I think that it is important particularly for general practitioners who are members of our two Colleges to bear in mind that there are many different roads to Rome, and in all of these schemes, in all of the examples which I have mentioned, the general practitioner can and should take an active part in contributing as a colleague to the planning and the execution of experiments in the field of teaching outside the hospital.

If I may however, I would like to confine myself entirely from now on to the subject of what teaching can be done by the family doctor himself. What are his assets? What does he have to offer? What can he teach? Is this a practical proposition? From now onwards you must forgive me if I sound as if I am preaching, since I intend to limit myself to my own personal experience and the privileged experience I have had in working both with general practitioners who are members of my full-time staff, working it must be confessed in rather specially created and favourable circumstances with access to the advice and assistance of a well qualified medical social worker and a senior public health nurse, but also with colleagues whom I sometimes refer to as real general practitioners, i.e. doctors who do a full day's work in unsubsidised and ordinary general practice conditions as they obtain in the British National Health Service. Because we have found out that it is indeed possible for a doctor to be fully engaged in earning his livelihood as a general practitioner and still be able to contribute effectively to the training of senior medical students.

What then have we general practitioners to offer the medical student? Firstly, we can show them the circumstances under which we work, the nature of the clinical and social problems with which we are confronted, the tools we have to do our job, the way in which we relate ourselves to the preventive, medical and social services which are available in the community. We can present the students with factual information about general practice, and we can show both what is good and what is bad in the daily work that we perform. By this means the student can equip himself with a number of facts, gain some impressions, and acquire attitudes and opinions. He will be able to begin to build up a picture of the way that general practice relates to other branches of the profession. We can present the student with a more complete picture of the range of interests, challenges and opportunities with which the community challenges this profession of ours. This is a worthy goal, and one which is easily within the compass of the ordinary practitioner who is willing to devote the necessary time and energy to the job, and who will take the trouble to learn a few simple techniques of imparting information, creating interest, and exploiting the normal and healthy curiosity

which I find characterises the average medical student.

Having said this however, I wish to emphasize that while this is the easiest task for us to discharge as general practitioners, it is not necessarily the most important, and I am always on my guard to avoid succumbing to the temptation to give this kind of teaching a high priority. It is comparatively easy for instance for me to show a student what the family doctor carries in his little black bag and to discuss the use of drugs and instruments and techniques which we commonly employ. The student is interested in the contents of the doctor's bag, and it is easy to spend quite a bit of time simply allowing him to look inside your bag. What is much more difficult but very much more worth while however is to let the student look inside your mind, because if there is anything at all that is unique in the family doctor-patient relationship as contrasted with the relationship between the patient and the consultant or specialist, then it is in this area surely that we have indeed a unique contribution to make.

If I were asked to attempt to summarize my experience and convictions about teaching in this field in a single sentence, I would certainly say that the whole essence of the problem lies in the nature of the relationship between doctor and patient as it obtains in general practice. It is for this reason that I have considerably changed my own views over the years about the criteria we should look for in the general practitioner who has something worth while to contribute to undergraduate teaching. I go so far as to say almost to the exclusion of anything else that if a doctor is in real general practice, i.e. he is not trying to do two or more different jobs — he is not a frustrated specialist, but is in fact a down to earth ordinary real family doctor, then, if that man or woman has a sound relationship with his patients, not only will he be able to teach, but it is this very doctor-patient relationship which is in fact the vehicle of his teaching. Having established rapport, a sound relationship with his patients, if he is equipped with reasonable clinical skills, with intellectual integrity and a modicum of humility, that doctor will certainly be able to give a student an experience which is of the highest possible educational value.

If we carry this analysis a little further we will see in fact that it is not strictly speaking the doctor who teaches at all. He merely practises medicine, establishes and maintains his doctor-patient relationship, and then manoeuvres the student into this doctor-patient relationship where the student — only one at a time — is present with the consent of the doctor, and even more important with the full and unqualified consent of the patient. Under these circumstances the consenting patient brings the student into this doctor-patient relationship and in the final analysis it is the patient who actually teaches the student. The patient knows what a family doctor is. He or she recognizes the student's role as that of an apprentice to the family doctor, and the patient is anxious to let the student know what he in turn must know about his patient, about the illness, about the relevant social, psychological and personal relationship factors in the patient's environment, so that he in turn may become a family doctor.

While there is therefore a tremendous amount of factual information, of worth while knowledge, information and techniques, which can be demonstrated to the student, and while the students at the beginning of their attachment are primarily interested in these matters of fact — these objective matters of fact and of detail — I am suggesting that the really important lessons to be taught relate not primarily to facts and to information so much as to attitudes of mind. If the family doctor fails to help his student to see a patient or the clinical problem or the clinical-social complex as it appears through the eyes of a family doctor, then he has really failed the student, but since he is a family doctor all that he really needs do is to cultivate the skills of demonstrating this patient and the problem that it presents, as he himself sees it.

I can perhaps emphasize this point by asking you as we ask our own students to examine the implications of two characteristics of general practice which are of special significance to this field of medicine. First, is the fact of direct access. Among all medically qualified men it is the general practitioner par excellence who has the special responsibility to grant to the patients of his practice direct access. This means that in the final analysis it is the patient who initiates the doctor-patient contact, and it is the patient who determines the kind of problem — the kind of illness — he will bring to the doctor. This is in contrast to the circumstances under which the specialist practises. By definition the specialist predetermines the kind of clinical problem with which he will be confronted. The family doctor cannot and indeed may not pre-determine the kind of illness or the kind of problems which his patients may bring to him. The customer can have any kind of illness he likes. He can have a major illness, a minor illness, a social problem, no illness at all. The challenge to the family doctor is that of making an adequate and complete diagnosis when, for instance, a patient comes to him with nothing wrong with him.

There must be something wrong with the patient who comes to the doctor when there is nothing wrong with him. The general practitioner therefore is exposed to the full range of clinical and social problems which confront humanity, and he is in fact confronted in his consulting room or on a domiciliary visit by just such a range of problems. This itself presents unique teaching opportunities because the student sometimes for the very first time in his academic life is able to sit in and see a doctor being put on the spot when the waiting room door opens and a patient appears with a completely undifferentiated problem. It may not be within the competence of the doctor to resolve the problem or out of his own resources to prescribe the appropriate

clinical or social therapy, but at least he has to make a provisional diagnosis and decide what is to happen next. He cannot escape by claiming that the situation is irrelevant to him or that the disease is incurable, that the patient is wicked, or that society is wrong. The fact is that the patient is there and will be there tomorrow and the next day. This is his problem and he must act. A very important lesson therefore that the student can learn and have demonstrated to him dozens of times is just this. What happens at the periphery, on the fringe, when the community, the patient, meets the profession for the first time. This is the first contact with medicine. In this situation the student has wonderful opportunities of learning vividly what medicine can and especially what it cannot do. What society asks of medicine, and what answers it is given in turn.

The second characteristic of general practice of rather special significance to us is the continuity of access which the patient has to the doctor. Continuity of care provided by the general practitioner enables the student attached to that doctor to think of a disease process as having four dimensions. A demonstration of the significance of the time factor in the evolution of an illness can be used to arouse the student's interest in the physical and social consequences of disease, not only as they affect the patient at a given point in time, but as they are likely to affect him and his family both in the immediate and in the distant future. The importance of arriving at an accurate prognosis, and the realistic but practical difficulties of answering the patient's questions openly expressed or delicately hinted at, can be eloquently demonstrated. The husband and family of a woman with malignant hypertension and third degree retinopathy cannot be fobbed off with a generalisation based on her statistical chance of being alive at the end of two years.

The student in the middle of this situation can see the doctor being pinned down to supply information to deal with the realistic and practical questions and anxieties which this family must meet, and plan for, and adjust to, in the present and immediate future. Similarly continuity of medical care which has been provided by a doctor for a patient and his family in the past, and which is continuing into the future, is readily and vividly appreciated by the student who can be brought by the family doctor to the realisation that his patients are indeed the children who are not yet born, and his responsibility extends into the next and succeeding generations.

Once a student has grasped this notion, and it is comparatively easy for a family doctor to demonstrate this in his own practice, the student begins to realize that in a practical situation where the individual doctor is confronted with the individual patient, there is no sharp dividing line between preventive and curative medicine, between medicine itself and sociology, and when later he returns to the hospital or to his future work in teaching or research, he is likely to retain some insight into the indivisibility of medicine, and the importance of relating the work which he will later do in his own chosen sphere, to that of his colleagues working in different branches of the profession.

In this regard I would reiterate my personal conviction that teaching in the field of general practice, and particularly teaching by general practitioners, should not be primarily directed towards a vocational bias. Most medical schools deny that it is their special responsibility to turn out ready-made general practitioners or potential specialists or research workers. In the same way it can be claimed that the educational experience to which a student can be exposed by a family doctor is of particular value to the student who is not destined to enter general practice but is already aiming at a career in academic medicine, in research, or in the public health services. If there are any priorities it is probably more important for the future consultant to have this experience than it is for the future family doctor.

I would like now to turn to a brief consideration of some of the more practical issues which are frequently raised when the teaching of medical students by general practitioners is discussed. The first concerns the very important topic of how acceptable is this to our patients. Will they tolerate the intrusion of a student into a private consultation with their own doctor? Until ten or fifteen years ago in my own country, and certainly in the United States, patients who were visited by students in their own homes were certainly confined to the lowest social class and income groups. They in fact accepted a student because they were indigent or medically indigent, and had no other opportunity of obtaining personal medical care. The introduction of a National Health Service in Great Britain abolished the category of medically indigent and, while most of my own patients belong to a social class which would normally have but limited access, by payment, or as a right to a personal doctor, all of them are now completely and unreservedly entitled to refuse to have a third party present when they consult the doctor of their choice. Occasionally an individual patient will exercise this right. Occasionally a doctor will himself take the initiative in dismissing a student from a particular interview, but we have had no real difficulty at all in introducing the students, providing they come only one at a time, into the most intimate of consultations. Indeed in very many instances it is the student rather than the patient who is embarrassed and slightly ill at ease in the course of some consultations.

The general practitioners in the city who are associated with me represent in their practices the widest possible range of cultural and social class among their patients, and I have no real evidence that there is any category of patient which presents any special difficulty in this regard provided always that two circumstances obtain:

1 that the circumstances are adequately and personally explained to the patient by the doctor, and the

patient's right to refuse to co-operate is clearly and unreservedly accepted, and

2 provided that in all cases a real and adequate family doctor-patient relationship already exists before the student is introduced. In other words, I suggest that where there are difficulties they are to be found in an inadequate patient-doctor relationship, for instance a new doctor in a new practice.

A second topic of practical importance is the optimum time in the medical curriculum to introduce students. I am firmly convinced that this instruction must remain in the undergraduate category and not be delegated to a postgraduate or specialised experience, and having said that I personally prefer to have the student as late as possible in the curriculum. The more he knows, the more clinical skills he possesses, the more he can extract from this experience, the more easy is it for the doctor to delegate some degree of responsibility because the student is unlikely to get a very great deal out of this if he cannot be given some delegated and purely personal responsibility for a diagnostic assessment, and an essay into the field of therapeutic management.

Thirdly, the only other practical point that I would like to raise here is the question of whether this experience should be in a solid block, and if so for how long, or whether it should be an interrupted and more prolonged experience. I personally prefer to have the student for ten hours spread over three or even six months, than to have him full-time, day and night, in my practice for the same number of hours. The student is likely to get very much more out of his experience if this is being interrupted by return visits to the clinical wards of the teaching hospital, by systematic lectures and reading, so that he has the constant challenge of seeing a problem of hospital diagnosis and management in terms of what the social and family implications of this illness are likely to have, so that he is thinking of what happened to the patient before he arrived at the hospital, and what is likely to happen to him later when he leaves. This also helps the student to integrate his knowledge and experience and not regard his visit to a general practitioner as an interesting trip down a side alley which is not immediately and obviously relevant to the studies which he is at present pursuing in the medical school.

A second reason for advocating this interrupted experiences is that the student who has spent four or five years in the study of medical science will, if he has been adequately taught, approach any new subject in the spirit of scientific analysis. This is the essential and necessary approach, the clue to the method of medical advance. In the practice of medicine however, the clinician and especially the family doctor has to begin with a scientific analysis of the problem presented by the patient, but has to go on from there to a process which is essentially that of synthesis, of putting this scientific evaluation of the clinical problem alongside his knowledge of the patient as a person, as a member of the family, as a member of the community, and thereby arriving at a complete diagnostic rationale for a regime of therapy. The essential feature of this approach therefore is one of synthesis rather than analysis. The acquisition of new attitudes, a different philosophy, or a different approach on the part of a medical student, cannot be brought about overnight and certainly cannot be inculcated by didactic methods of teaching. There are some things that the student has to learn for himself, and he has to take time to ponder before drawing his own conclusions. The student does not believe me if I quote Rousseau to the effect that there are no diseases but only sick persons, but when he has been manoeuvred by a family doctor into a situation where he has to study an individual patient as a person, it is surprising how often he himself will sum up the situation in words which are a very close approximation to this dictum.

I therefore prefer that the student's exposure to family medicine should be co-ordinated with his teaching in other academic departments. This has the special advantage that it brings together the academic teacher and his general practitioner colleague. I do not think that the choice of the subject which is linked with general practice is necessarily of paramount importance. The clinical disciplines, particularly medicine, surgery, psychiatry and paediatrics, have obvious and strong links with family medicine, but there are also very great potentialities for co-ordinating a general practice experience of the student with the teaching being done concurrently in an academic department of preventive or social medicine. Whether this takes the form of study projects, of group enquiries, or joint seminars, is relatively unimportant so long as the academic teachers involved devote the necessary time to join in consultation and planning with their colleagues in general practice, so that the teaching objectives are clearly defined and fully accepted by all concernod, and the precise details worked out in the light of local circumstances, opportunities and challenges.

I would like now to conclude with one final point. General practice is in a state of flux. Patterns of morbidity and the clinical and technical problems which they present, have changed quite dramatically in the past twenty years or so. The extent of this provision of community medical and social services have also in most countries undergone dramatic change. The effects of these changes are by no means worked out and we can only begin to detect trends. I certainly would not like to forecast with any degree of precision what the family doctor will be doing, what kind of work, what kind of clinical and social responsibility he will be accepting twenty years from now. What will be his relationship to his hospital colleagues and to his colleagues in the field of public health and preventive medicine — and yet this is in fact the challenge which faces all medical schools namely to turn out a graduate who will be basically equipped to be able to make the necessary adjustments in his skills and techni-

ques, so as to become the kind of doctor which the community will need to have in twenty years time. Most of the pressing problems which face up to-day will not be resolved by us, but will have to be tackled by the students whom we teach. It is important therefore that every medical graduate should leave his medical school reasonably knowledgeable concerning the problems of providing integrated and comprehensive medical care for the community. It is important that he should learn to analyse the nature of the present day problems of the general practitioner. It is just as important, perhaps even more important, that he should know what is wrong with general practice, and if occasionally we show him an example of very good general practice under optimum conditions, then we should not be too disappointed if when he is launched into the world he is frustrated or angry about the circumstances in which in reality he will have to work.

In fact it is only by producing a generation of angry young men who see the potentialities of good general practice, and who are angry enough because the facilities are so inadequate, that they are imbued with a desire to do something about it. It is only when this obtains that they in their turn will make the most effective contribution to the next generation.

Members of the Netherlands College of General Practitioners are in the main individuals who have faith in family medicine, but who are impatient and anxious to raise the clinical and professional standards of all family doctors, and I can think of no more effective way of making a lasting and worth while contribution than by suggesting that they should join forces with their academic colleagues in the field of preventive and social medicine in an attempt to see that the next generation is better equipped than we are, to raise these standards.

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61-025. Verslag van de Dutch study tour 1960. *Poslavsky, A. (1960) Mbld. v. d. Geestelijke Volksgezondheid 15, 193.*

Dit verslag geeft de ervaring en indrukken weer van een tiendaags bezoek van Nederlandse psychiaters aan instellingen, werkzaam op het gebied van psychiatrie en geestelijke volksgezondheid in Engeland.

Opvallend is de grote doorstromingssnelheid in alle bezochte instellingen, welke niet wordt bereikt door betere diagnostiek of door het gebruik van voor Nederland onbekende geneeswijzen, doch het gevolg is van een accentverschuiving in het psychiatrisch denken. De psychiatrische aandoening wordt vooral gezien als een stoornis in het sociale gedrag, van de sociale aanpassing. Hierdoor krijgt de psychiater een grotere bewegingsvrijheid. Men wordt vooral getroffen door de centrale plaats welke wordt gegeven aan de gedachte: wat is de taak van onze instelling in onze speciale gemeenschap?

Het Engelse ziekenhuis, zowel het psychiatrische, als het algemene, maakt veel meer dan hier deel uit van de gemeenschap. Het publiek loopt veel meer ongedwongen in en uit. De patiënten en de medische en verplegende staven onderhouden intensieve contacten naar buiten. De afstand tussen binnen en buiten het ziekenhuis is veel kleiner dan bij ons. Hierdoor wordt tijdige opneming bevorderd en een onnodig lang verblijf in het ziekenhuis tegengegaan. Op deze wijze verliest de psychiatrische inrichting het karakter van gesticht. Alle psychiatrische ziekenhuizen bezetten een centrale plaats in de psychiatrische zorg in de maatschappij; daarnaast bestaan daghospitalen, bureaus voor huwelijks- of gezinsmoeilijkheden en voorlichting aan huisartsen. Nergens ontbreekt de maatschappelijke werker en de polikliniek en ook hierdoor vermindert de afstand tussen ziekenhuis en maatschappij.

De medische staf van de psychiatrische ziekenhuizen bestaat uit een geneesheer-directeur, part-time consulenten, psychologen en sociaal opgeleid personeel. De directeur is verantwoordelijk voor het beleid in het ziekenhuis en voor de verbindingen met de buitenwereld. De consulenten zijn belast met de psychiatrische behandeling, zij werken naast, niet onder de geneesheer-directeur.

In Engeland wordt veel gewicht gehecht aan „hospital"- en „nursing-administration". Het zijn erkende leervakken voor geneesheren-directeur, directrices, hoofdzusters enzovoort.

Bij de behandeling wordt de patiënt gezien als lid van het gezin of de gemeenschap, waarin hij thuis hoort. Het contact tussen patiënt en familie wordt zoveel mogelijk bevorderd door de maatschappelijke werkers, door dagelijkse spreekuren des avonds en door bijzondere maatregelen. Zo worden bijvoorbeeld bij opname van moeders met kleine kinderen ook de kinderen opgenomen. De aandacht van de patiënt wordt vooral gevestigd op de problemen, die voor hem reëel en actueel zijn. Zo vindt men soms op de afdelingen keukens, waar de vrouwen weer kunnen leren koken. Ook de familieproblemen worden onder ogen gezien; in een ziekenhuis voor bejaarden spreekt men bijvoorbeeld bij ontslag af, dat de patiënt weer kan worden opgenomen, wanneer de familie met vakantie gaat. Men tracht de behandeling zo veel mogelijk met de patiënt te doen plaats hebben en niet voor en over de patiënt. Zo regelen de patiënten de recreatie en men tracht de organisatie van de arbeid, van de dagindeling enzovoort met of zelfs door de patiënten te laten regelen.

De uitstekend opgeleide verpleegsters hebben een andere status dan in Nederland. Zij worden beschouwd als gelijkwaardige partners van de artsen en genieten een hoog salaris. Zij zijn dus goed op de hoogte van de ziektegevallen op een afdeling en van het beleid. Vele verpleegsters wonen buiten het ziekenhuis en leiden een intensief sociaal leven. Zij leren dat het niet voldoende is medische voorschriften uit te voeren, doch, dat zij moeten leren handelen op grond van eigen inzichten. Het begrip toewijding maakt plaats voor realistisch inzicht.

Intensief is ook het werk rondom de psychiatrische inrichting. In de dagsanatoria wordt gepoogd door een soepele, op de behoeften van de patiënt en familie afgestelde, behandeling opname overbodig te maken. Van belang zijn vooral ook de polikliniek en de sociale dienst, die de voor- en nazorg behartigen. Ook dit vergemakkelijkt weer de overgang ziekenhuis-gemeenschap en omgekeerd. Bovendien hebben de meeste ziekenhuisartsen een deel van hun taak buiten de inrichting. Men krijgt hierdoor een betere indicatiestelling tot opname, omdat zij beter op de hoogte zijn van de mogelijkheden van het ziekenhuis en van de verhoudingen en mogelijkheden in de maatschappij.

De gebouwen waren bijna overal oud en weinig doelmatig; de inrichting was echter aantrekkelijk en gezellig. Het beschikbare geld is vooral belegd in mensen; de medische staf is zodanig, dat niet het minimaal, doch het optimaal mogelijke met en voor de patiënten wordt gedaan.

De schrijver eindigt met de verzuchting: „De uitkomsten, die in Engeland worden bereikt zijn zodanig, dat niet alleen de