people. It may be that these comments are superfluous, and reflect only my own lack of knowledge. If so, then although some of the blame lies with me, some must lie with those who only six years ago taught me in medical school, for failing to direct my reading. If the concepts put forward are accepted, even if altered, then the dovetailing of the family doctor with the specialist will be effective, and not as now, too clumsy: each will know his own job. Equally, what I have said will only apply fully in the context of England: clearly a doctor who cannot set a Colles' fracture is a poor doctor 100 miles from specialist help: but equally a doctor who only sees one Colles' every two years would be failing in his duty if he did not ask a specialist five miles away to do so.

I understand that the Vocational Report on General Practice Teaching has been well received in many quarters. I am concerned that as its syllabus stands at present it should not be too well received, for it fails to distinguish what should be taught by specialists to general practitioners, what should be taught by general practitioners to specialists and those whose aspire to be general practitioners, and what should not be taught but quickly acquired. It does not define a corpus of knowledge which is peculiar to general or family practice. Dr Ian McWhinney, in the *Lancet*, defines such a syllabus completely, and effectively, though not in detail.

Acknowledgements

My thanks are due to Dr William Cammock of Tuxford and Dr Pinsent of Birmingham for their constructive criticism, although of course I am entirely responsible for the views expressed: I think they disagree with me on a number of points.

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THE STRUCTURE OF THE COLLEGE OF GENERAL PRACTITIONERS

A radical view

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IN THE HISTORY OF THE College few major issues have been more keenly debated than the criteria for admission to membership. The controversy continues despite a tightening of regulations in November, 1964, but

these still permit the grant of membership without a compulsory examination.

The present position is as follows. Some believe that entry to membership should not be too demanding; thus a relatively large section of the profession could take advantage of the educational, research and other facilities which the College is committed to provide. Others disagree because they hold that the successful candidate must have a thorough and special knowledge of general practice. They argue that the qualification should be highly selective and of a standard commanding high esteem from general practitioners, other medical colleagues and lay bodies. Current membership regulations represent a compromise solution which is still unacceptable to a proportion of members who favour the latter view.

The crux of the dispute is not the disagreement over membership. Rather it is concerned with a principle which, if accepted, would have a profound effect on general practice itself. To stimulate debate the subject may be expressed in the form of two propositions:

1. It is now timely for general practitioners to adopt very high standards of professional competence and so to identify those doctors who reach the desired standard.

2. Thereafter, if their contribution to medicine in general practice is deemed worthy by their elected peers, such doctors should receive special academic and financial recognition.

In this paper I am concerned largely to question the validity of the assumption on which these propositions are based, namely, that it is in the best interests of general practice to link a strong competitive stimulus with academic performance. The argument may be presented with greater clarity if I offer the reader certain practical conclusions drawn from the basic propositions.

Preliminary conclusions

The College is today the only academic body representing general practice. It cannot fulfil completely its main objectives, as laid down in the Memorandum of Association, unless the structure can be modified along the following lines:

1. A diploma in general practice should be introduced forthwith. This diploma, attainable only by examination, should become the College's highest objective standard of professional competence. As such it should be critically selective.

2. The College structure should be allowed to evolve further so that fellowship may be accorded *de facto* supremacy. Since fellowship would denote academic distinction, it is desirable that the candidate should satisfy the following criteria:

(*a*) he should be a diplomate of the College;

(*b*) he should furnish evidence, in the form of an approved M.D. or Ph.D. thesis, that he has broadened the base of his medical education.

In the process of final selection before election, particular attention should be paid to the quality of the candidate's original contribution to medicine in general practice.

3. The current regulations for membership should remain unchanged so that

entry to the College is not prejudiced.

A competitive stimulus: Is it necessary?

The question can be considered only in relation to the future role of the practitioner in society. This is a complex problem, but there may be two main alternatives:

1. The practitioner would be a medical field worker with limited clinical responsibility. He would render domiciliary first-aid to the sick, and would deal with minor illness, certification, and the day-to-day care of the chronic invalid and the elderly. He would become increasingly committed in the fields of social and preventive medicine, with special reference to routine immunization, health education and repetitive screening procedures.

2. The practitioner would function as the patient's personal doctor, accepting full responsibility for overall medical care. Narrowing his range of interest to some extent, he would be concerned predominantly with the diagnosis and treatment of illness in the environment of the patient's home and in hospital. Affairs connected with preventive medicine and certification he would usually delegate to the staffs of the medical officer of health and regional medical officer respectively.

In short, practitioners can become either the errand-boys of medicine or general physicians with a special interest in the continuity of personal medical care.

The first alternative does not imply mere cynicism. There exists today a majority of established doctors who are content to practice in such a manner, given a reasonably secure income. Moreover, it must be evident to the discerning that both the health departments and the specialties are privately anxious to foster this concept of general practice. Obviously no academically slanted incentive would be necessary. A reasonable degree of proficiency could be achieved by means of a compulsory course in domiciliary medicine for new entrants, supplemented later by regular periods of revision.

Theoretically, the second alternative should prove more attractive to practitioners. It cannot be achieved unless many doctors are prepared to give service of much higher quality than is general today. Leaving aside the important question of facilities and ancillary services, a political problem, this means that practitioners must become as skilful in their own field as are specialists in theirs. A comprehensive vocational training programme would be vital to this end, but of itself inadequate; the young doctor would need to show fitness to accept clinical responsibility by reaching an objective standard of clinical competence.

Inevitably, if a mode of practice based on competitive selection is introduced there would be a drastic reduction in the total complement of doctors. However, these men would be highly skilled. If such skill can be employed with maximum efficiency I suggest that it should be possible to maintain an effective personal medical service with an establishment not in excess of ten thousand.

Recruitment

If it is our aim to promote service and research of high quality, general practice must attract a reasonable number of the most able, dynamic and

ambitious graduates emerging from the universities. These men and women can afford to be selective in their choice of career; potential earning capacity, facilities for research, opportunities for teaching and private study, and ultimate standing both within and without the profession are factors which will influence their final decision.

Competition for such a service would be keen. In particular the specialties have a certain appeal because of insistence on high standards and the evolution of a hierarchical academic and fiscal system which places a premium on valuable, original work. By contrast the present picture of general practice looks somewhat uninviting.

A recent survey of opinion amongst 5,000 junior hospital staff has proved at once enlightening and depressing. Dr Maurice Rosen (1965) was reported as saying that 7.6 per cent of doctors wanted to go into general practice, 16.2 per cent had definitely decided to emigrate and 40.1 per cent at present intended to be consultants. Of the 40.1 per cent, 10.3 per cent said that they too would emigrate if they did not seem likely to gain a consultant appointment and conditions did not improve. An obvious conclusion can be drawn from these figures, namely, that the most talented and capable of our younger men reject openly the concept of the errand-boy doctor.

Summary

I believe that the College must clearly define its future purpose. If it is to survive, it must reconsider, in my opinion, its policies along the lines suggested.

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CLINICAL NOTES

WAX IN THE EARS AND ITS MANAGEMENT

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THE ATTENDANCE AT THE CONSULTING ROOM of patients suffering from the effects of impacted wax in the ears is a common happening. Studies have been made of patients presenting with wax in ears in general practice (Horder and Horder 1954, Davies 1958, General Register Office 1962) but there has been no attempt to assess the need for wax removal in patients seeking advice for other reasons. An attempt is made here to discuss the