How are the university departments faring?

THE Government's squeeze on universities has passed the point of being a transient political inconvenience. To make matters worse for medical schools, the further and probably inevitable decision of the University Grants Committee to withdraw the long-standing financial protection which clinical medicine has enjoyed in the past has forced medical faculties thoughout Britain to embark on complicated but inevitably crude assessments of the cost-effectiveness of teaching in all their clinical and pre-clinical departments. The results have been particularly threatening to the survival, let alone prosperity, of departments of general practice.

The cost to a university of teaching a student for a given period under the aegis of a general practice department has been widely found to be about double that required in other clinical disciplines. This extra is not so much because of the necessary concentration on small group and one-to-one teaching (shared by many other clinical departments) but more because of the absence of support from the NHS, which hospital specialties depend on so substantially to underpin their teaching and research activities (*Journal of the Royal College of General Practitioners,* 1980). There are important reasons why general practitioners should be well informed about the implications of this finding.

What NHS support for teaching implies

In the days of relative plenty the knock-for-knock agreement between the NHS and the medical schools was that NHS staff taught 'free' and in return university staff looked after patients on an honorary basis. Rationalization of the balance between these activities was confined to identifying the so-called SIFT (Service Increment For Teaching (DHSS, 1976)) element of teaching-hospital funding by subtracting the 1975 cost of an 'average' district hospital from the cost of an 'average' teaching hospital, and dividing the figure by the number of students taught. On this basis and at current costs, it can be argued that the NHS is contributing to the costs of the teaching and research activities of hospital medicine to the tune of between £15,000 and £20,000 for each student taught for one year—not in real money available for re-allocation but through supporting "the higher levels of medical and nurse staffing and of clinical facilities in general" appropriate for a teaching hospital (SHHD, 1977). A general practice department teaching 100 students for four weeks each thus starts at a relative financial disadvantage of at least £100,000 a year when its costings are compared with hospital clinical departments with equal teaching loads. Any fees earned for clinical care by departments of general practice are certainly not equivalent to this money; such income represents direct payment for clinical work actually done. It does not represent any part of the additional contribution from the NHS to the teaching costs of departments of general practice which Section 51 of the 1977 National Health Services Act (Section 47 in Scotland) implies should be made by the Secretary of State in the same way as he contributes to hospital-based departments.

The present position and problems

Although all medical students now receive some teaching in or about general practice, the individuality of medical schools is clearly reflected both in their variable commitment to general practice as an academic discipline and in their uneven application of its needs in terms of structure and support.

Early developments were clearly weddings of opportunism and determination. Two patterns have emerged as viable, each with some strengths and their own important shortcomings. The model which is easier for clinicians to understand is the department based on the relatively well-staffed but otherwise typical group practice of 5,000 to 10,000 patients, often based in an inner-city area where general medical services are in short supply. The clinical work generates income which meets a reasonable part of staffing costs and provides clinical credibility both within general practice and the medical school. However, the work of patient care even in small-list practices expands inexorably into the time which should be given to wider academic activity; worse still, university accountants understandably see the solution to economic difficulties in terms of taking on more patients, a course of action which can only mean putting the hopes of academic achievement further into pawn. Most of the larger departments are based on this model; they have, on the whole, had longer to lay foundations than the others and now seem to have a wide enough base of support and respect within the clinical and academic communities to guarantee their continuation.

The second model has been based on a smaller departmental unit, with academic staff seeking clinical links in existing practices which have no connections with the university. This model has offered greater academic opportunity to those university staff working within it and has generally cost the medical schools less. On the other hand, departments run in this way still cost more than non-clinical departments and it is too early to be sure that the smaller number of full-time staff they employ provides a sufficient 'critical mass' to sustain the necessarily wide range of interests expected of generalists.

The real problem lies in medical schools which have opted for departments based on compromises between the two systems. Many of these departments are single-doctor departments, and the apppointment is either frankly or effectively sessional in that the doctor's livelihood is dependent on his ability to subsidize himself or his university through practice earnings. Often the doctor continues to work as a full or salaried partner in his own practice, and balancing priorities between academic and clinical responsibilities becomes increasingly difficult as his understanding of the challenges of each part of his work increases. This model almost seems designed not to work and seems to represent a lack of either good faith or insight on the part of the medical school proposing it. Equally it can only be because of frustration at the absence of progress towards any better alternative that local doctors eventually agree to support it and hope for the best. Any truly academic return from this kind of investment reflects miracle-making by those who achieve it; departments based on this model are also all too easy prey for amputation in times like these, because no loss of full-time jobs is implied in making cuts. It is a sad commentary on the traditional medical establishment that such departments or units seem to be concentrated in the prestigious medical schools of the London area and its surrounds.

Solution

Clearly, the first requirement is to identify the principles on which university general practice should be built; the second is to cost them realistically and the third to negotiate a fair cost-sharing partnership between the NHS and universities analogous to those now being worked out throughout the country for other disciplines. The principles (which must include freedom to build on local needs and opportunities) should recognize that where practices are run they must be staffed to guarantee adequate academic opportunity; that—whatever the style chosen—staffing levels must allow creation of a reasonable academic 'critical mass'; and finally that proper payment must now be made to local doctors whose teaching is increasingly valued and increasingly professional.

Achievement of these simple but so far elusive targets requires a genuine desire to see the academic contribution of and to general practice succeed. The desire must also be shared, on the one hand, by the universities, their medical schools and the health departments, and on the other by general practitioners in general and by their academic and political representative bodies.

The heads of departments of general practice have set the necessary discussions in motion with a carefully prepared submission to the Health Department. Although it faces difficulties in being implemented because of problems in interpreting the relevant sections of the NHS Acts, the submission offers a real and relatively inexpensive solution to difficulties which have spanned two decades and affected all medical schools. The initiative has the support in principle of the College and of the BMA, and many Deans are actively canvassing for its implementation.

Nineteen eighty-three will be the mid-point between the inception of the Charter in 1966 and the year 2000. Those with experience reaching back into the pre-Charter days need no reminder of the changes in the standards and standing of general practice now as against then. The university contribution is one of several that have both gained from and contributed to these changes. It is in the interests of universities, of students, of general practitioners and of patients that the contribution continues to develop. To guarantee this development the academic departments now need widespread and informed support aimed to ensure that the neutral or negative views held in some influential parts of the medical establishment will become increasingly untenable.

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Medical audit in general practice

MEDICAL audit in general practice is the subject of an essay by Dr M. G. Sheldon with which he won the 1981 Butterworth Prize. Now published as *Occasional Paper 20,* it consists of a valuable review of the literature with reference to general practice, an analysis of several of the key issues, and includes a description of Dr Sheldon's own experience of audit.

In the early sections the author attempts to define