years in general practice, some have special expertise in environmental medicine, some have a hospital background, but all have come into this type of work whether part-time or full-time because they have a special interest in students.

It need hardly be added that the financial rewards compare unfavourably with those of ordinary general practice. Anyone who is familiar with the literature (and some of the basic documents are not quoted in your bibliography, e.g. the Memorandum of the Royal College of Physicians on University Health Services)[2] if not with the practice of medicine in our universities will have no misgivings about the standard of medicine practised but can only be filled with apprehension at the suggestion that ordinary general practices without a special interest and training in the care of students and university problems should " take over ".

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Sir,

I am sure that the British Student Health Association will comment officially, and much more ably than I, on your editorial on Student Health Services (February *Journal*).

Most of us working in the field of student health would not, I think, be so presumptuous as to consider ourselves specialists but we do fulfill a function which would be difficult if not impossible for neighbouring general practitioners to manage.

I made special note of my case load on the day I received the *Journal*—and it turned out to be a typical day—and it does, I feel, exemplify my argument. Forty seven patients were seen at the Student Health Centre, most of them fairly trivial such as sore throats, coughs, warts and muscular aches and pains following sporting activities.

There were, however, two very depressed students each of whom required an hour of my time; there were two students having difficulties with the contraceptive pill who required about 20 minutes each; three students wanted information (one was worried because one of his testicles hung lower than the other!) and students are not satisfied with mere reassurance: they want explanations. There was also a case of illegitimate pregnancy whose distress had to be assuaged and whose future had to be decided.

In between these cases my weekly "health education" article for the student newspaper had to be compiled, letters written for students going overseas, a report for the Student Welfare Committee prepared, letters of referral for two patients drafted and finally three students visited in their digs.

Now none of this is difficult and it could all be done just as well, if not better, by any general practitioner. But I know how busy my colleagues are in this area and I do not believe that they could possibly give patients the individual time that many students require. Indeed it is my impression that they were quite relieved to shuffle off some of their student patients when I began this job about two years ago.

Of course much of what you say is correct and of course there is a problem of imbalance between the frenetic rush of term time and the monastic calm of vacation, but since I am on call 24 hours a day for seven days a week, I feel I can luxuriate in the restfulness of the vacations without a guilty conscience.

As this rambling discourse may reveal, Student Health services are necessary not only for the benefit of the students but also for the sanity of nearby general practitioners.

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REFERENCE

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UNIVERSITY DEPARTMENTS OF GENERAL PRACTICE

Sir,

Professor Byrne's useful survey of university departments of general practice (*Journal* Supplement Number 1, 1973) contains several statements that I wish to clarify, correct, or challenge.

On page 8, he says that the Aberdeen Department has a small number of university medical staff not engaged as principals in general practice. Though literally correct, the statement should be clarified; all of us here work part-time as honorary assistants in four different practices, thus maintaining our clinical skills. It is my hope that we may be designated honorary principals in general practice, thus enjoying the same status as our academic hospital colleagues—and, by no means incidentally, avoiding some of the problems presented by university general practices.

On page 10, Professor Byrne states that the general practitioners in Livingstone New Town have lists restricted to 1000 patients. The correct figure is 1500 patients.

On page 11, Professor Byrne asserts that departments like Aberdeen can be developed more quickly, cheaply, and with fewer problems than can those with a university practice. This I must dispute. I have always argued that a university department of general practice should, like the other academic clinical departments, not have to depend on income earned by doing work for the National Health Service. This means that a department such as ours is more, not less, expensive, but in my view principle is more important

than expedient. As to speed of development, I would have thought that the cheaper any proposal is, the more likely it is to progress—but at the price of more service demand and less time for teaching and research.

Finally, may I commend the concluding section of the report which neatly says that no one yet knows the best way, or best ways, to develop a good university department of general practice, and which encourages all of us to experiment—exactly what Aberdeen is trying to do. And, I may add, to do this we have entered into a satisfactory and mutually respectful partnership with the Royal College of General Practitioners.

I. M. RICHARDSON
Professor of General Practice

REFERENCE

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CHOOSING A PRACTICE

Sir,

Having recently been through the mill of finding a practice, I read with interest your series of articles on this subject in the December *Journal.*

Fortunately, I was able to spend a year in a good teaching practice, but several of my friends were disappointed with theirs. Some of them were even grossly exploited as unpaid assistants and received very little tuition. Perhaps there is a need for a feedback of information to the trainer selection committees from all trainees at the end of their attachments. If compulsory vocational training is to be implemented, from where are all the trainers to be recruited without lowering the standards?

I found that some advertisements for practices were excellent, whereas others were significant for the facts omitted, e.g. poor facilities, low salaries, sleeping partners and grossly unequal rotas. Box numbered advertisements, which regrettably the College *Journal* accepts, were often the most deceptive.

The grapevine could be, a useful source of information. In large towns, vacancies in the better practices were often filled without advertisement by direct contact with the local hospital mess. The worst training practices were filled by doctors from more distant medical schools, as the grapevine had deterred local applicants. Sometimes the grapevine could prove very misleading. The 'great fellow' from the 'old Medical School', the Chairman of all the local committees, or the general practitioner who referred all his private patients to your 'boss', was not necessarily running the most desirable practice, despite the opinion of your chief. For every golf fanatic or medical politician, there may be a junior partner managing the practice in his absence.

Interviews enabled me to see a spectrum of working conditions. I was able to visit some excellent practices, but I also met in my travels, rogues, misers and gross eccentrics, who were dedicated to money and not medicine. Some were unaware of the value of vocational training and would not give credit for completing a recognised course. It is impossible to assess a practice in one afternoon and to delve beneath the rosy façade presented by the interviewers, especially if it is out of the range of the grapevine.

My advice to younger doctors about to enter family medicine is to find a good trainee post, preferably on the recommendation of former trainees. Failing that, if family commitments allow, become a roving locum for a few months. It is important to have every agreement in writing as they can mysteriously change between interview and appointment. Believe no one, double check through the grapevine and be prepared for some surprises and disappointments. With luck, most of us find a suitable practice eventually.

K. C. HARVEY

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MEMBERSHIP OF THE COLLEGE

Sir,

Can anyone tell me why the reaction of six out of eight of my colleagues (general practitioners) to my telling them that I had become a Member of the Royal College of General Practitioners was "What on earth should you bother to do that for?"

I. D. KERR

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COMPUTERS IN GENERAL PRACTICE

Sir,

I am collecting information about the use of computers by general practitioners and there may be cases where this information is not known by any central agency.

I would be grateful if any of your readers who are using a computer would be kind enough to let me have details.

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