EDITORIAL

Teaching undergraduates in general practice

GENERAL practice has now become established as a part of the core curriculum of almost every medical school in the United Kingdom. The support which medical schools give to this teaching in terms of the numbers of academic and other staff, and accommodation and equipment, varies greatly. There is, however, one aspect of the financing of clinical teaching which greatly disadvantages general practice compared with all the other clinical subjects taught in the medical school.

The National Health Service has a statutory responsibility to make available to the medical schools of the universities clinical facilities for the teaching of medical students (DHSS, 1976). Funds for this are provided by the service increment for teaching (SIFT), which the NHS adds to the budget of teaching regions. The figure is based on a projection of the number of undergraduates a particular school is expected to have in the clinical years. Currently a teaching authority with a medical school whose annual intake is 100 students would attract an annual increment of more than £3·5 million.

There are several ways in which these monies may be used. For example, they may be used to employ extra clerical staff to enhance the quality of medical records, or pathology and x-ray services. They may be used to increase the number of nurses and other health care workers. The intention is to provide in the teaching hospital an appropriate environment for excellent clinical care and so for excellent clinical teaching.

One of the most important uses of SIFT monies is to create time for teaching by consultants working in teaching hospitals. Effectively this allows a teaching authority to increase its consultant staff by about 20 per cent above that found in a non-teaching district general hospital of comparable size. This recognizes the fact that all teaching takes time.

Teaching in general practice similarly takes time; but the financial implications for the practitioner are more direct and serious than for his hospital colleague. As an independent contractor his National Health Service income is derived mainly from three sources: basic practice allowance, capitation fees, and item-of-service payments. If he is to give time to the student, he must necessarily reduce his clinical commitments accordingly; and this implies a reduction of the capitation fees and item-of-service payments which he can expect to earn in unit time. The presence of students thus results in loss of remunerative time. Although most medical schools recognize his contribution to teaching by paying a small honorarium, the latter is unrelated to this loss of remunerative time; and no contribution is currently provided from SIFT monies.

There are many problems with such an arrangement. First, it is difficult for the university department of general practice to have an expectation of a regular commitment to teaching, let alone a commitment over many months in each year. Secondly, there can be no insistence that the general practitioner teachers adapt the pace of their work, or the organization of their surgeries, to meet the needs of the students when they are present. Yet it is unlikely that effective undergraduate teaching can take place unless the general practitioner halves his consulting rates when a student is present. Time must also be found for tutorials, advice on student projects, and so on. Thirdly, while the geographically scattered nature of teaching in general practice demands close co-operation between clinical teachers and academic staff in medical schools, there can be no expectation that further time will be taken by general practitioner teachers to achieve this.

It is thus essential that general practitioners who teach medical students are reimbursed for the loss of remunerative time, which is an inevitable consequence of good teaching. By definition, in the absence of such payments and contractual obligations on both sides, the relationship between the general practitioner teacher and the university department of general practice must remain ambivalent, and the teaching amateur rather than professional. The mechanism for making such funds available already exists. It requires only political will to use SIFT monies for this important purpose.

It is widely recognized that undergraduate teaching from general practice plays a crucial part in the basic training of all future doctors, whether they later work in hospital or the community. If university departments of general practice now fail because there is no proper financial support for their teaching, the cost will be borne not only by general practitioners, but by the profession as a whole and by our patients.

Traditionally the Royal College of General Practitioners does not concern itself with such matters as payment and politics. But here the politics of the NHS and of the universities conspire against the academic development of our subject and against the better care of our patients. This must be put right.

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Reference

Department of Health and Social Security (1976). *Sharing Resources for Health in England.* Report of the Resource Allocation Working Party (RAWP). London: HMSO.