Preparation for teaching in general practice*

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THE South-west England Faculty meets today to honour Arthur Gale, a pioneer in education for general practice, a friend of the general practitioner, a man who had the prime qualification for any pioneering—fire in the belly. Pioneers rarely see the ways in which their efforts develop. They point directions which those who follow will bend to meet new circumstances and new challenges. These today give general practice a unique opportunity to help to shape its own destiny, by defining its role in the future community and for the first time in modern history by learning to teach itself. It is doubtful if even Arthur Gale could have foreseen that this opportunity would come so soon, but there seems little doubt that he would have regarded it with satisfaction.

'By preparing teachers—and for this College there is no more urgent task', was a phrase I used in a lecture earlier this year.[1] In many places in the United Kingdom and in Europe and the New World, people are preparing for the first time to teach and train for the practice of medicine in the community. How they will teach, what will be taught, are questions which must be answered. The answers will vary and depend to a large extent on individual experience, judgement and opportunity. Little is accurately known of teaching in general practice, much is postulated on opinion or subjective evidence, while there has been a common failing of planning a process of self-replication, rather than of planning for the future.

After 30, busy, satisfying years of practice in a rural area, chance has provided me with the opportunity and duty to help to develop a programme of teaching in and for general practice in a far-seeing and wholly helpful medical school. Manchester, the centre of one of the great connurbations of Britain, and 80 miles from my beloved Westmorland, is changing from a sooty Victorian sprawl into an exciting, modern, functional city. The proposed new education precinct on whose ground plan all the new university buildings are being placed, will cover 284 acres and house—when completed—25,000 students.[2] In late middle-age I have been—like Bottom—translated, and the experience of complete change in environment, in a way of life and thought is a stimulating process. This is the first point I would wish to make. Whoever may seriously take up teaching must be prepared to accept major changes and to regard them as necessary, exciting preliminaries in the evolution of a defined medical discipline.

Because we in general practice have no long academic tradition we are at a disadvantage in that we have a sense of inferiority and awe in the presence of medical academics —often those who taught us. These feelings are sometimes translated into an aggression which can never assist in that true communication we wish to achieve. It is clear, I hope, that the term 'academic' refers to whole-time university teaching, for there is much in medical literature to prove that academic thinking is a function of many general practitioners. Years of effective service with its implication of voluntary continuing education have been given by thousands. In the application of our knowledge there has been planned forgetting, the putting aside of the irrelevant or obsolete. This is right, but there is another greater difficulty—the problem of temporal compression of thought pro-

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cesses in order to make a long series of daily decisions, some of which become almost intuitive. In the new situation of academic combined with service life, it becomes necessary to reverse this process, to expand in time thought processes leading to decisions so that verbal communication is then understood by the inexperienced student. Planned forgetting too has to be re-adjusted so that we may readily recall sources, alternatives previously discarded, or material associating us with other disciplines. At the same time we find our service situation is easier, and the results improved at least in terms of satisfaction by the feeling of more clearly intellectual decision making.

These matters I have begun to learn, and it is difficult to believe that they will not apply to others. The next point therefore in our preparation is that we humbly go back to school—back in the sense of intellectual rehabilitation and of learning new knowledge and skills.

Perhaps one of the great advantages of trying to develop something new is that no instruction manual exists. Much of theory and concept has to be put to the test of practice. Success or failure, and the reasons therefore, are equally important to record. Provided all concerned in such exercises faithfully report and record in this way, the more quickly will our textbooks and our definitions emerge, the more fully will we help each other to make our teaching and our practice progressive and viable.

While fully realizing their implications, it is for these reasons that I propose to discuss our proposed programmes at Manchester, and then the reasons for having a university department of general practice. We may at last begin to talk of preparation for teaching.

It seemed necessary to think of education for general practice as a continuous process. The undergraduate—or basic—education up to registration, vocational training normally in the immediate post-registration years, and the continuing education of in-service practitioners are three parts of a continuum. Administratively and conceptually it is convenient at times to regard them as separate entities, but in planning to teach it is essential never to forget their interrelationship. Teachers of general practice would normally be expected to teach in any or all of the three situations. If we accept this it follows that there should be some academic overseer of the three portions and that the university department can accept this function. This concept, readily agreed by the medical school, was more recently supported by the Recommendations of the General Medical Council[3] and the Report of the Royal Commission on Medical Education.[4]

There are many people involved in such a large scale teaching exercise. There are the personnel of the several departments, the undergraduates, later to become the trainees, the in-service general practitioners to be informed and from among whom will emerge our teaching colleagues. All these hold views and attitudes, all play a part. There are several overall objectives of the medical school and its curriculum to which an embryo department must subscribe and contribute; there are the logistics of buildings, of staffing—medical and ancillary, and their cost in provision and maintenance; there is the prime need to offer first-class patient-care as the base on which all else may rest, and the need to combine the demands of service, teaching and research.

Among such a welter, it could have been difficult to find a starting point, but fortunately one was available. In its own enlightened tradition Manchester had commenced in 1954 to teach all undergraduates in general practice, many at the University Teaching Health Centre at Darbishire House.[5] Since that time 100 per cent of our undergraduates have spent a fortnight in an attachment to general practice either in the centre or in one of the 80 selected peripheral practices with an individual university approval and relationship. It was possible to find out in the last year much about the undergraduates' attitudes to this experience. This knowledge is a useful guide in the planning of method, if not of content. We have been able to look at the teachers in terms of attitudes and ways of thought, to survey the attitudes and opinions of the

practitioners in the region in relation to continuing education, and to devise and secure Ministry funds for a regional plan for vocational training conceived as educational research.[6]

A new curriculum commenced this month and in it the place of general practice teaching is defined. The university's objective in teaching undergraduates in general practice is quite simple. It is to expose the student to general practice. That alone.[7] At the same time we believe that this exposure should be in two different settings, the one in the idealized academic central units and the other in first-class service practice. This concept agrees with the medical school's policy of teaching undergraduates both in the teaching and in the district general hospitals.

This policy conceives the central teaching hospitals and medical school as the focal point of region-wide teaching, with both the permeation of medical school influence and its own receipt of information in return. Here is an acknowledgement of a medical school's first prime function, to produce doctors to give medical care to people.

During this exposure, however, there must be displayed and emphasized certain unique essential features of general practice. The emphasis is such as to show first the common ground of clinical competence which we share with hospital colleagues and then to develop some special features. The points our teaching practices are asked to stress are as follows[7]:

1. To show the general practitioner as a competent generalist-clinician, keeping good records. This is most necessary. Many students enter their attachment believing they will not see the practice of medicine.. We must show the same sound clinical principles as they see in hospital. It becomes essential to ensure that our normal speed of experience is tempered whenever possible to provide time for explanation.

2. To stress the wide spectrum of morbidity in the community and to invite comparison with that of the hospital. To show the value and use of the 'list'. To show the wide range of the normal.

3. To demonstrate the conscious and purposeful use of the doctor–patient relationship and the effect of illness on the family. This list is taken from a document circulated to, and agreed by, our teachers in the peripheral practices. One colleague invited to criticize wrote 'witchcraft'—in red ink—in the margin opposite this third suggestion. Apart from my belief that he has not been, and the hope that he will never be himself a patient, he has a valid point. There have been many books written, there are many more lectures to be given on the doctor–patient relationship. It is a term bedevilled with emotion while sentiment at times overcomes reason. But the doctor–patient relationship exists, is capable of some definition and depends for the doctor on 'know thyself'.

4. To demonstrate and explain Stephen Taylor's 'fundamental qualities of general practice' of *continuity* of care and *availability*.

5. To demonstrate early diagnosis, the natural history of disease and 'interventive' medicine.

6. To demonstrate patient management which includes the use of the 'health team'; relationships with the hospital and other bodies; aftercare and preparation of the patient for hospital.

7. To show the care of the infant, the mother, the aged, the dying, and of vulnerable groups.

8. To show how the general practitioner may make and take opportunities for health education.

In the new curriculum, it is hoped that undergraduates in general practice will be taught in the following situations:

1. In the introductory clinical course at the beginning of the third year—or first clinical year. With 160 undergraduates in each year the staff will be heavily involved in teaching history taking and clinical examination.

2. A block of 8–12 weeks rotating through a 'community medicine' course, shared with the departments of social medicine and occupational health. This rotation will be in the first full clinical year, in the central practices. Students will be given projects and each of the departments will share in topic teaching.

3. A fortnight in residence in year four—the second clinical year—in one of the peripheral teaching practices.

4. A weekly elective tutorial in the final year when the emphasis of teaching is on general medicine.

5. Elective periods of up to two months also in the final year for those who may choose them.

The undergraduate will thus be taught in general practice in each of the three final years.

His attitude towards teaching in general practice—to which I will later refer—is likely to be modified when each of his main experiences in general practice will have the curricular significance of that continuous class assessment which is to replace our formal once-and-for-all examinations. Dr Johnson remarked that "when a man knows he is to be hanged in a fortnight, it concentrates his mind wonderfully".

In addition to elective periods in our own departments we are hoping to provide reciprocal elective arrangements with other British and overseas medical schools.

It is proposed to offer in the central practices transient training situations for nurses, midwives, health visitors and medical social workers. So, the undergraduate health team in training may be taught and, we hope enthused, by the service team in action.

The proposed new University Health Centre at Withington Hospital—itself being developed as a teaching hospital—will afford a unique opportunity to experiment with the integration of the three arms of the service. Several university departments are prepared to co-operate in exchange and topic teaching. An infant welfare teaching clinic is planned in co-operation with the department of paediatrics and the local authority.

It seems quite natural that this wide and considered exposure of the undergraduate should lead then into the phase of vocational training. It is hoped to use for the general practice portion of this training the same peripheral teaching practices which teach the undergraduates. These practices have for some time been teaching undergraduates; we are together developing a common premise and most of them have attended the courses for teachers we have organized in the past three years. They might well have a claim to be the pioneers of the 'highly selected' practices of the Todd Report.

The proposed vocational training plans[8] for this region aim to provide three-year post-registration training programmes for up to 100 people each year from 1970. We intend to produce three quite different programmes and will in each case attempt to assess the changes occurring in the period from before training to in-service practice, in knowledge, skills and attitudes. These groups and the changes we effect in them will be compared with the changes occurring in a fourth group of those who will enter general practice in the next few years without any formal training whatever. At the same time it will be useful to attempt to assess methods of thought as well as changes in attitudes in the undergraduate population. The arrival of a new curriculum and regional vocational training presents an opportunity to study these changes in a whole undergraduate year over a period of ten years or so into their eventual career in service.

There is a body of knowledge on these matters, but we hope to cast some objective light on certain points. First, we might seek to determine what sort of people enter general practice. Do they each require the same kind of training? Do they benefit equally? Can we show that courses of training really do confer the benefits we believe they will, or is the individual who learns solely by informal apprenticeship in fact better prepared? At the same time a secondary benefit of such observations may lie in a better way of career advice.

This programme owes a great deal to John Ellis. In it, the department will have a major part to play, and the director will act as the regional organizer for the vocational training scheme.

Behind these plans—now beginning to become a reality—lies much assistance. The foresight of John Stopford, of Robert Platt and the city council who set up Darbishire House, the continued support of Lord Platt who created this unique opportunity, the welcome and continuing encouragement of Professor Douglas Black, of the deans

and many other members of faculty, not least Professor Alwyn Smith of the department of social medicine. The original steering committee of Senate has been disbanded and so we are to become a sub-department within the division of medicine, as are the sub-departments and chairs of rheumatology, of occupational health, psychiatry and social medicine.

We believe that the size of the central practices and the number of doctors working in them are direct factors of the teaching load. In other words, until the curricular time required for each student is known the necessary size of the department is unknown. We have, as I have said, 160 undergraduates in our first year this term and will have at least 200 by 1973.[9] General practice presents, and must continue to present, a strong personal relationship between doctor and patient. The teaching situation is commonly in the patient's home, and this important situation is the one most approved of by the students. You cannot take the usual descending hierarchy of the ward round into a Moss Side tenement. Teaching on the patient in the home should be a private affair with one or no more than two students allowed to blur the privacy. On the other hand, more general concepts and topics may be taught in groups or seminars in the centre itself.

Bearing these points in mind we have decided that six whole-time university-appointed general practitioners, with lists of about 1,500 in each of two university teaching centres will meet the teaching load. The practitioners will be grouped in 'firms' of senior and junior principals, each firm having eventually its own trainee and its own special interest. The provision of secretarial, and nursing staff, health visitors and medical social workers is generous, while diagnostic and research facilities are readily available. We will be whole-time university staff, yet under contract with the executive council in the usual way for our lists. All the practice income will be paid to the university. The first three whole-time practitioners, among whom and so welcome, is John Wright, have been appointed and it is cheering to record that selection had to be made from an *embarras de richesse*, in which prominent college members were prominent applicants. This was practical proof that the College stands for action as well as for theory.

It seemed a useful part of preparation to discover what the undergraduates felt about attachments and to this end I have collected answers to a questionnaire from about 100 students. To some degree these answers complemented an earlier survey published in *The Lancet* in January this year.[10] Here in 1966 we found that 96 per cent of the students wanted attachment to be part of the curriculum but with some modifications. Seventy-two per cent thought the attachment was essential to give insight into general practice, but more than a third commented that the general practitioner had not demonstrated how he used local authority personnel for individual patients sufficiently well for them to understand. I quote again from this paper:[10]

"When asked how the attachment could be improved (from a set list of suggestions) the following was the order of frequency mentioned:

1. More complete facilities for examination
2. More time per patient
3. More use of technical aids in diagnosis and treatment
4. More clinical demonstrations
5. More understanding of teaching methods in conveying unfamiliar ideas to the students
6. More explanation and demonstration of emotional and personal problems and how the doctor handles them."

Our own students approved—most of them enthusiastically—to the same extent as did the students in the national survey. Sixty per cent of them felt they had not enough time to examine patients and about one half did not have the time they wished to talk with patients. Two thirds of the students thought that their experience afforded a good opportunity for revision in social medicine but only half saw an opportunity for

clinical revision. Only one half of them said they used part of the attachment period as an opportunity to read, but three quarters found they had time and that it was valuable to discuss medicine and patients with their teacher. All were agreed that an attachment within two months of finals was a mistake.

When we turned to the teachers, we found a uniform feeling that the attachment should be in the second or third clinical years as otherwise the students complement of knowledge and skills was inadequate to make full use of the experience. As do the students, many doctors find that the tempo of normal service makes it difficult to find teaching time and most of us have difficulty in giving the students sufficient work to do.

Earlier this year I undertook a survey of postgraduate education in the North-west region.[11] Forty-eight per cent of the practices in the region responded. It had been considered when preparing the questionnaire that a significant amount of education lay in conversation with other doctors and with ancillary staff. Accordingly the respondents were asked if they had a regular opportunity to talk medicine with any of a wide-ranging list of medical colleagues. Of the 762 individual respondents only 36 per cent said they were able to talk regularly with local authority ancillary staff. This low figure showed clearly not only the lack of an educational opportunity, but in terms of service far too great an absence of the health team we talk so much about. While the principle of ancillary attachment is becoming more widely accepted it is not yet widely practised. Nor are general practitioners using sufficiently the new financial provisions relating to direct employment of ancillary staff.

Nearly half of all the respondents said they had not got adequate time for reading, nearly half said they had inadequate library facilities, only 29 per cent said they had a postgraduate centre available. Yet of those who had, only one in five attended more often than once a month for postgraduate purposes. Only four per cent had a journal group in their area and only ten per cent a tape circuit. Fifteen per cent had never been on a course of any kind. Eighty per cent said that the lack of locums was their greatest difficulty, and one half said they had difficulty in getting away. These figures were obtained from those who took the trouble to reply to this detailed questionnaire sent to every doctor in the region.

Three weeks ago we held our fifth course for general-practice teachers and the course nobly permitted itself to have an afternoon of psychological testing. Our earlier results on convergence and divergence in thinking were confirmed.[12] Virtually all of the 42 able people on the course fell into a band of balance between the two methods of thought. They showed themselves still competent when stressed.

In the course of their group work these teachers discovered for themselves on the second day the importance for the teacher of 'know thyself'. They suggested the attitudes the teacher should have in regard to general practice. The attitudes of viewing the patient as a whole person in a family in the community, of the need for a real health team with which most of them worked, of the need for delegation, of the need to keep good records, of a positive attitude to health shown in preventive medicine and health education; of courtesy and compassion, and a professional attitude to teaching. What was most marked was the way in which wide and often keen discussions showed no foolish belief in Utopia, but a quiet job satisfaction and pride which was most refreshing to observe, all the more so because it was implicit. Above all was the declared need and willingness for co-operation with all branches of the service, even though this could be difficult at times.

You may feel that I have been discursive, away from the subject of preparing for teaching, but I have tried to display some evidence and with yet some more we may be in a position to make judgements.

An opinion stated in the results of our 1966 survey was that "current attachment

schemes were found to be amateur, haphazard and to have little academic supervision". C. M. Harris,[13] in a survey undertaken this year, comments that "these harsh conclusions were justified on the information obtained but it seems there has been some progress since then". He goes on to list the heartening details of new plans and programmes in most British medical schools. He shows the dawn of the day when the campaign of our College since its foundation will be rewarded by teaching in general practice in every medical school. Unfortunately the campaign has resulted so often in the reiteration of slogans. We have not yet given clear and adequate reasons why there should be a department, nor have we shown what such a department should do. We are not interested in universal attachment schemes *per se*, nor really concerned of itself with academic status, although it is necessary for the ultimate end.

Hence, my last piece of evidence, if it can be so called, is an attempt to answer these questions on which we so often fumble. As the starting point of the argument I would quote from an article by Professor Wolfinden in the *Medical Officer* of July[14] this year. Writing on the report of the Royal Commission he suggests to the Royal College of General Practitioners that "the commissioners envisage little more than a section of the department (of community medicine) concerned with the instruction of the medical student in some aspects of general practice".[5] The Commission would appear to be writing, and with truth, of the general practitioner of yesterday and of many of us today. We are writing, thinking of, and preparing to create a very different person, the general practitioner of tomorrow. We are also aware, as were the Royal Commission, of the context in which we believe he should function. There are other portions of the report which might well have been quoted. There cannot be a battle between community medicine, as defined by the Royal Commission and so highly approved by Professor Wolfinden, and the new general practice.

"Community medicine" says the report "is the specialty practised by epidemiologists and by administrators of medical services, e.g. medical officers of local authorities, central health or other government departments, hospital boards or Ministry and by the staffs of the corresponding academic departments."[5] We will be practising clinicians in the community and concerned with people, with persons. The community medicine specialists will be concerned with populations and not normally as clinicians. These two rôles are clearly defined, both are proper, each important. There is no objection—on the contrary there should be every encouragement—if some general practitioners wish to make epidemiology their special interest, or if some specialists in community medicine wish to undertake some clinical or general practice. Yet the basic distinction of the care of patients, of people as individuals and families on the one hand, and the observation of populations on the other, will remain. If one may accept this, and the Commission and the Royal College do so, the place of general practice as a discipline improves at once. The delivery of medical care in the community should become the better and more satisfying if it be given by doctors prospectively trained to give it by those who are themselves in practice. Non-clinicians, and by that phrase I mean people not taking full clinical responsibility, may never inspire nor should they attempt to train clinicians, although they may share in teaching. We are clinicians first and last.

To encourage the development of academic general practice is the easiest way for the epidemiologist to become able to observe real communities and not have to rely on groups of bus drivers, service men or pupils at various kinds of college.

When our department is fully developed we will offer to the medical school, and use ourselves, a teaching and research laboratory of unique and enviable proportions. There will be a sector population of about 20,000 based on the medical school, cared for by whole-time university academic general practitioners. In addition we will have a further population in our invited teaching practices of about 300,000 scattered throughout the region. Every university department of general practice could create these opportunities

for the study of epidemiology, of social and clinical problems particularly in the early stages of degenerative and psychological illness.

I conceive the creation of a university department of general practice as not only a justifiable end in itself but a desirable part of the means to a wider end. This wider end is the creation of 'the third faculty' of Stewart[15] supported in our previous paper. This wider end may only be reached by co-operation, by symbiosis with the departments of social medicine, of occupational health, of bio-statistics, paediatrics, psychiatry and others. For we must prepare the planned marriage of social and biological—or clinical diagnosis and therapy[16] which demands special knowledge, skills and attitudes for its consummation.

In our own curriculum I mentioned the course we will share with the departments of social medicine and occupational health and other developing liaisons particularly with the department of child health. I would like to see, and believe that it can and will come to be, a strong department of general practice taking its equal place in a division of medicine in the community whose chairmanship will rotate between the various constituent departments. In such a division should lie the fertile seeds of better medical care. This type of division equates with the Academic Institute of General Practice proposed some time ago by J. N. Morris[16] and others. It could be created in any university in different ways. In view of the Royal Commission's definition it should not be called the division of community medicine but of medicine in the community.

This is not to deny the closer association of some general practitioners with the hospital, but general practice belongs in the community and it is in this context and for this purpose that the greater portion of training should come to lie.

General practice has an inordinate amount of academic leeway to make good, and made good it must be. In such a division as I have described we cannot achieve the fundamental results we wish for, the greatest welfare of our patients and job-satisfaction for the practitioner, with weak general practice and strong epidemiology. We neither propose to make take-over bids nor to submit to them. Our first goal is to become academically *paris inter pares.*

The spirit of oecumenism is not merely for the churches. Although it may be just as difficult to pursue in medicine, it is what we in our College and in our departments of general practice should strive for and know that others will respond to. Then may our departments take a full and rightful place in experiments seeking the best in medical care in the community. This is the key-note; here is the field in which we are to teach.

The definition of objectives is of first importance in any teaching exercise. Once they are known, and only then, can one prepare for teaching. I hope that this long prelude has succeeded in making clearer what is to be done.

The Royal Commission's Report envisaged two kinds of teaching practice; the one 'highly selected' which would take part in the period of general vocational training in the first three post-registration years. The other less highly selected but nevertheless still giving first-class medical care. We can laudably aspire to either.

First we must learn to communicate in the students' academic language. Secondly in our teaching practices, we must show the best of contemporary methods with an emergent future portrayed in continuing development.

By the students' academic language I mean that the teacher must not only be competent and contemporary in his subject, his knowledge demonstrably built on the best of the past with intelligent projection into the decade ahead, but he must also be familiar with the broad outlines of the current undergraduate curriculum and perhaps take a closer look at those parts of it which border or overlap his own field. I wish that some others in medical schools shared and practised this belief. For general

practice this is no mean feat but it must be successfully attempted if we are fully to subscribe to the philosophy of the medical school and the aims of the department.

No one department in a medical school may survive in the vacuum of its own discipline. Each requires the support and co-operation of other departments, often not medical at all. Yet this support is more effective and the more willingly given if it be shown why it is needed. This is why in our courses for teachers we have tried to indicate, and one can do no more in a week, those facets of the undergraduate curriculum wherein the experienced general practitioner will discover the greatest change. These changes I suggest are most evident and knowledge of them most important in clinical physiology and biochemistry—the latter to be stressed less, in epidemiology and statistics and in the behavioural sciences. The last is the essential field in which the empirical knowledge of my generation may be widened and strengthened by new learning. You will note that I have omitted reference to clinical subjects, the main reason being that the postgraduate fare at present offered is well filled with an adequate clinical content which one expects the teacher to have retained. All this means a high level of continuing education, a level for academics. It is not easy to reach but it must be reached.

Every university department teaches on an advancing fringe of knowledge. For us the major fringe is that of the delivery of medical care in the community. Every teaching practice should show an actual health team in action. The recording should be first-class and under continual review, leading always to the day when we will use the computer and have the advantages of comprehensive recording.

Ideally, the premises of the practices should be such as to enable the best of medical care to be given in a well-organized way. They may be Section 21 buildings or—Why not? —built by the private enterprise of the practice, but they should be properly planned with accommodation for teaching. Prospective teaching practices should be prepared, for they will be expected to reach this standard.

They should also undertake research. Some in our College persist in referring to teaching or research practices. There cannot logically be such a separation. Any practice which is undertaking the one activity should be also involved in the other. For teaching and research are interdependent and mutually stimulating. There will certainly be varying emphasis on the one or the other, but what matters most is that the research is genuine, relevant and not bogus, as much that emerges into print so clearly is. Questions must be asked and the literature read, with evidence given that this has been done. The protocol of the research must be scientifically constructed for its purpose and recording and analysis painstakingly undertaken. It may well be that many practices contribute to a wider project. Their contributions are valuable and valid but they are, and let there be no mistake, assisting to answer someone else's questions. This is eminently right and the individuals taking part deserve great encouragement, but more should learn gradually to formulate and attempt projects of their own, and in this the university can help.

From general practice alone can best come investigations into biological norms and the earliest beginnings of much illness. There is every reason why the department of general practice should have its laboratory, and as much reason why some general practitioners should—especially in an academic department—emerge as scientists as should some hospital doctors. Research depends on competence, on inspiration sparked from interest, and the availability of material and facilities. We have so much available, and much unused except for operational reports. We need no longer rely, as we have so long done, on others. Now we are for the first time producing our own body of professionals with our own facilities, the regular production of scientists in general practice will be a signal sign of its academic coming of age. Then we will subscribe to the second objective of a medical school—to advance medical knowledge.

As far as teaching methods go the mature general practitioner need not take too

long to learn them. He needs to know much more of learning processes.[17] In our colleges of further education the usual students are very young. Not only must they learn the substance of their profession and its methods, they must be given confidence in three short years to face in their fearful youth classes of 30 to 40 people up to 15 years of age from whom they will have removed bicycle chains and flick-knives before class begins. We have learned some time ago that the best way to have authority is to assume it. Our probable pupils are almost uniformly co-operative and dedicated to the task in hand. They are like Barkis—willing. Willing to be taught, willing to learn, willing us to teach them. We need to know more of small group teaching, about which much is known, and of person-to-person teaching, about which little is known. We should be able to plan a lecture and deliver it without boring our audience, proceeding at a pace and at a level which will challenge but not bewilder. We must learn of audiovisual aids, of their use and misuse, and produce material for these media. Then we will have teachers who fulfil the students' suggestion that they have learned how to teach. We will have teachers of whom 100 per cent will talk with and work with other teachers and ancillary staff in a true team. Teachers who have time to read medicine, for time is not something you have, but something you make.

I have said that we are now, for the first time, beginning to produce a professional body of teachers. These teachers will by no means be all in the universities. All, however, must have a professional attitude to teaching. We owe it to our students, and no less to ourselves, to be prepared for teaching. You may feel that my suggestions are hard, that they will impose burdens, that dedicated amateurs are sufficient. It is this latter belief in practice which is one of the contributory factors to student unrest. In universities, teaching is not yet sufficiently studied.

The first selection of teachers will be self-selection, the formal announcement of willingness to teach. A body of volunteers exists in every faculty and preparations can begin at once. But from this body there will have to come another self-selection, that of the level at which and the locus in which one will aspire to teach. For the whole-time university level there will be keen selection, and some coming prepared to teach there, should be further prepared to be on occasion disappointed. This is another facet of professionalism which can be hard to face. I believe, and on good evidence, that there exists a body of people who are prepared to face these challenges. They are challenges worth facing. Successfully met they will achieve for general practice a new purpose, a new status, new satisfactions, new opportunities and the greater good for the important people—our patients.

We may be the more readily receptive to exhortations in the awareness that the Royal Commission suggests that it is a task for which we should be handsomely remunerated, while our consciences could be quietened by the knowledge that we would earn every penny.

Arthur Gale, I suspect, would rejoice that the fires he helped to light are burning more brightly. He would surely applaud the continuing work of your faculty with a special thought for the efforts of Dr W. H. Hylton. This is a family affair when we are met to do honour to a worthy man. You may think that on this occasion you have invited to join you a wild man from the north bringing pie in the sky. But under the force of the gravity of circumstance the pie must come down. It will do so much more rapidly if we make a long arm and reach for it.

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On 27 December 1967 a red warning was issued by the emergency bed service to all hospitals in the London area, when it became clear than an outbreak of influenza was going to cause unusually heavy demands on acute medical beds.

Fortunately the epidemic was short but it served to highlight administrative problems within the hospital services; hence the formation of the King's Fund working party. Their report describes the facilities which were available and the steps taken to use them and the findings of the detailed enquiries which followed.

The working party recommends that hospitals, regional hospital boards, the Department of Health and Social Security and the emergency bed service, should in future make an annual review of their instructions to all those concerned in medical, nursing and administrative sectors to ensure adequate early warning of trouble, the maximum use of all hospital beds whatever their official designation, and the mobilization of available voluntary services, especially nurses, to assist with staffing problems.

The emergency bed service was formed in 1938 and has continued to satisfy ever-increasing demands on its services. In its first year 7,000 admissions were arranged but now the annual figure is 50,000. Even so these figures do not adequately reflect the vital part which the emergency bed service plays in the life of general practitioners in the area which it serves. The cool, efficient, yet always cheerful way, in which the staff manage requests for admissions is an example to us all.