Education of the General Practitioner in Leyden and the Other Medical Schools in Holland*

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SUMMARY

The new medical curriculum and specialization in the Netherlands are discussed. In Leyden a 'peripheral clinic' has been established where 128 GPs work together with the university. The idea of a junior co-assistantship of only 3 days in the second year is introduced. The student gets a mentor (GP) and a family in the practice of his mentor. He visits this family several times a year during 4 years. The subject of 'choice-education' is discussed and a description given about the system of 'medical problem solving' as it is used in Leyden.

During the last few years medical education in the Netherlands has led to intensive discussions and many plans. Until now there has been no specific training for general practitioners in Holland. In a curriculum lasting 7 years the university educated all students for a uniform examination for medical doctors. With no further training every doctor could establish himself as a general practitioner after this examination. Future specialists had to follow a special training of 4 or 6 years, medical health officers for 2 years.

In the new curriculum there will be 6 years' training, the same for all doctors, concluded by an examination as an assistant doctor. After that there will be courses for specialization: 2 years for medical health officers, 4 to 6 years for specialists, depending upon the subject, and 1 year for general practitioners. This training of the general practitioner will take place in a hospital for 5 months, for 5 months in a general practitioners' practice and for some weeks in the institute of general practice connected with the university.

These are the rough outlines and during the coming years when this special training will start, we hope to find a definitive form. Probably the execution of the basic programme until the examination of the assistant doctor will differ from university to university. All universities in Holland have now already started the new curriculum preceding what we call 'the 7th year'. In the training for general practitioners we can of course not restrict ourselves to the 7th year, but in the preceding 6 years we have to include an important part of general practice, especially because this is the only way for the future specialists and medical health officers to become acquainted with general practice.

Not all universities in Holland are at the same stage in the new curriculum. In Utrecht, where Dr Jan van Es, who visited South Africa 2 years ago, is professor of general practice, the new curriculum started 6 years ago, so in 1971 the first year of training in general practice will start. During the next few years the same will happen in the other universities. Every university has its own method of dealing with the problem. Twice a year there is a meeting of the staffs of all institutes for general practice where developments are reported, while the professors in general practice meet once every month. By this intensive co-operation we hope to come in future to a more or less uniform training programme.

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METHOD OF TEACHING

Apart from some practical courses in the basic sciences during the first years of study, until some time ago the 'look and listen' lecture was the only way to pass on the knowledge to the student. By using the modern audio-visual resources such as slides with sound, video recording of TV tapes, films and teaching machines on the one hand, and bringing students and teachers together in colloquia on the other, a lot of changes have been made. We try to visualize the medical examination and the interview with the patient and to show this to the student.

However, there is a great danger in using these technical media for the sake of the technique itself and in my opinion we will have to seek a combination between the traditional lectures, the use of teaching machines and other audio-visual aids and education in colloquia. While lectures, teaching machines and films reaching hundreds of students need only a few teachers, colloquia require an extensive staff. In Leyden we tried to solve this problem by establishing our so-called peripheral clinic and also in Rotterdam this method is practised. For this purpose we made certain of the co-operation of 128 general practitioners within a radius of no more than 20 miles from the university. From the large arsenal of more than 500 general practitioners these 128 doctors were chosen by self-selection. If every one of these 128 general practitioners made themselves available for only 1 hour once a fortnight for leading a colloquium this would mean an output of more than 3 000 colloquium hours a year, something not possible for a full-time staff of 4 doctors in addition to their normal work. But apart from that, the advantage is that these 128 general practitioners are working daily in their practice, so that they can bring the problems from the background of their own experience.

How to transmit the problems of general practice to the students and at which stage of the curriculum? My personal experience, and this is shared by many lecturers, is that the student has to be acquainted with general practice as early in the curriculum as possible to counterpoise the mass of facts offered by the clinical specialities. With this in mind I want to mention to you the system of junior clerkship in Utrecht, where already in the third year the student spends a period of 1 week with a general practitioner. Because of the great work load imposed by this on the general practitioners round the university it is still not possible to have also a senior clerkship, or as we say, a co-assistantship in general practice.

It is my opinion that this confrontation is useful and necessary and in Leyden we are considering introducing,

apart from the senior co-assistantship that takes place during the 6th year, a junior co-assistantship, of only 3 days. This can only be a fleeting acquaintance, but with this plan we intended to start a more intensive contact between the training general practitioners and students. The general practitioners who receive a junior co-assistant introduce this student into a family in their practice. It is the intention that the co-assistant visits this family, makes a report on the medical condition of this family and discusses this report with his mentor-general practitioner yearly. After 3 years he can do his senior co-assistantship with the same doctor. This means, that every general practitioner out of our peripheral clinic will receive a junior co-assistant on average twice a year for 3 days, and a senior co-assistant twice a year for a fortnight. In addition to this he has to have a discussion once a year with all 8 co-assistants for whom he is the mentor, about the reports on the families, but it is possible to do this in a colloquium with all 8 students together. During the course of 1971/1972 a start will be made in Leyden with this junior clerkship and the mentorship of the general practitioner on a voluntary basis.

In addition we have in Leyden and in the other university towns during the 4th year the so-called 'choice education' in which the student during some months can make a choice between two courses.

In the course named 'Life-cycle' the effects of ageing are discussed. This course includes among others the following subjects: the clinical picture, perception of disease and growing older, growing and maturing till adult, growing old, exercise in old age, medical support of those growing older, sexuality in old age, the life-cycle and contemplation of life, dying and death.

The alternative course is named 'General Practice'. Subjects of this course are: tasks and functions of the general practitioner, orientation and methods of the general practitioner, after care and reactivation, preventation and screening, support and communication, organization and co-operation, and selection and treatment.

During and after these introductions group discussions are held about a number of cases concerning the collection and evaluation of facts that are useful for the analysing of medical problems and for formulating alternative solutions. This is what we call in Leyden: 'Medical problem solving', and it might be useful to explain to you what we understand by this term and how we apply this method. Problem solving is a method derived from commerce and industry, but in America it has been introduced also into medical education. In principle this method can be applied in every field and in Leyden first the department of medicine and afterwards our department of general practice has started to give the students an insight into medical problems in this way. During the summer of 1970 Dr Peter Ways of the Michigan State University in East Lansing, USA, gave a course in Leyden for the medical lecturers. Dr Ways is one of the fellow-workers of Professor Jason, who introduced the method of problem solving into the medical profession. The chief characteristics of the European approach of the question: 'How to become a medical doctor' are the systematics. The subjects of the first 3 years of the curriculum represent the parts and functions of the human body in its healthy state and its environment. After the first examination the same is rehearsed, but now with relation to the sick person.

It seems that until now medical education throughout the world was very strongly 'discipline oriented'. This had its educational advantage, but also its disadvantages. The chief disadvantage was seen to be that it became more and more impossible to fit the patients with all his problems into the scheme. It is difficult to place in one of the categories of the curriculum a 70-year-old, mentally disturbed woman, with severe diabetes, a blood urea level of 800 mg/100 ml and a badly healing fracture of the neck of the femur. It must be clear that it is not always possible to consider a patient as suffering from only one disease, as this disease allows itself to be analysed into a number of problems. So it is better to take 'problem oriented' education as a starting point.

In the procedure of 'medical problem solving' a brief case history of a patient is distributed to a group of 10 to 15 students. This is a real case and the facts are also those with which the general practitioner works in practice. The students are given 5 minutes to study these facts. The facts are arranged in a number of categories and, following the scheme of Medalie, we use these categories:

the primary physician (Medalie: diagnostic level)
the general doctor („ : care level)
the personal doctor („ : personal level)
the family doctor („ : family level)
the community health physician

When the GP acts as a primary physician, he draws up his medical working hypothesis, that is to say formulating the symptoms, the signs and diagnoses on which his conduct of selection and treatment is based, provisional or definitive. When he acts as a general doctor he widens the medical diagnostics and treatment by registering and taking into consideration the former diseases; by the treatment of chronic diseases and multiple abnormalities and by tracing abnormalities in patients of a special risk group.

When he acts as a personal doctor he is individualizing the medical care by considering the structure of the personality and the individual patterns of life of the patients in his diagnostic considerations; by adapting the treatment to the personality of the patient as much as possible and by offering himself as a sensitive medium.

When he acts as a family doctor he considers the circumstances of the environment of the patient in the diagnosis as well as in the treatment.

When he acts as a community health physician he promotes national health by individual hygienic information, by good teamwork with other institutions and by taking part in activities directed to the promotion of a healthy mental climate.

An article has been written by some members of the Leyden Institute of General Practice on this approach to general practice.[1]

We ask 5 students respectively to evaluate the facts in each of these categories. This is, as it were, the analysis of the problem. After this we ask one of the students to formulate the problem again, bearing the preceding analysis in mind and now we discuss in the group the alternative solutions, after which the group chooses the best alternative. This done, the group makes a plan for the treatment.

Our scheme, and that of Medalie, are used to prepare the students for the co-assistantship with the general practitioner. This is the last time we are occupied with the medical students before they start specialization. The document I mentioned before has been discussed with the host-general

practitioners and has to be studied by the students before they enter their co-assistantship. During their stay of a fortnight with the general practitioner they have to consider on which of the levels the general practitioner is working on a special case, and they have to discuss this later on with the general practitioner.

With this method we hope to ensure that the students, both future general practitioners and future specialists, learn that the general practitioner should not only think in terms of clinical diseases, but also that he meets the patient as a general doctor, a personal doctor and a family doctor, bearing in mind also the community, and in doing so, giving his own dimension to general practice.

REFERENCE

1. Ten Cate, R. S., Dijkhuis, H. J. P. M., Van der Ent Braat, P. K., Hennink, M. P. and Van der Kooy, S. (1970): Huisarts en Wetenschap, **13**, 313.