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

medical audit as it is practised in the United Kingdom, and establishes his own working definition. He outlines the essential characteristics of audit in general practice and goes on to review the literature, concentrating particularly on the North American contribution, with reference to the writings of Donabedian.

One of the author's main contentions is that general practitioners should be involved in the setting of objectives or criteria; he believes that external audit is likely to be not only valueless but counterproductive to the struggle to establish quality of care.

In the middle section Dr Sheldon describes an audit carried out in his own practice on the prescribing of antifungal treatment and the effect this had on practice policy. He discusses the lessons learned and from these draws some general conclusions which he believes are fundamental requirements for medical audit. In an appendix to the main text he offers a protocol for auditing the care of children with earache in general practice.

In December 1979 this *Journal* carried an editorial on medical audit in general practice which reflected the high hopes of the profession at that time. These have not really been fulfilled. Since the RCGP/GMSC initiative, with its joint conference and follow-up in the regions, the flame has been kindled, but is not yet alight. However, the recently published *Members' Reference Book* of the College does show evidence that several faculties are now responding to the challenge and discussing audit widely.

Medical Audit in General Practice is not the first, nor will it be the last, word on this important and difficult subject. It is, however, an important review and a thought-provoking analysis of one of the major issues facing general practice today. It can be warmly commended as valuable guidance on how any general practitioner can apply audit in everyday practice.

Reference

Journal of the Royal College of General Practitioners (1979). Medical audit in general practice. Editorial. **29**, 699-700.

Medical Audit in General Practice, Occasional Paper 20, is obtainable from the Publication Sales Department of the Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, price £3.25 including postage. Payment should be made with order.

Antidepressants in patients with heart disease

Twenty-four depressed patients with heart disease were treated for four weeks in a double-blind trial of imipramine, doxepin or placebo to assess the effects of tricyclic antidepressants on ventricular function and rhythm. The tricyclic antidepressants had no effect on left ventricular ejection at rest or during maximal exercise. Premature ventricular contractions were reduced by imipramine but were not consistently changed by doxepin or placebo. Treatment with imipramine and doxepin, but not placebo, was associated with significant improvement in standard ratings of depression. Our findings underscore the need for a reappraisal of the cardiovascular risks of tricyclic antidepressants and suggest that, in the absence of severe impairment of myocardial performance, depressed patients can be effectively treated with these agents without any adverse effect on ventricular rhythm or haemodynamic function.

Source: Veith, R., Raskind, M. & Caldwell, J. *et al.* (1982). Cardiovascular effects of tricyclic antidepressants in patients with chronic heart disease. *New England Journal of Medicine,* **306**, 954-959.

Negative responses to patients

Responding anonymously to a questionnaire asking them to list medical conditions and social characteristics of patients that evoked negative responses, 439 family physicians specified 1,846 medical conditions and 1,591 social characteristics. Of the medical conditions, the largest category (60 per cent) represented conditions for which medical treatment offered little or no likelihood of cure or alleviation. Of the social characteristics, the largest category (33 per cent) involved behaviour that violated the physician's personal norms, even though it had little or no bearing on the patient's health.

It appears that the responses accurately reflect the Protestant ethic value system characteristic of western Europe and the United States, but this constellation of values is accentuated in physicians by their selection and their professional training. Although negative responses to patient characteristics do not inevitably lead to inferior treatment of the negatively perceived patient, negative feelings might be reduced through changes in both the undergraduate and graduate levels of medical education.

Source: Klein, D., Hajman, D., Kohrman, A. F. *et al.* (1982). Patient characteristics that elicit negative responses from family physicians. *Journal of Family Practice,* **14**, 881-888.

Births in 1981

The number of births in England and Wales during 1981 is estimated to have been 634,000, 3.4 per cent fewer than in 1980.

Source: OPCS Monitor, FM1 82/1.