University departments of general practice and the undergraduate teaching of general practice in the United Kingdom in 1972

In 1967, the General Medical Council recommended that all medical schools should have "growing points" for the undergraduate teaching of general practice.

This recommendation was supported by the Royal Commission on Medical Education in 1968. Paragraphs 277–9 of the Commission's Report contain the statement: "No department in the medical school is ideally fitted to provide the necessary teaching". They went on to say "we think that universities should offer senior academic appointments in this field, and that general practitioners taking part in the teaching of medical students should be properly paid and given university status appropriate to their standing as teachers and contributors to research".

The Royal College of General Practitioners at its foundation proposed that there should be a department of general practice in each medical school in the United Kingdom and has supported this ever since. The British Medical Students Association also approved this in their report of 1960, and it was also contained in the 'Charter' for general practice in 1966.

C. M. Harris (1969) surveyed the undergraduate teaching in general practice in British medical schools. At the time of his survey there was only one independent department of general practice, at Edinburgh, which boasted the first chair of general practice in the world.

In the ensuing four years many changes have taken place, not only in Britain but in most other developed countries. In Holland, for example, each of the six medical schools is by statute required to have, and has, a professorial department of general practice. There are many in Canada and in the United States of America, one in South Africa, and others in Israel, Norway, East and West Germany, to name some of the better known. There are also many more units of undergraduate teaching operating as sub-departments of, usually, departments of medicine or social or community medicine, in these and other countries, for example, in Brisbane and Monash in Australia, and at Dunedin and Auckland, in New Zealand. The results of this survey reflect international trends in which the United Kingdom continues to play a leading part.

RESULTS OF SURVEY

A postal survey of medical schools in the United Kingdom was undertaken in March, 1972 and all the schools replied. The changes which have occurred or which are contemplated are of interest and are described, comparing the present figures with those of Harris' survey in 1968 and where applicable with Eimerl, Pearson and Byrne in 1965. Details of curricula which Harris obtained are not given although the wide range of curricula and the timing of the placement in general practice of this teaching in the undergraduate course is shown.

Table 1 shows the growth of departments and of chairs and in particular the increasing numbers of schools in which all students are taught in general practice. There are still 11 schools which do not provide an honorarium for general practitioners assisting their teaching, as discussed below.

TABLE 1

THE CHANGES IN TEACHING FOR GENERAL PRACTICE IN MEDICAL SCHOOLS IN THE U.K. 1965–1972

	Number of medical schools (TOTAL 29)		
	Pearson, Eimerl & Byrne (1965–66)	*Harris* (1968)	*Byrne* (1972)
Departments of general practice	1	5	11
Chairs in general practice	0	1	6
All students taught in general practice	8	12	22
Honorarium paid to general-practitioner teachers	0	14	19
Reports from students	3	9	12

There are still too few attempts to obtain feedback from students of their general-practice experience, and it is perhaps significant that the more objective methods are used in schools where departments exist. The comments in 1965 containing the words "amateur and haphazard" seem no less fair in the context of 1972, although less widely applicable. (Pearson, Eimerl and Byrne.)

TABLE 3

TIMING OF PLACEMENT AND EXTENT OF GENERAL-PRACTICE TEACHING BY YEAR OF CURRICULUM

	Number of medical schools (TOTAL 29)		
	Pearson, Eimerl & Byrne 1965–66	*Harris* (1968)	*Byrne* (1972)
Year one	0	0	2*
Year two	0	0	2
Year three—first clinical	0	0	3
Year four	0	3	8
Year five	most frequent	6	10
Year six	2 weeks	12	8
Any clinical year	—	—	2

* In several schools teaching takes place in more than one year.

The length and chronological placement of general practice in the undergraduate curriculum demonstrate a wide range. In one school, general practice is to be used as a learning situation in each of the five years; in one, in each year except the first; in three, it appears for the first time in the third or 'first clinical' year; and in the remainder in the fifth and sixth years in the proportion of ten schools to six. Where all students are taught in general practice the longest period of time is four weeks whole-time in the final year and the shortest, eight mornings in the fifth year.

Most schools offer electives which are of up to two months but there were no figures available as to how many students take up these opportunities.

In 21 schools, teaching in general practice is a formal part of the curriculum which all students must undertake. Eleven schools have a department of general practice, and 12 more say that they intend to create one.

Although each school uses general practitioners to teach students, in six schools there is no member of staff responsible for the arrangements (other than presumably the

TABLE 2

COMPARISONS BETWEEN UNDERGRADUATE TEACHING IN GENERAL PRACTICE IN 12 LONDON MEDICAL SCHOOLS, 4 SCOTTISH MEDICAL SCHOOLS AND THE REMAINING 13 MEDICAL SCHOOLS IN THE U.K., 1972.

	Medical schools (TOTAL 29)		
	London (12)	*Scotland & N. Ireland* (5)	*Remaining U.K.* (12)
University departments of general practice	1*	4	6
Chairs in general practice	0	4	2**
All students taught in general practice	8†	4	10
Honorarium paid to general-practitioner teachers	4	4	11

* The active unit at St Thomas' is a sub-department of the Department of Community Medicine.

** One more chair has been announced since this survey was completed and another is being considered.

† Three schools say that electives are available to all students.

dean). Not all respondents answered this question but of those schools without departments of general practice 11 had appointed a whole-time member of staff to be responsible for the teaching arrangements and five a part-time member. Five of the whole-time members are in departments of medicine and nine in departments of social or community medicine. The university grades of these members ranged from the dean, the dean of clinical studies, each in one instance; four professors, one reader, five senior lecturers, three lecturers and one person described as a 'tutor' part-time.

Not surprisingly the bogey of inadequate finance presented difficulties in the creation of existing departments and is considered to be an important factor by those schools who intend to create departments.

On the other hand there were very few schools, three in each instance, which when creating departments had had problems with local medical committees or with the Department of Health and Social Security, only four which had problems with other departments in the medical school and one which experienced difficulty with 'other departments in the university'. Of those schools intending to create departments, one was hopeful of discovering a 'generous donor', while another commented that general practitioners were concerned 'more with status than with education'.

In the selection of a school's part-time teachers of undergraduates the old boy network was properly favoured. The personal knowledge of clinical staff and their appraisal of the school's general-practice teachers is surely a reasonable method to adopt. Again, however, there was a wide and interesting range of methods. Two schools consulted the postgraduate dean or the regional adviser in general practice, one uses a questionnaire, and in another the students themselves play a major part in selecting the teaching practices to be used. In yet another, practices are personally visited by a senior member of the department of general practice. Two said the local faculty of the Royal College of General Practitioners was consulted.

Whole-time teachers are selected by a normal university appointments committee, reinforced by an executive council appointing-committee in the five schools where a university practice is also involved.

In only six schools are students themselves responsible for any payment to their general-practitioner teachers.

Evaluation

Twenty-two schools reported a variety of methods of evaluation of the students' general-practice experience. Twelve schools use either reports or questionnaires from students, seven discuss experience later with them, while three rely also on the fact that students voluntarily choose general-practice experience as a measure of its value.

Two schools commented on increased recruitment to vocational training as an indication of successful undergraduate experience. One school reports a survey conducted by students themselves in which they placed their general-practice experience at the top of their clinical curriculum. Another commented on the 'puzzlement of the psychiatrists at the skills obtained by students from their general-practice experience'.

DISCUSSION

Above and beyond the importance of the increasing numbers of professorial and other undergraduate departments is the finding that every medical school makes wide use of approved service practices to sustain its own undergraduate teaching. It is clear that the impending massive postgraduate exercise of vocational training for general practice (Royal College of General Practitioners, 1969) will demand an even greater teaching contribution from probably a majority of the same practices.

This can raise problems of teaching content and of standards. The medical schools, being themselves responsible for their undergraduates, will have the duty and the intention of appointing their own general-practice teachers. These teachers will be expected to subscribe to the philosophy and curricular needs of their medical school and to meet those standards which the school will wish to set.

These requirements are normally and successfully met by meetings and discussions between members of the medical school and the teaching practices. The administration of such teaching is undertaken by the medical school or by the department of general practice on the school's behalf.

In postgraduate training the situation is quite different. The teachers will be appointed by the regional general-practice committee. The educational content of training will be provided to standards laid down by the Royal College of General Practitioners, while the administration will be the duty of the regional postgraduate committees of which the postgraduate dean, his regional general-practice adviser(s), and administrative staff will be the executive officers. The advisers are to be university appointments.

Remuneration

Teaching practices

It might be expected that teaching practices would normally teach in and about general practice in each of the three phases of medical education. There is provision made for the remuneration of teachers, including general practitioners under Section 63, a Section concerned with continuing education. The trainer has always received a fee and now this fee has been significantly increased.

It is thus important that consideration be given to the situation revealed by the questionnaire for the remuneration of the general-practitioner teachers of undergraduates. The range of remuneration was wide, from 11 schools who made no payment at all, to one where the general practitioner receives £8 per morning or afternoon session of student teaching in his own practice. The average figure of remuneration for this type of teaching appears to be in the region of £6 per week.

When a student is present in the practitioner's surgery and accompanies him on his visits it is true that the tempo of work is slowed a little, but while it seems difficult to

sustain an argument for the high figure quoted it is impossible to support the substantial number of schools who offer nothing.

There is a difference too between the payments made to those teachers who have students for a few sessions a year and those who in several schools act as 'inner ring' regular teachers of students. It is almost impossible to make any meaningful comparisons between the arrangements of different schools as the curricular requirements vary so much. One school, for example, requires every student to spend eight mornings in a general practice. Another requires its external general-practitioner teachers, some of whom may live some distance from the medical school, to travel to it and there conduct seminars or engage in topic teaching on two or three afternoons a week.

There is, however, a sharp distinction between the time and effort involved in teaching while giving service in one's own practice and teaching away from it in a more formal fashion which often requires careful specific preparation. One way round these difficulties could be the logical development of teaching practices which would teach in each phase of general-practice education, receiving 'block fees' appropriate to their contribution.

Whole-time staff

One cannot leave the subject of remuneration without commenting on the wide range of salary and status which is displayed in the whole-time appointments in university departments of general practice. Four schools, for example, say that senior members of such departments have honorary consultant status and as such are eligible for distinction awards, although in honesty they also, with one exception, doubt the likelihood of such awards becoming a reality. When it is further considered that in one or two instances departmental heads could be in jeopardy even of losing seniority awards it seems that there should be some potential financial cushion to balance the differential between the financial possibilities of university and normal service practice.

However dedicated they may be, it seems unlikely that there will be forthcoming as many of the younger able men whom developing academic practice so urgently requires if their recruitment means that they will suffer major financial disadvantage.

It seems also unlikely that this situation will be improved unless and until the profession itself is prepared to reappraise the situation and promote change. It is interesting to note that agreement has been reached that the new regional advisers in general practice will be paid sessionally at top whole-time consultant rates. This provision by no means extends to all whole-time senior members of university departments of general practice. (This is not a personal plea, I have no complaint.)

Independence of departments

The long continuing promotion by the Royal College of General Practitioners and the British Medical Students Association in particular is producing results in the development of departments of general practice. Perhaps the London medical schools have special problems or perceive different needs but it is notable that only three of these schools have a department and only one is independent in its medical school.

In the process of development of a department to the maturity of a chair and independence in the faculty, it is necessary that some academic chaperone be provided. It does not matter which department undertakes this function, and it seems that social medicine and medicine do so predominantly, but it does matter and is quite undesirable that an incumbent should begin with a chair and no other furniture in the shape of supporting academic teaching and ancillary staff.

FUNCTIONS OF DEPARTMENTS

What seems to be fundamental are the reasons why such departments should be created. Perhaps they might be seen as the recognition of what Richard Scott called 'a demonstrable body of achievement', neither as a status symbol nor as a sop to the Cerberus of general practice. The fact is that general practice is now provided by the Royal College of General Practitioners (1969) with a task definition that depends on a dynamic mixture of basic, clinical, and behavioural sciences which distinguish it as the oldest new discipline in medicine, therefore to be represented in its own right in the medical school.

It seems, however, appropriate that, in the presence of the patient, undergraduate teaching in general practice should normally be on a 'one teacher one student' basis. This ancient learning situation is well capable of producing great satisfaction for both teacher and student but it is, alas, very expensive, and the right of the patient to the personal attention of his doctor in the privacy of the consulting room or home cannot be ignored. It is a constant source of surprise and gratitude that such a large majority of patients take so kindly to the presence of students but it seems likely that these two factors will always limit the amount of practical teaching, however desirable, which is possible in general practice.

Association of university departments

There are, however, further and equally important reasons for the creation of departments of general practice. The first is the possibility of achieving, with such departments *paris inter pares* in the medical school, the 'third faculty' of Stewart (1967). This association of the departments of general practice, psychiatry, paediatrics, geriatrics, occupational health, epidemiology, social medicine and perhaps sociology provides a major potential for teaching, research and experiments in medical care in the community. Here the aggregation of its teaching practices can produce for a medical school a teaching and research laboratory of enviable proportions and effectiveness. The department of general practice should lead in a variety of experiments in medical care.

Community care

Secondly, there are important possible practical operational bonuses which can derive from the positive philosophy of caring for patients in the community rather than from the negative attitude of keeping them out of hospital.

The creation of departments of general practice is seen thus as the end of the beginning, a proper end in itself and a proper means to a wider end, which cannot be achieved by other means.

The general practitioner is entitled to teach on those common illnesses which never reach the hospital, on the presentation and natural history of disease, on the progress of disease to the point of resolution, cure or referral, and then continuing care. At all times he may teach, as he practises, the principles of interventive, preventive and whole-person medicine.

General practice itself provides in the United Kingdom so much basic epidemiology of the morbidity patterns of the community that this is an area where those providing the statistics can be encouraged to present them.

Whole-person medicine

However much other clinicians and other disciplines may subscribe to the concept of whole-person medicine, it is the general practitioner who is its prime exponent and professed protagonist. This is the feature of general practice which our present students, with their strong social conscience and consciousness, approve above all.

Other functions

The department has several other roles not yet fully understood and requiring experiment. It seems logical that it should play its part not only in teaching medical undergraduates but those of social work, health visiting, community nursing, hospital administration and various other disciplines. Such experiments are being fashioned in Manchester where the department teaches in each of those situations, a reminder that it is a part not only of the medical school but of the wider university to which it should also contribute.

Timing of general-practice teaching

What is not yet by any means clear nor agreed is the proper placement of teaching in general practice within the undergraduate curriculum. Much depends on the views taken of the capacity and resources of the general-practitioner teachers. The demonstration of general practice as a clinical discipline supported by a philosophy is essential if only to provide the student with more valid grounds for his career choice.

Teaching and demonstration in the area mentioned above may take place in any clinical year and in a variety of situations—lectures, topic teaching or seminars, for example, as well as in the practice. The demonstration of the philosophy and practice of whole-person medicine which implicitly includes the community health team should surely be placed as early as possible in the clinical years, before the student has become what Robert Platt termed "a hospital-conditioned animal".

A fruitful period for general-practice departments could be the pre-clinical years. This is not perhaps the place to question the artificial division of the medical curriculum between science and people, a division which is not questioned enough nor effectively.

Medical students in many schools in so many countries complain of the theoretical presentation of the behavioural sciences in the preclinical years. Even if the student accepts their relevance to the practice of medicine he finds it harder to discern in the preclinical void of patients.

The various concepts of class, of status, of family, of community could be practically illuminated and reinforced by the audiovisual aids of real people in real environments. Such arrangements would be a refreshing change from the reverse of anthropomorphism displayed by those whom one student bitterly considered to have "bats in the belfry". The access to patients and a teaching role are two provisions which could be made by departments of general practice. The perceptive and original curricular proposals of Nottingham are well worthy of examination in this connection.

The placement in the medical curriculum might thus be considered as being either of the teaching in general practice as a clinical discipline first introduced in the first clinical year, or of teaching by general practitioners who complement the teaching of other disciplines in each and every year of the medical curriculum.

One thing is however quite certain. The learning objectives of each contribution must be clearly defined, the contributions constantly evaluated and objectives modified. There is all too often a failure to undertake this monitoring and until it is widely practised and reported no pontifications should be heard either from inside or outside general practice.

Preregistration year

There is yet another wholly unexplored area of teaching in general practice which, though not a subject of the questionnaire, is worthy of comment. It is stated in the Medical Act that six months of the preregistration year may be spent in "an approved health centre". No one has taken advantage of this proviso since 1951.

As the preregistration year is not normally regarded as coming within the province of the postgraduate dean it is relevant to the university department. It seems illogical

that we should continue to propose to train for general practice with three hospital postgraduate years to follow three undergraduate hospital years. This is a tacit admission that 'vocational' training for general practice is, in fact, limited to one year.

We expect a great deal from this year. Not only must it contain training but, also in general-practice terms 'reconditioning', with apart from new knowledge the introduction of concepts, philosophies and attitudes which differ properly and essentially from those of the hospital. Every effort should be made to experiment with the existing provision for the preregistration year. It is a situation for which developing teaching practices based on health centres could be suitably prepared.

Departments of general practice thus should have a big part to play in the total continuum of education for and in general practice. If they are successful in their appeal to students, more of the latter might be expected to enter general practice purposefully rather than *faute de mieux* or as 'failed consultants'.

All students will at least have observed, and some will have absorbed, the philosophy of general practice and its contribution to medical care. The departments should have the facilities and capacity available to train their own members and their teaching colleagues of the region in the task of teaching (Byrne, 1969). Then general practice will make a more significant contribution to its own continuing education. It will also share the educational load with consultants, which is badly needed.

PROBLEMS OF DEPARTMENTS OF GENERAL PRACTICE

The concept of the department of general practice is much older than is its implementation. Not surprisingly the problems which arise are only now beginning to become apparent. The departments now existing in the United Kingdom show two major patterns. The first, represented in Edinburgh, Manchester, Cardiff and St. Thomas's, has a university staffed National Health Service general practice as its base. The medical staff are in contract with the appropriate executive council; all the practice income goes to the university; and the staff, medical and non-medical, are whole-time university employees.

The second, seen in Newcastle and in Aberdeen, has a small number of whole-time university medical staff not engaged as principals in general practice, relying on selected service practices for their teaching on patients.

A variety of compromises between these two extremes are demonstrated in other situations. Thus, in Belfast, the Professor adds his new academic functions to those of his original general practice, while in Dundee, the Professor is about to become a member of an existing selected and co-operative practice in the city.

Aims

Perhaps the most difficult situation confronts the university department which also conducts a National Health Service general practice. First, it is necessary to consider the aims of the departments. Surely they must be:

1. To subscribe to the philosophy of their medical school
2. To provide and demonstrate first-class patient-care
3. To teach
4. To undertake research

Within the overall aims are some objectives which are likely to be idiosyncratic for individual departments. For the objectives must be constructed in realistic terms and therefore will be largely dependent on such variables as the curricular time and timing obtained, the number of students, the resources of staff and particularly equipment. There will always be ultimate objectives representing targets expected, both present and future which can be expected to be achieved at a particular point in time.

Curricular time and timing present a fascinating series of problems. How may a department make bids for each or either unless it has defined its objectives? Are such bids likely even then to be accepted by an unconvinced faculty of medicine? Will the resources be available both in quantitative and qualitative terms to meet these objectives? Each department will have to solve these and more problems in its own situation and its own way.

Service needs

A series of dilemmas present themselves. The first is that the university priorities are the teaching of undergraduates and research, while the several general-practitioner members of the department's practice(s) cannot escape the statutory, ethical, individual and corporate first priority of the care of patients. Thus, whatever happens in terms of practice crises, patient-care must come first, and teaching or research take second place.

University hierarchy

The second dilemma is unexpected and has to be experienced. Its solution requires a good deal of readjustment on the part of each member of the department. In the service situation all principals are equal, sharing night, weekend, and holiday rotas. In the department the same people are in the usual university hierarchy.

To compound the problems each principal has an inescapable load of patient-care while he himself is in the position of being consultant, registrar, senior house officer and house officer combined in one person. He cannot share teaching or patient-care as there are no junior staff.

Academic status

A third dilemma, common to all departments, which again does not emerge until the department is established, also concerns priorities. Departments are by no means universally accepted by medical schools and by medical academics. It is essential for the department to seek to achieve its academic acceptance as representing a discipline of medicine. At the same time it should surely wish to be accepted by the profession to which its members belong and whose discipline they seek to practise and to teach, even while assisting in the creation and acceptance of definitions of the discipline.

Academic coinage is assessed in terms of research monies and academic acceptance on objective evidence including publications.

A common agreed division of working time in academic clinical units—arbitrary though it may be—is two thirds service or patient-care, and one third teaching and research. If the basic general practice working week is accepted as is that of the academic consultants, as 11 sessions or 44 hours, then this division means that the academic general practitioner is providing service for seven and one third sessions and undertaking teaching and research for three and two thirds sessions. This means that he provides patient-care for the equivalent of about three and a half working days a week. (In addition there are of course, his evening, night and weekend duties.)

In such a case he would be able to enjoy and use profitably the facilities of the academic situation which he was motivated to enter. In fact if he does not have this time for these purposes, he cannot hope to fulfil his academic potential.

In reality, few of the whole-time academic general practitioners are able to achieve this working situation. Patient-care and teaching take up their time and so much less is left for research. It is wise to allow a new department a period of at least five years before projects can be planned, completed and written up, if the research itself is to be relevant and of good quality.

It is most important that good research be conducted for general practice to confirm its academic status. Sadly the difficulties are not appreciated, particularly by other

general practitioners, whose criteria of quality are naturally based on service. Those in the departments are not in jeopardy of living in ivory towers. They are in real jeopardy of being frustrated in their attempts to undertake research. Most people in departments urgently need understanding, sympathy, and help from their colleagues in general practice, and particularly from college members.

Loss of freedom

When able and experienced general practitioners enter an academic department they do so because they wish to teach and to undertake research. They have often had such experience previously in their own practices. Many of them have also served the College as examiners, members or officers of Council and its committees, or of faculties. They were enabled to do so because either they were single-handed and could please themselves or because their partners were prepared to support such activities by one member. When all the members of a department practice wish to undertake such activities, none may do as much as before—a most annoying paradox.

Trainees

One way in which the provision of much-needed academic time may be found is by the use of trainees, who are, after all, so analogous to the registrar that many have thought this a more appropriate title.

Thus a suitable 'firm' in a university teaching practice might well consist of two senior lecturers (each of whom would be a principal on the list of an appropriate executive council) and two 'trainees', district nurse(s), health visitors, midwives and a social worker (who might herself be a lecturer), together with receptionists and secretaries caring for a 'list' of about 4,000 patients. (This size of the list will vary according to the many variables involved. This figure cannot be regarded as the only possibility.) The practice could of course contain as many firms as were required by its size.

The rationality of such a situation is obscured by tradition and ignorance. Training committees, few of whose members have ever trained anyone themselves, executive councils and above all—patients—can be calculated to view such a proposition with the same proportions of scorn and horror as would many service practitioners.

Yet the same possibilities of first class patient-care and time for other essential medical work have been attempted elsewhere—in Livingstone for example, where the general practitioners have lists restricted to a 1,000 patients and undertake up to five sessions per week in hospital. They also have 'trainees'.

There seems in practice little difference between this widely publicised and applauded situation and the previous proposition made by colleagues in the Department in Manchester. Certainly such a teaching practice would be different from the more usual concept of service practices. It is not necessarily either better or worse but by its very nature and objectives it must be different. Such an experiment, for like that at Livingstone this is what it would be, should be supported, mounted and critically reviewed.

Departments and regional advisers

Many people have referred to the need for education in and for general practice as a continuum through the phases of undergraduate, vocational training and continuing education. This valid concept presents a further major problem. Throughout the country the regional advisers in general practice have been appointed faster than have substantial departments been created. Some have been appointed where there is no department, for a solitary unsupported senior lecturer can be seen only with sympathy as an uneasy nucleus for a future department. Whether a department precedes or follows the regional adviser in terms of time, they both have considerable advantages in a working symbiosis.

As the department's undergraduate teaching practices might well also be postgraduate teaching practices, the 'trainers' might well also teach undergraduates. Thus the regional adviser and the departments have mutual teacher colleagues. They should share common learning objectives with the postgraduate adviser, building on the undergraduate base.

Whoever comes first in time, the regional adviser should have an honorary membership of the department to help in the creation of the symbiosis. For in the end the greater proportion of teaching in and for general practice in any region will be conducted by practitioners in practices which have a dual allegiance to the department and to the regional adviser. They must not be divided by a common faith.

Career prospects

Recently a problem of career prospects has emerged. As departments develop young doctors will be trained in them, achieve postgraduate qualifications and research experience. They might well then expect to spend some time in a good service teaching practice to gain further solid clinical experience. But how may this be done? If they are honest and explain to prospective partners that they wish to stay for four or five years only and then seek a senior lectureship it is most unlikely that they will be appointed. If they remain silent until the time of their early departure it would not be long before, rightly, practices refused to consider such applications.

One way around this difficulty might be to create posts in inner or outer ring teaching practices where the university would find the difference between the agreed salary and the sum of allowances which the presence of the newcomer would attract. A new formula would need to be devised.

The length of time in post would not be fixed but should be considered as four to five years. Although supernumerary to the existing service establishment many such busy practices would find attractive an extra pair of able hands freely provided. They would find also plenty of clinical work for the incumbent who in turn would develop and assist in the practice teaching and research.

CREATING NEW DEPARTMENTS

Finally then to those medical schools which wish to create a department of general practice, it may be said that the creation of one such modelled upon Aberdeen or Newcastle may be carried out quickly, cheaply and with fewer problems. Departments seeking to model Cardiff, Edinburgh or Manchester will take longer to create, because suitable opportunities must be seen and then taken; will be more expensive—at least initially—and will create more problems. It remains to be seen in the long term what relative advantages and disadvantages emerge.

For some years to come these different situations must be observed and evaluated. Until a great deal of such experimental evidence has been painstakingly achieved, we are in no position to make valid judgments on any chosen method of working by any existing departments.

References

British Medical Students' Association (1960). Report.

Byrne, P. S. (1969). History of a course, *Update*, **1**, 547–553.

Byrne, P. S. (1969). Preparation for teaching in general practice, *Journal of the Royal College of General Practitioners*, **17**, 69–79.

Byrne, P. S. (1971). Men capable of doing new things. Victor Johnson Oration, *Canadian Family Physician*, **17**, No. 12, 29–35.

General Medical Council (1967). Recommendations as to basic medical education. London: G.M.C.

Harris, C. M. (1969). General-practice teaching of undergraduates in British medical schools. *Report from General Practice No. 11.* London: *Journal of the Royal College of General Practitioners.*

Pearson, R. J. C., Eimerl, T. S. & Byrne, P. S. (1968). Medical students and general practice, *Lancet*, **1**, 81–83.

Postgraduate Council (1972). *British Medical Journal.*

Royal College of General Practitioners (1969). The educational needs of the future general practitioner, *Journal of the Royal College of General Practitioners*, **18**, 358–60.

Royal Commission on Medical Education (1968). Report. London: H.M.S.O.

Stewart, W. H. (1967). *Perspectives in Biology and Medicine*, **10**, 462–470.

APPENDIX

List of 29 existing medical schools in the United Kingdom at 18 August, 1972.

Aberdeen
Belfast
Birmingham
Bristol
Cambridge
Cardiff
Charing Cross, London
Dundee
Edinburgh
Glasgow
Guy's, London
King's College, London
Leeds
Liverpool
Manchester
Middlesex, London
Newcastle
Nottingham
Oxford
Royal Free, London
St Bartholomew's, London
St George's, London
St Mary's, London
St Thomas's, London
Sheffield
Southampton
The London
University College, London
Westminster, London