which will fit him for his future career. Undergraduates are not being provided with training in the type of medicine they are going to practice, rather than not being able to practice the sort of medicine for which they were trained. It is the training that is wrong, not the medicine that the general practitioner is forced to practice. Naturally the graduate needs a sound grounding in academic medicine, with a thorough knowledge of pathology, signs, symptoms, and their interpretation. But he needs more than this. He needs an understanding of what the public wants from its doctors; and this he does not get from the formal education provided by the medical schools. Training is at present orientated towards hospital medicine, as others have pointed out before. Plans being formulated now to provide vocational training for general practice must be extended to the undergraduate years so that the bias to hospital-based medicine is less strong, thus giving the student that wider view of medical practice which will better fit him for his future career. Something of the order of two thirds of the output of the medical schools will be entering general practice and it is quite ludicrous that the content of their training should be biased away from this.

Those currently in general practice have an important and useful part to play in the future of medical education. It is not only required that they should be in a position to teach the subject; they must also learn to be competent teachers. Many know their subject well but do not have the ability to pass on this knowledge. To establish a 'training panel' of 1,000, as will be required, is not enough; this select body must of necessity be trained in teaching. One should be able to assume that the knowledge of what has to be taught is already possessed by the future teacher. But we cannot assume that the knowledge of how to teach it is there. There are many departments of education devoted to training men and women in developing an ability to teach. That is to say, training them how to pass on the knowledge they already possess, in a palatable and assimilable form. It is not necessarily true that the more we teach the better we become. We have all suffered from the brilliant man who is the master of his subject, but whose delivery is virtually incapable of passing on this knowledge. It is this aspect of having, or learning, the ability to teach that is now becoming increasingly important. It is in this field that training is most required. The time is long past when teachers were appointed merely because of academic success without attention being paid to their ability to teach. The future general-practitioner-trainer must first be trained in teaching, and only then will vocational training schemes be fully useful. More than this, the competent and trained general practitioners will be in a position to correct the bias of present medical training. In this way future general practitioners will no longer complain of being unable to practice the medicine for which they were trained; they will have received the right training for the medicine they are going to practice.

The College is already active in this field. It runs training courses for future trainers at headquarters, and at least one has been held in the periphery. The time has now surely come for an increase in this activity. If the College does not become more active in promoting such activities up and down the country, the matter will be taken out of its hands, and a vital opportunity will be lost. I am well aware that the College is non-political; but some political activity may be necessary if it is to continue to lead and influence general practice. The potential for good is enormous and it should be put to use. The symposium on Education for General Practice held at Manchester in May 1968, produced many good ideas, and a fairly comprehensive review of the current situation; so did Dr C. M. Harris in his report published in April of this year. It is now up to the College and its members to waste no more time in discussion, but to get to work and organize on a national scale so that it is ready and able to provide the training facilities regionally as well as centrally. The university may be the place for teaching, but it is not the place for learning general practice. This can only be taught and demonstrated in the field.

Cardiff.

H. CAIRNS.

Bell's palsy in infancy

Sir,

I was interested to read the clinical note on the above in the May issue of the Journal. In 1962, I had a similar case of right-sided Bell's palsy occurring in my practice. The infant, a male and a first born, was delivered by forceps extraction under general anaesthesia due to delay in the second stage associated with small pelvis in the mother. Birth weight was 7lb. 8oz. and there was no abnormality in the baby apart from a small haemangioma on a lower limb.
At nine months, his mother noticed paralysis of the right side of his face and, on examination, a right non-suppurative otitis media was present. A course of oral antibiotic was prescribed. Shortly afterwards, a rubella-like rash developed but this rash may have been that of rubella or roseola infantum since it occurred in the first year of life. The possibility of encephalitis associated with a rubella infection was considered but the facial paralysis was present before the appearance of the rash and this association was thought unlikely. Complete recovery from the paralysis took place over a period of six weeks without any further treatment.

At the age of approximately ten years, I suffered a similar condition following, to my knowledge, my one and only attack of otitis media.

It would appear that, in infancy and childhood, when the incidence of Bell’s palsy seems relatively rare, a homolateral otitis media may be associated.

Dundee. J. M. Langlands.

Undergraduate teaching in general practice

Sir,

Dr Byrne’s letter in the May issue of the Journal criticises both the editorial board and myself—mistakenly, I think.

His assertion that there is no reference more recent than 1966 is curious since a long second paragraph in my article criticises in detail aspects of the Todd Report. The matter of timing of references and acknowledgement was the subject of personal correspondence between Dr Byrne, the editor and myself which had, I hoped, resolved differences about this and about editorial policy.

The letter is unfortunate principally, however, because it distracts from the main purpose of the article which was to outline a method re-establishing for the undergraduate the truth that doctors (all doctors) should be able to share the common experience of applying scientific method, allowing for variation in the exactness of the science which they apply. The remainder of the article depends on this point—the need for it and the other aspects which would have to be taken into account in introducing it in a medical school. Recent developments—if we are to believe Harris—have not this as their primary aim and the arguments in my article are legitimate, even if Dr Byrne disagrees with them.


REFERENCE


‘The S.R.N. Clinician’

Sir,

Though I have been retired for over six years and have recently been prevented by ill-health from attending even local meetings, I still take some interest in developments taking place in the field of general practice.

Hence it is that I have been reading the report of the symposium recently held in my home town, and would like to make a few observations, particularly in regard to the ‘screening’ of patients by an ‘S.R.N. clinician’ as suggested by Dr M. C. Stone, using her in quite a different capacity from that for which she is trained.

I always used to maintain that if the general practitioner had a speciality it was that of diagnosis, and I see no reason to alter that view as I approach old age! After all, he is the first to see the patient either at home or in the consulting room, and it is one of his most important tasks to sort out the ‘serious’ from the ‘trivial’, however much he may weary of the latter.

Apart from the fact that in many cases the trivial does not appear by any means so to the patient, this is a task that he must not delegate to anyone unqualified in medicine however good she may be in her own sphere, and I would suggest that should he do so it might indeed be at his peril.

Early appendices have not been unknown to walk into the surgery—indeed, when I had mine I drove myself to the surgeon! The same is true of other serious or potentially serious conditions.

Suppose your nurse missed such a case and a complaint was laid before the executive council? Past experience as a member of such a body prompts me to suggest that the general practitioner, not having seen the patient himself, would be in grave danger of