General Medical Council education conference

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Noah commanded his fellow travellers to enter the Ark two by two and so the General Medical Council invited every British medical school to send two delegates on 27 February 1974 to its third educational conference. The subject was *The contribution of the teaching of general practice within the context of the aims of undergraduate medical teaching.*

From the chair, the President, Sir John Richardson, emphasised the modern graduate is a medical-scientist ready for vocational training, not the safe general practitioner of yesteryear. Dr John Fry opening, stressed the General Medical Council was actually charged by statute to educate doctors " for the British system of medical care " and it was critical those not entering general practice should see it in action before qualification, especially diseases and episodes outside hospital where resources never met utopian demands. Professor Bryne described the variability of present schemes: 7 of 29 medical schools still make no provision for any general-practice teaching for all students, many have minimal schemes and there are still only six English chairs, none in London. Teaching required a philosophy with correct attitudes, backed by resources, but with flexibility, experiment and evaluation. The morning discussion perseverated on the gauntlet thrown down by a Guy's consultant " What can general practitioners teach better than consultants? " Many key general-practitioner teachers rose to this, giving examples of their methods, but it appeared their words more heartened the faithful than miraculously converted some teaching hospital establishment figures. In spite of valiant attempts by the G.M.C. President and the College Secretary, Donald Irvine, to move the discussion to a more fruitful, constructive field, this remained the gut issue of the day. Professor Wilkes was agreeably surprised to find students appreciated the older general practitioners who know their patients, rather than the academic young " with-it " types. The value of practitioners on hospital teaching rounds was agreed, except that they needed changing regularly because, with time, they became hospital orientated. Students from Glasgow, who followed self-poisoning patients home (including interviewing the general practitioners) found their attitudes change when they saw, at first hand, the person behind the problem.

After a talking lunch, Dr David Morrell of St. Thomas', London pointed out the inverse law of teaching general practice that the nearer the teaching hospitals the greater the incentive needed for good general practice. He outlined his solutions. Professor Knox itemised ten problems, including how to sack a bad general-practitioner teacher. Does a student's presence materially alter a consultation? He asked should a student seek bad (non-excellent) practices and if so by whose judgment? Dr Jimmy Walker of Newcastle described how, by evolving teaching from basic first principles, consultants and practitioners had come closer together, not only as teachers, but for the benefit of patients. This was later corroborated by Dr Walton the Dean. Mr Watt, of Newcastle, the student spokesman from the B.M.S.A., spoke with maximum assurance and effect, whether quoting from the Consumer Association, W.H.O. or *Homes and Gardens.* He advocated the team approach epitomised in the health student group. In training general practitioners for the year A.D. 2000 he deplored elitism and valued behavioural sciences, using peer groups to mould attitudes.

Afternoon

The afternoon discussion was more practical the curriculum's insatiable appetite for time, how to find 125 teaching practices in one region, the use of problem orientated records, and the disappearance of the general physician and his replacement by the organ specialist.

Professor Marshall Marinker summed up the meeting in a characteristic fashion, leaving no consultant in any doubt that the college book *The Future General Practitioner—Learning and*

Teaching was applicable to undergraduates. He emphasised the incompleteness of practice, the absence of high technology, the closeness of doctor to patient, the types of diagnosis, the conflict between the welfare of the individual and the population. He stressed the resources of time and space needed, but felt general practitioners had the challenge to humanise medical teaching which was increasingly veering to technology.

Summary

The day was provoking rather than satisfying. In part it was like a college meeting, swapping ideas and solutions with problems, but mixed with this was a dialogue with consultants, varying from the converted in Newcastle to the entrenched at Guys. Perhaps the overall impression was the unevenness of present facilities for all students to have at least one week in practice, certain London schools appearing antediluvian in this aspect.

Nevertheless it was an inspired idea to make each medical school send delegates and especially to survey the range of general-practice teaching arrangements. These varied from highly organised professorial units, to the virtually nonexistent who did not actively obstruct those students who wished to sacrifice overseas trips in electives for their only chance of seeing British general practice. The General Medical Council in Hallam Street was certainly, to many, a novel venue and there was some false jocularity over initial uneasiness of the setting. I could not help wondering if the back-woods medical schools would alter attitudes and if not what more could be done. Finally this conference was an endorsement of college influence in academic spheres. Each medical school who chose to send general practitioners seemed unanimously to select college fellows and members to represent them. It is difficult to envisage such a conference if the College had not existed and as undergraduate education in general practice moves from a phase of experimentation to consolidation it is obvious the College is well poised to help.

REFERENCE

Royal College of General Practitioners (1972). *The Future General-Practitioner—Learning and Teaching.* London: British Medical Journal.

BALINT GROUPS IN HOLLAND

Although Balint's teaching has entered the language of general practice, less than one per cent of British general practitioners have personally attended long-term seminars to discuss the psychological problems of patients in their practices. Furthermore, these seminars are rarely available outside London. This contrasts with the experience in Holland where 15 per cent of established general practitioners over the whole country have attended similar groups including their college President, past President and Dutch professors of general practice. To investigate why the Balint type of training has spread so successfully in Holland, Dr Robin Steel of Worcester was awarded a Council of Europe Fellowship, and has published a personal report entitled *Le Phenomene Hollandais.*

In this he points out the Dutch are still chiefly in single-handed practice and have little postgraduate education. Both the Dutch national temperament and the compact geography of Holland fostered growth of discussion groups which were heavily sponsored by the Dutch College of General Practitioners. Dr Steel makes 12 specific suggestions to British general-practitioners, teachers and regional advisers. For maximum benefit, seminars should last over two years, meeting fortnightly with nine to 12 doctors who have been long enough in practice to appreciate the problems of continuing relationships. This provocative report is designed to stimulate debate.

There are a few remaining copies available on request.

Steel, R. (1973). *Le Phenomene Hollandais,* Council of Europe Fellowship Report. St. John's House, 28 Bromyard Road, Worcester.