Correspondence

TEACHING PRACTICES

Sir,

Donald Irvine's excellent *Report from General Practice No.* 15 is so good as to be dangerous (June *Journal*). While he is careful to point out that the College's recommendations on teacher selection suggested a weighting of 40 per cent to practice matters he does not point out that this is itself an arbitrary judgement unsupported by evidence.

Byrne and Freeman (1971) have studied in depth, in academic and personality terms, many of the teachers studied by Irvine and we can find no correlations between our several scores.

This may mean, as I suspect, that there is no overall correlation between clinical performance and practice organisation. It may also mean, which I more strongly suspect, that our several scoring systems require review. Our own measurements, however, reveal aspects of a potential teacher which hardly emerge from his practice logistics. They give some indication of his capacity and motivations as a teacher, which, and it comes almost as a surprise, is what the exercise is all about. Irvine's study is one valid way of looking at some aspects of practices and of practitioners who have been selected by others to teach. It does not pretend to assess them as clinicians or as teachers.

One of our own best clinical and teaching practices is housed in premises isolated in a sea of demolition which must have scored low on Irvine's measurements. They are, and have been for some time, awaiting a new Section 21 health centre, but it is the people who teach, not the premises.

A word must be said about the figures quoted. Irvine constantly refers to '20 per cent' or ' one third of'. It should be noted that he is comparing fractions and percentages of widely differing wholes.

Thus 20 per cent of Manchester teachers (86) is approximately the same number as 100 per cent of the North-east England teachers (17), 130 per cent of Wessex teachers (12), and more than 50 per cent of Thames Valley teachers (32), and of his remaining 32 combined teachers.

Accepting Irvine's score of 149 as a cut off point, his Table 35 then shows 40 'acceptable' practices in the Manchester scheme, 29 in Thames Valley, 16 in North-east England, 12 in Northern Ireland and 24 in the combined scheme. Manchester, Irvine might have been moved to say, thus contains 40 out of 121 'acceptable' practices, or about a third of the total. Absolute numbers do count when one is building up schemes.

It would be equally true to say that it contained none of the small group of 18 practices scoring so highly in Table 35.

Statistical manipulation apart, Irvine's paper is vastly important. He properly points out the difficulties highlighted by the Manchester figures of implementing the agreed policy of vocational training by 1977. What must also be taken into consideration is the requirement for teaching undergraduates. In a paper in the press I report that in 1972, 22 British Medical Schools teach all their students in general practice.

It seems illogical that there should be two different groups of teaching practices; one for undergraduates, the other for postgraduates. People should teach general practice. What is important is that the Todd concept of 'high quality practices' applies much more to the postgraduate training period than it does to the undergraduate. The undergraduate is not learning to be a general practitioner, he is learning about the philosophy and academic content of general practice as a contribution to the overall knowledge and skills of the basic, undifferentiated doctor which the curricula are calculated to produce. He also observes and, hopefully recalls the attitudes of the general practitioner to patients.

The postgraduate trainee on the other hand is learning not 'about' general practice, but is learning 'to become' a general practitioner. He will be permanently influenced by the conditioning of his present trainee year by all the aspects of his teaching practice, including staff and premises, but surely most of all by the clinical performance of his teacher.

Irvine's study, of 222 teaching practices, shows how difficult it is, albeit with such small numbers, to find teaching practices even with sufficient quality of premises. Yet in 1977 we will have some 3,500 undergraduates in each year and will have therefore to find, if only 40 per cent of these graduates are to enter general practice annually, thereafter about 1,400 teaching practices as a minimum. If we add a reasonable factor of 30 per cent to cover:

(*a*) more than 40 per cent of graduates wishing to enter general practice,
(*b*) a wide variety of possible practice problems

then a total of some 1,900 teaching practices appears to be a minimal target for 1977.

It seems therefore that, while every effort must be made to upgrade teaching practices overall, we must also be prepared for some time to accept standards far from ideal.

We might also consider the scoring system for practices. For instance, a practitioner in Irvine's study gets six points out of a possible 400 for using a slide projector. A blackboard is not even mentioned. He gets the same three points for the specialist journals such as *The New England Journal of Medicine* and *Hospital Medicine* as he does for the *Journal of the Royal College of General Practitioners.*

On the other hand if 'the principal has previous experience of teaching or has completed a recognised course' (presumably a teachers' course) he scores four points. M.R.C.O.G. is equated with D.Obst.R.C.O.G. at three points, while M.R.C.P. scores only two and an M.D. whatever its narrow context—five.

These are perhaps nit picking points. The danger of this major contribution to a new look at teaching practices is that a potentially most valuable tool will become immediately regarded as a complete answer to a thorny problem.

Donald Irvine has given us the framework of a method of selection of teachers. It must surely be developed into a more meaningful instrument which assesses clinical and above all teaching capacity as well as organisational methods. There are many who welcome this paper, and as many who will be prepared to assist in the development of the method. It is still too early to rely too much on the scoring system used.

P. S. BYRNE
Professor of general practice

Department of General Practice,
University of Manchester,
Darbishire House,
Manchester, MI3 0FW.

REFERENCES

Byrne, P. S. & Freeman, J. (1971) *British Journal of Medical Education*, **5**, No. 4, 292–304.

Byrne, P. S. (1972). *Journal of the Royal College of General Practitioners* (In Press).

Irvine, D. (1972). *Teaching Practices:* Report from General Practice No. 15. London: *Journal of the Royal College of General Practitioners.*

POPULATION AT RISK

Sir,

In the June *Journal*, neither the article on the *Analysis of Summarised Data* from the Research Unit of the College, nor Dr Dinwoodie's report on *Morbidity Recording*, stress the need for an accurate knowledge of the population at risk in calculating rates recorded during morbidity surveys. Indeed, Dr Dinwoodie states it is not possible to relate his data to practice populations, as only one partner from the practice was taking part.

Professor J. N. Morris (1970) illustrates how the actual membership of patients in a general practice was very different from that recorded by a survey of the National Health Service cards. I think it should be stressed that not only are age–sex registers needed for studies of morbidity rates, but that these can only be made when either or all the partners take place in the investigation, or if one out of several takes place, that he looks after a defined list of his own.

In addition, it is necessary to review the age–sex register with a critical eye at fairly frequent intervals, so that the inevitable errors of the list may be kept within reasonable bounds, which I suggest is about five per cent. Without this the figures are not really useful and the exercise is largely wasted.

E. J. C. KENDALL

52 High Street,
Epsom.

REFERENCES

1. *Journal of the Royal College of General Practitioners* (1972). **22**, 377–81.
2. Dinwoodie, H. P. (1972). *Journal of the Royal College of General Practitioners*, **22**, 417–20.
3. Morris, J. N. (1970). *Uses of Epidemiology*. p. 42. London.

NATIONAL TRAINEE CONFERENCE

Sir,

We welcome the opportunity to comment on the eloquently irrational letter of Dr S. L. Barley (June *Journal*)[1].

We think his attempt to belittle the intellectual capability of the trainees ill-founded. The trainees voiced conclusions in one week end that the intellect of Dr Horder took years to reach, and this surely highlights the value of the conference.

We completely agree (as did the conference) that discussion was severely limited, due in part to the excessive panache of the speakers[2].

A pioneer conference must inevitably retrace steps to find common ground, and the most fundamental principles of vocational training are not 'old hat' to some trainees, particularly those involved with the old scheme. Incidentally one of these (that the majority of trainees were *not* in favour of compulsory vocational training) seems to have found its way under a college carpet.

Isn't education largely learning from others' mistakes—at a national as well as regional and practice levels? On a practical note not only will regional conferences probably cost more; but under Section 63, financial assistance to trainees travelling outside their own region is restricted to courses not available locally.

We suspect the cross-fertilization Dr Barley envisages is likely to give rise to non-viable Mendelin recessives! However, regional solutions (aired nationally) can have wide reaching applications; Newcastle hasn't a hierarchy but will be pleased to share its organised anarchy,

Finally we would challenge the repeated assertion that a conference requires a hypothesis. A conference is 'a meeting for discussion and exchange of views'[3].

We thank Dr Barley for the velvet glove and the stimulus to think again, 'why a national trainees' conference? '—We still think its a good thing.

W. J. D. MCKINLAY
C. K. DRINKWATER
Vocational trainees
University of Newcastle scheme