

The need for academic general practice

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MY Inaugural Lecture gives the opportunity to discuss the new academic discipline of general practice which I believe has much to contribute to medical education. I am deeply conscious of the honour the Queen's University of Belfast has conferred by appointing me to the first Chair of General Practice in Ireland. It ranks fifth in order of establishment in the United Kingdom.

I have endeavoured to concern myself since my appointment with the creative use of knowledge and experience, gained through 20 years in general practice. Academic general practice is still weak in theory, but I believe it has a specific catalytic function in bringing together specialised bodies of knowledge in a systematised and meaningful way. I am trying to develop a new framework of knowledge, skills and attitudes applicable to the practice and teaching of general medicine in the context of general practice, which will also contribute effectively to the basic education of all medical undergraduates. Perhaps fifty per cent of graduates from medical schools will be needed to meet the needs of primary care in the future, if teaching and research are to be adequately developed, and real integration of hospital and community care achieved.

The flood of medical science has produced in recent years an ever widening gap between medical education and the needs of society, between knowing and doing, and between the art and the science of medicine. The purpose of this address is to show the need for academic general practice to bridge this gap and to alter attitudes to general practice and community care. Super-specialism has fragmented medical care and medical education, and the pendulum has swung too far towards equating disease with science. My theme today is the motto of the Royal College of General Practitioners *Cum Scientia Caritas* which epitomises the blend of compassion and science expected of the modern general practitioner. These need not be divergent ideals. General practitioners are in a unique position to teach the holistic perspective of medicine, comprehensive person-centred care, because it is the essence of their daily practice.

Definitions

General practice is the term used in the United Kingdom to describe the principal system of primary care. The general practitioner is a doctor who provides primary, continuing and personal medical care to individuals and families. A British Medical Association report, *Primary Medical Care* (1970), suggested that the term 'primary care physician' should replace the traditional term 'general practitioner'. Therefore, I may from time to time use the terms 'primary physician' and 'primary care'.

Recent history of general practice

To begin to understand the need for the academic discipline of general practice one must first look at the changes in various aspects of service in hospital and general practice since the coming of the National Health Service, and the impact of super-specialism on medical care and medical education.

At the start of the Health Service about two thirds of the general practitioners in the United Kingdom were practising single handed with such a deficiency of socio-economic resources that the term 'cottage industry' was coined to describe the conditions. Terms of service were harsh and income levels were low. Collings' (1950) attack on the

quality of primary medical care, especially in industrial areas, shook the profession and stimulated the formation of the Royal College of General Practitioners in 1952, an academic body committed to raising academic standards in general practice. Collings' described poor clinical standards, and inadequate investigation due to appalling work load, and a complete lack of human and technical facilities. A decline in the number of general practitioners occurred in the 1960s. The rapidly expanding hospital service began to absorb increasing numbers of graduates. There are now more hospital doctors in England and Wales, 23,478, than general practitioners, 20,391, (Royal College of Physicians and the Royal College of General Practitioners, 1972).

An American social scientist called Honigsbaum (1972) recently asserted that quality of practice had shown little improvement since Collings' report of 20 years' earlier. His paper is a challenge to general practice, but his criticism is subjective and based on old material, not his own work. He pays scant attention to the benefits bestowed on general practice by the family doctors' charter in 1966. These included the introduction of a new system of remuneration designed to stimulate the rapid development of a well organised primary care service based on group practice or health-centre development and the health-team concept. Under this system general practitioners obtained 100 per cent reimbursement of practice rates and rent and 70 per cent reimbursement of the costs of ancillary staff.

These measures were designed to encourage more and more young doctors to move into modern, purpose-built, well-staffed premises.

Super-specialism

The increasing complexity of knowledge during the past half century has led to super-specialism which in turn has resulted in fragmentation of care and knowledge.

The power base of medical education became the teaching hospital as universities ceased to be involved in the provision of primary care. Medical schools largely ignored the potential teaching and research resources of the human laboratory on their doorsteps. Medical students learnt little about the processes and skills of primary doctoring of patients, whose needs range far beyond those found in the teaching hospital. Stevens (1966) summed it up by saying "the consultant won the hospital bed and the general practitioner won the patient."

The net result was an undesired end product to medical education, a highly-trained technical graduate, not trained nor interested to provide good community care. The answer in America and other countries was to deliver primary care through groups of diluted specialists not attuned by education to social needs or mental complexities. The attitudes of such doctors to primary care were best summed up by Davison (1955) "to consider the patient as other than a fleshy container for pathology too often seems unscientific and inappropriately idealistic."

There has been a growing consensus of opinion during the past 20 years about the defects of medical education, but few academics until very recently would seriously have considered general practice as an academic discipline in its own right. Roberts (1948) stated explicitly his attitude to academic general practice "the general practitioner would be completely out of his element, his daily life casts his mind in a mould, which unfits him for systematic teaching . . . the gulf between the hospital and domiciliary aspects of medicine cannot be bridged."

Pressure for change continued however, and from its foundation the Royal College of General Practitioners pressed steadily for the development of academic general practice in British universities. The departmental autonomy and vested departmental research interests of universities made radical changes slow and difficult. The concept of the basic doctor, as distinct from the traditional safe doctor concept, emerged eventually from the Report of the Royal Commission on Medical Education in 1968.

General practice was to become a vocational specialty with its own particular skills and training. Yet some intellectuals regard general practice as mundane, characterised by humaneness, empiricism and pragmatism. They forget that clinicians everywhere rely on experience and observation. The development of academic general practice should strengthen theory based on scientific principles. The emphasis in medical education should be on flexibility and integration. The old Queen's medical curriculum was like a plum cake, sagging in the middle with the fruits of many specialties, but badly needing the human ingredients of general practice to produce a sound mixture and rich flavour.

It is appropriate now to define the educational needs of general practitioners, which determine the core content of academic general practice.

The academic content of general practice

Knowledge

The Royal College of General Practitioners (1969) has defined the vocational training needs of the general practitioner in five areas (figure 1). These are clinical medicine,

ACADEMIC CONTENT OF GENERAL PRACTICE IN FIVE AREAS. (R.C.G.P.s 1969)

AREA I.	Clinical Practice	:	Health and diseases
AREA II.	Clinical Practice	:	Human development
AREA III.	Clinical Practice	:	Human behaviour
AREA IV.	Society and medicine		
AREA V.	The Practice		

Figure 1. Academic content of general practice in five areas. (R.C.G.P. 1969)

human development, human behaviour, society and medicine, and the practice. The last area is professional and covers management and practice organisation. Areas I-IV cover a combination of knowledge from many academic disciplines, which are illustrated in the following diagram (figure 2).

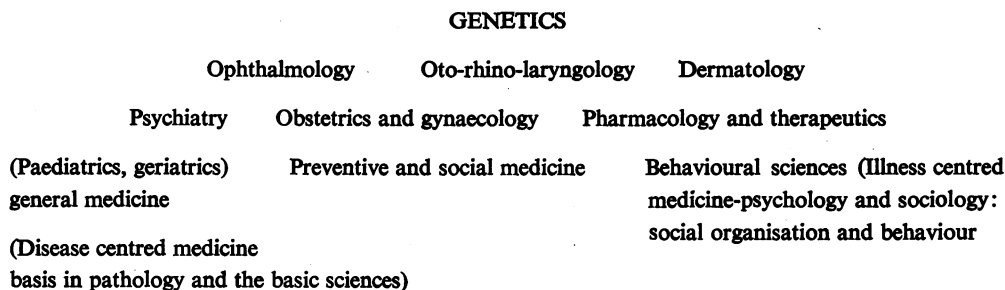


Figure 2. The disciplines comprising academic general practice

Clinical and social medicine must remain the foundation of general practice. Knowledge derived from these disciplines constitutes the core content of academic general practice.

One may define illness as a state of being ill due to sickness or specified disease. A dictionary definition may not absolutely differentiate between illness and disease, yet the meaning of the words has changed in the past few decades in the teaching hospital environment, due to the increasing emphasis placed on scientific medicine. Teachers and students alike are conditioned to think of the significance of being ill in terms of specified morbid processes, associated usually with molecular or cellular pathology or with psychotic mental processes. Psychological, functional or social aspects of sickness appear to matter much less and thus appear less significant. These aspects of sickness have become associated with 'illness' *not* 'disease'. Any doctor with an encyclopaedic

knowledge of the minutiae of scientific medicine should be successful in hospital clinical medicine. He might not be so successful in the milieu of general practice. Here the concept of illness is at times quite different. Organic disease is still significant, but sickness should often be functionally interpreted in its total sense, comprising its behavioural aspects and social consequences. This 'psychological' distinction between disease and total illness leads to role differentiation between the clinician in hospital and general practice. A sound knowledge of the basic sciences is required to cope adequately with 'disease centred medicine' in and out of hospital. However to diagnose and manage 'total illness-centred medicine' one requires as well a profound understanding of the behavioural sciences, particularly psychiatry and sociology. Knowledge of human genetics is required for family counselling.

This combined knowledge is applied at several interfaces in the field of work of the general practitioner:

- (1) The interface between hospital and community,
- (2) The interface between disease and social environment,
- (3) The interface between health and disease.

Let us now briefly discuss the areas defined by the Royal College of General Practitioners.

Area I

General medicine is still the most important area and is applied at all three interfaces. The general practitioner is concerned with whole-patient medicine and the emphasis is on the interaction between physical, psychological and social factors in clinical situations, which differentiates general practice from the practice of general medicine in hospital. There are signs recently that the third interface between health and disease is becoming increasingly important as people more and more accept the need for practical preventive health measures.

The general practitioner must have knowledge of epidemiology of the common diseases. He has to learn how to identify practice needs and vulnerable 'at-risk' groups of patients, in addition to providing general care. In this area students have to be taught about the different morbidity patterns in general practice. The following show with Dr Keith Hodgkin's permission, the marked differences between the incidence of some disorders in hospital and general practice (Hodgkin, 1973).

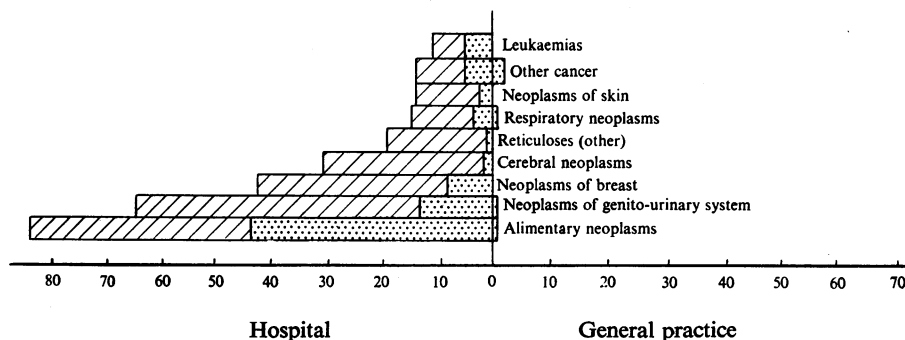


Figure 3. Malignant diseases
 Figures indicate rates per 1,000 incidents of disease
 Light shading = Student experience

Figure 3 shows the much higher incidence of malignant disease in hospital. On the left is Dr Hodgkin's hospital experience (light—student, dark—internship), and

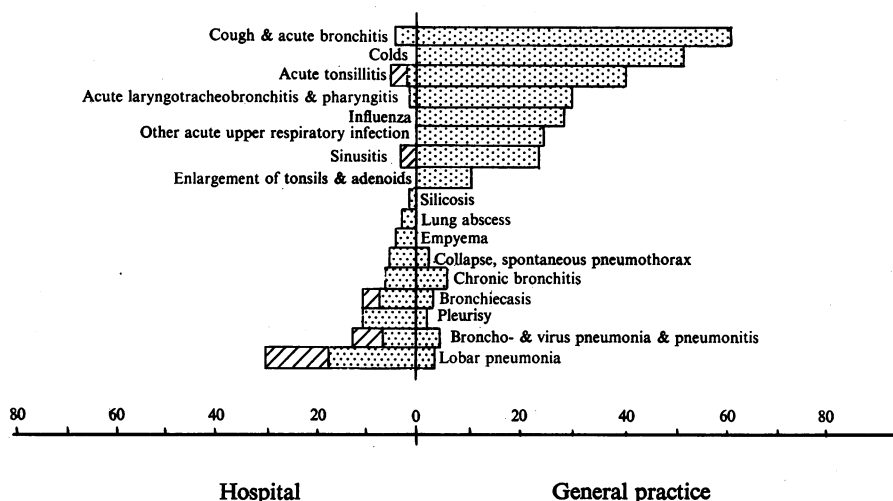


Figure 4. Respiratory diseases
 Figures indicate rates per 1,000 incidents of disease
 Light shading = Student experience

on the right his experience during one year in general practice.

Figure 4 shows the much higher incidence of upper respiratory diseases in general practice.

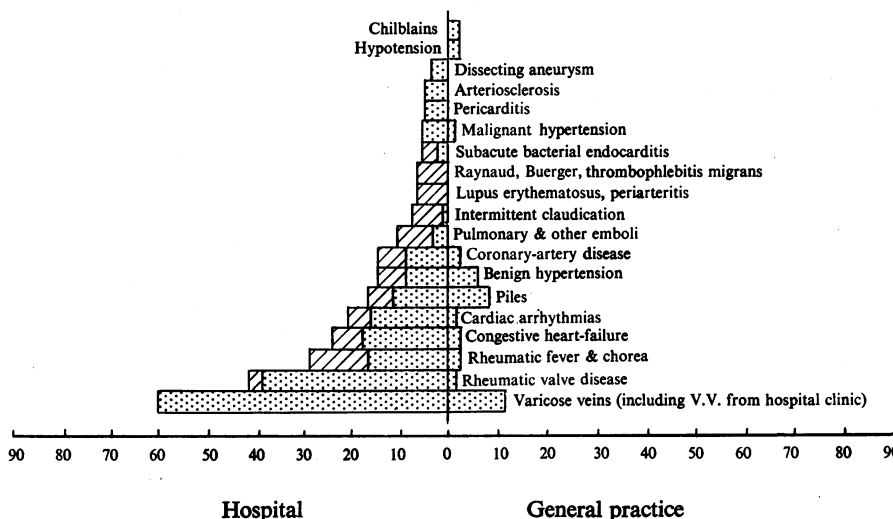


Figure 5. Cardiovascular diseases
 Figures indicate rates per 1,000 incidents of disease
 Light shading = Student experience

Figure 5 shows the much higher incidence of advanced and uncommon cardiovascular diseases in hospital.

Figure 6 shows the much higher incidence of tension and behaviour disorders in general practice.

Students must also learn about symptomatology in general practice. The same

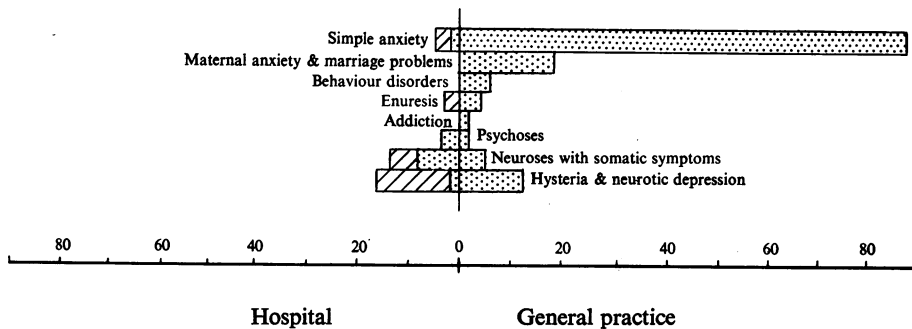


Figure 6. Mental diseases

Figures indicate rates per 1,000 incidents of disease
Light shading = Student experience

symptom may have a very different significance in the environment outside hospital depending upon its relationship to different phases of the disease process, or it may be influenced by social behaviour.

Area II Human development

It is necessary to have knowledge and experience of physical, intellectual and emotional development at all ages to be able to identify early departures from normal. As personal friend and spiritual counsellor the family doctor is involved in the seven ages of man, from conception to senescence. Because of the paramount importance of knowledge of human genetics in family counselling students must learn the genetic characteristics of certain conditions. Theirs need not be a knowledge in depth, but enough to ensure that risks can be assessed and specialist help sought, when it should be.

Area III Human behaviour

The behavioural discipline is an integral part, but not the whole part, of general practice. Much of the general practitioner's everyday work is concerned with the recognition of psychological illness providing simple psychotherapy and helping patients to live with intractable life situations. Knowledge of the behavioural sciences, particularly psychology and sociology, provides a means of understanding better why patients have consulted the doctor, and why they have behaved as they did. This area of knowledge merges with that of society and medicine, which is applied at the second interface between disease and social environment.

Area IV Society and medicine

There is no sharp division in general practice between social and medical pathology. Social factors influence the aetiology and management of disease and the way the patient functions in society. The cure is often to manipulate the social environment. The family doctor is frequently confronted in his work with the flotsam and jetsam of society—inadequate personalities, psychopaths, and the social diseases of alcoholism, stress and drug addiction. His answer to these problems is two-fold. Firstly, he applies systematised knowledge of population medicine, which includes the effects of culture, race, sex, religion, class and occupation on the incidence of disease and its severity. Secondly, he has to learn to work with and understand, through the interdisciplinary team approach, the skills of the social work profession. He has to become familiar with a wide range of statutory and voluntary welfare services.

There remains to describe a clinical core of skills and attitudes inappropriate to hospital experience.

Primary care skills and attitudes are more appropriately taught by general practitioners than by hospital specialists. The doctor-patient relationship is different, being continuous and more intimate. Frequently the degree of rapport, understanding and communication established during a consultation dictates the success or failure of care. The diagnostic process in general practice is greatly influenced by the general practitioner's previously acquired knowledge of his patient's health, and of his patient's social and personality background. All students must observe and attempt to understand the 'dynamics of the continually changing doctor-patient relationship in general practice'. It is a therapeutic as well as a diagnostic relationship, as described by Michael Balint in his book, *The doctor his patient and the illness*, which was published in 1957. The doctor uses himself as a drug—a measure which can have its own side-effects. This has been described as "the most important book on general practice to be published this century" and as "a watershed in the development of general practice." It has been said in an Editorial in the *Journal of the Royal College of General Practitioners* (1972) that "what Freud has become for psychiatry, Balint will become for general practice." These are strong words and indicate the importance attached to the hidden content of many consultations in general practice. Students, therefore, have to be taught communication skills, how to establish rapport, how to obtain information indirectly by enhanced perception and by cultivating the art of listening. They have to learn the basic skills of primary diagnosis, how to differentiate unselected primary illness with sometimes inadequate evidence and minimal diagnostic resources. They should be taught the responsibilities of decision-making and management in primary care.

Area V The practice

The practice includes knowledge of organisation, premises, staffing, equipment, recording, communications, practice management and research methods. This will be taught in more detail at the postgraduate level. Nevertheless undergraduates should learn about organisational developments and the role of the paramedical team. The family doctor's charter in 1966 negotiated between Government and British Medical Association, improved considerably the terms and conditions of general practice as already described. Steady progress has been made, particularly in Northern Ireland, in health-centre development and the provision of better facilities. Figure 7 is shown with Dr Pat Maybin's permission.

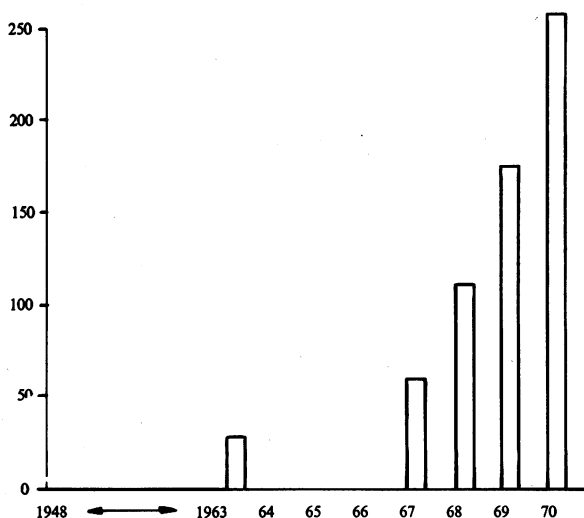


Figure 7. Statutory health centres in operation in the United Kingdom 1948-1970

It shows the total number of statutory health centres in the U.K. in the years 1948–1970. There has been a five-fold increase, in less than five years.

The number of centres in operation at the end of 1970 was 217, but by July 1972 that number had increased to 307 (Aberdare, 1973).

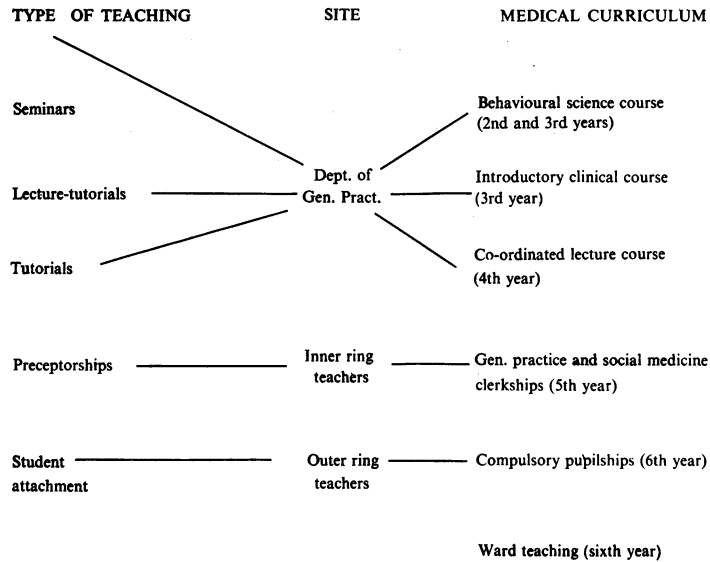


FIGURE 8

It is estimated that by 1975 over 50 per cent of general practitioners will be working in health centres.

Establishing a department of general practice

There are many administrative difficulties in establishing a new department of general practice and a central teaching unit. There is no blueprint to work from. It is difficult to duplicate the joint relationship between the University and Northern Ireland Hospitals Authority built up since 1948, because the Northern Ireland General Health Services Board which controls general medical services outside hospital is an executive body with no policy-making powers. Consequently the rules have had to be bent a little with goodwill on all sides to arrive at a triple relationship. Representatives from the Northern Ireland Hospitals Authority, Northern Ireland General Health Services Board, and the University have tried to resolve amicably, as a matter of urgency, the many problems of my department including career structure and to relate this to Health Service general practice.

Future development

A plan has been developed to establish a health centre, containing the university practice and six other National Health Service practices, beside the Medical Biology Centre at the Belfast City Hospital. The top floor will house the Department of General Practice with built-in teaching and research facilities. The sector population of this health centre plus the department's nine inner ring selected teaching practices will amount to over 100,000 patients, much more if peripheral teaching units are to be included. The research potential of this human laboratory will be discussed later. In the interim period, until these resources are available, I use Finaghy Health Centre as my focus of health-centre

teaching and I am dependent upon the goodwill of my partners and of my selected teachers. There is now a well trained inner ring of teachers and a very sound outer ring of peripheral teaching practices scattered over the Province.

Teaching objectives

The general teaching objectives and specific teaching aims of my department are:

A. General teaching objectives

- (1) To broaden concepts of illness and disease,
- (2) To complement other clinical teaching by a new emphasis on 'holistic' or whole person medicine,
- (3) To assist in planning and teaching postgraduate general practice,
- (4) To keep students informed about advances in knowledge in the field of general practice,
- (5) To promote health team concepts and efficient organisation of general practice.

B. Specific clinical aims

- (1) To demonstrate basic clinical methods in general practice,
- (2) To show the relevance of personality and environment in the causation and treatment of illness,
- (3) To teach the dynamics of consultation and the therapeutic relationship between doctor and patient in general practice,
- (4) To demonstrate problems of after-care, rehabilitation and long term care,
- (5) To teach preventive clinical procedures and the application of epidemiology in general practice,
- (6) To teach morbidity patterns and methods of morbidity recording.

Many of these aims cannot be adequately represented in hospital and will become clear to the student only in the consulting room and home.

General-practice teaching takes place in the preclinical as well as in the clinical phase. Currently the main impact is in the community medicine fifth-year programme with the Department of Preventive and Social Medicine. Students are introduced to practical experience of general practice in nine inner ring teaching practices and this is followed by mandatory two-week pupilships in general practice in their final year, mainly attached to outer ring practices scattered throughout the province.

Evaluation and feed-back from the fifth-year teaching suggests strongly the need for a deeper involvement by general practice in the behavioural science course of the second and third years, to make it more relevant to later experience of primary care and secondly to condition attitudes earlier to comprehensive patient care.

The medical school has a dual responsibility to enhance knowledge and to produce a broadly educated doctor at graduation, although not a finished doctor.

During the past half-century the progressive university medical teacher has received little attention and less respect. Yet more and more students complain about having to assimilate apparently irrelevant factual data, particularly in the preclinical phase of their education. Could a better blend of learning and vocational needs not be achieved in the preclinical field? Could medical education not strive to enhance Newman's view of university education which was to give man "a clear conscious view of his opinions and judgment, a truth in developing them, an eloquence in expressing them and a force in urging them"?

The alternative suggested by some people is to stream students into two grades early

in their undergraduate careers. This is already being done in American universities. It goes against the broadly based undergraduate education with specialty training after registration, recommended by the Royal Commission on Medical Education five years ago. Experience in Eastern Europe and Israel of medical care systems based on inadequately trained primary care doctors, seems to indicate that specialists are wasted in doing work, which could be more competently and efficiently performed by a good general-practitioner service.

A century ago many medical schools were responsible through dispensaries for the primary care of indigent people. The wheel has turned full circle now and through my department this University is again becoming involved in community care. Academic general practice is an applied discipline which is developing its own core content of knowledge, skills and attitudes. The difference between undergraduate and post-graduate levels is one of emphasis and degree, not one of content.

Postgraduate education

The need for a continuum of education through the phases of undergraduate, vocational training and continuing education is generally agreed. Recently regional councils responsible for postgraduate education have been established with regional advisers in general practice appointed as organisers and executive officers. In most regions in England the general-practitioner adviser has been given an honorary appointment in local academic departments. There is obvious need for a close liaison between the academic department and the general-practitioner adviser. Under existing arrangements in Northern Ireland the Professor of General Practice is Chairman of the General-Practice Sub-committee of the Council and the general-practitioner adviser is a member of the medical faculty.

Teaching and research are not alternatives. Both are part of the same process of education, complementary activities in the academic community (Page, 1972). In establishing my department for professional and academic reasons priority had to be given to creating a sound teaching framework and content of knowledge, but research has not been forgotten. Large scale research will be impossible until the department has a staffing ratio commensurate with its responsibilities.

Research opportunities of my department act as the portal to the human laboratory of the community teaching practices. At national level epidemiological and morbidity studies have been performed very successfully by the General Practice Research Unit of the Royal College of General Practitioners, which is based in Birmingham. At local level the research resources of the College and university should combine, leaving each other free to act independently, if either should so desire. There should be no conflict—the College exists to set standards and the university to advance knowledge.

General practice may be divided into operational, clinical and educational research areas.

1. Operational research

The development of the plans for the proposed General Practice Central Teaching and Research Unit to open in 1976 offers a wonderful opportunity to examine modern methods of practice management and the potential uses of computers in general practice for data storage and retrieval. The Scots are well ahead in this field. They have a General Practitioner Research Support Unit developed in partnership by the Department of Health, Dundee University, and the Royal College of General Practitioners.

Gruer (1972) recently described an off-line computer-assisted general-practice records system at Livingston Newtown Health Centre near Edinburgh. A summary of the doctor's clinical notes is dictated, coded and fed into a computer file. This provides an index to the medical record, a monitoring device for screening procedures and speedy

access to data for research, management or statistical procedures. Current methods of continuously recording and coding morbidity devised by the Royal College of General Practitioners are economical and of proven worth.

Such data cannot however easily be linked to other desired parameters, because the full name and address of each patient is not recorded or coded. Punched cards and mechanical sorting are already regarded as obsolete by computer experts. One already has relatively economic access to computers by teleprint machines, soon to be augmented at more economic rates by cathode ray screens or visual display units, which will verify data as they are fed it. Monitoring facilities for surveillance of 'at-risk' groups of patients would transform general practice and stimulate a new interest in clinical preventive medicine.

Given access to such facilities the new academic unit of general practice could harvest a rich yield of research opportunities. I hope to devise new A4 sized clinical records with a structured format which will be problem orientated as advocated by Dr Lawrence Weed. I am trying to decide the most suitable methods of data collection, preparation and processing to meet the academic and service needs of the proposed teaching health centre. Another operational research interest being analysed on a small scale is the role of the paramedical staff and their relationship within the health team.

2. Clinical research

Here are a few areas I would personally be interested in:

- (i) The field of clinical epidemiology. Aided by computer data handling, large scale prospective screening surveys could be performed in the community. Biochemical data, morbidity data, diagnostic data and clinical findings from periodic health surveillance could all be correlated and help to provide more information about 'normal' ranges of biological values and the natural history of disease processes and symptom-complexes.
- (ii) The rapidly expanding field of virology. The general practitioner is ideally placed to record in this field, perhaps to provide vital clues to the aetiology of disease and to improve viral diagnostic laboratory techniques. A country doctor, Dr Will Pickles, became world famous for his research into infectious diseases. He was the first doctor in Great Britain to identify and describe Bornholm disease and to confirm the long incubation period of infectious hepatitis.
- (iii) The field of clinical pharmacology. I look forward to further co-operation with the Department of Pharmacology and Therapeutics and the Department of Pharmacy into drug research and prescribing habits of practitioners and pharmacists. Enormous quantities of psychotropic drugs are being consumed in increasing quantities each year without it being known for sure which drugs are likely to do more harm than good in the long term.
- (iv) The psychiatric field. Here research is needed to promote better understanding of common emotional and behavioural disorders and to evaluate drug and psychotherapy. It is difficult in this field to define abnormality as the normal seems to merge imperceptibly into the abnormal, and body and mind seem inseparably linked.
- (v) The field of preventive clinical medicine. Patients' needs are not always expressed by demand for medical care. Research is needed to find effective means, not only of identifying patients whose health is at risk, but also of ensuring a sound method of follow up and management.

3. Educational research

Lastly, in the field of educational research I have been interested for several years in using video-tape recordings and closed-circuit television techniques to teach clinical method, the art of consultation, and to demonstrate the patient in his own environment. Others have gone further and are teaching communication skills with the help of actors and video-tape simulation of the doctor-patient consultation. I hope to develop group audio-visual techniques further in the proposed Central Teaching Unit. Several designated teaching consulting suites will be cable linked to the large seminar room where groups of students will be able to watch and take part in tutorials on real interviews taking place elsewhere in the building. My hope is that research in these varied fields will promote imaginative discussion and new concepts of academic general practice will emerge. I have tried to indicate how my department through its research, as well as teaching activities, could complement work done in the hospital environment.

Conclusions

In conclusion, I may say that I have tried to demonstrate in this Address the need for academic general practice and to show its contribution to medical education. It was born out of the poor quality and socio-economic difficulties of general practice in the early years of the National Health Service. Its growth has been nurtured by the Royal College of General Practitioners since its formation.

Other inter-related factors have fertilised its soil of development and made possible the present renaissance in academic and vocational general practice. These are, firstly, the organisational developments in recent years since the implementation of the family doctors' charter. Secondly, recognition of the limitations of hospital education and the need to broaden medicine by including teaching of general practice and community care. Thirdly, the definition by the Royal College of General Practitioners of the educational needs of the future general practitioner. Fourthly, the recommendations of the Royal Commission on Medical Education (1968) aimed to produce at graduation an educated but not a finished doctor. This would be achieved by further postgraduate vocational training. "This does not mean that the vocational aspect of undergraduate medical education should be ignored: the student clearly has a professional career in view and his education must be biased in this direction."

Lastly, the socio-economic changes in society which produced a demand for an improved and more sophisticated primary care service. Medical education has had to change to take account of these factors. The academic discipline of general practice claims a unique synthesis of knowledge from its overlapping clinical and behavioural disciplines. This knowledge has a characteristic application in primary care, and so general practice, in the functional sense, is a 'specialty in breadth' within the discipline of general medicine. The teaching emphasis on the continuing doctor-patient relationship and the interaction of physical, psychological and social factors in the clinical situation differentiate it from hospital orientated general medicine, which emphasises more the signs and symptoms of specific organic disease.

The teaching role of my department is to complement learning provided by other clinical departments. The whole-person approach encourages students to view the patient's complaint or problem in perspective. It conditions them to think comprehensively, to acquire human understanding and compassion, and to assess the importance of all the environment in the aetiology and management of illness. I leave you with the concept of this department acting as a bridge between the medical school and its community, and as a catalyst between different academic disciplines. I hope you will reflect, as I often do, on the enormous teaching and research potential of the human laboratory that my department serves.

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GENERAL PRACTITIONER TEACHERS**Training for Course organisers and tutors**

A course for doctors who will be responsible for training general-practitioner teachers has been initiated by the Royal College of General Practitioners with the support of the Nuffield Provincial Hospital Trust. Instruction will also be given in the organisation of education programmes for vocational trainees and for established general practitioners.

The course will have six separate five-day modules. The first module will be held at 14 Princes Gate from 22 APRIL-26 APRIL 1974. The sixth module will be held at the end of March 1975. Members will be expected to conduct educational exercises themselves between modules. Help with these exercises will be available from the Nuffield Tutor, Dr Paul Freeling, who has overall responsibility for the course.

For further details, including the funding of course members, please apply as soon as possible to:

The Secretary,
The Royal College of General Practitioners,
14 Princes Gate,
London SW7 1PU.