purpose-built premises with others can have many of the advantages of partnership, while retaining freedom to organize the service he offers as he wishes.

Only 64 per cent in North's study had a practice agreement (and the fact that 94 per cent of these doctors were happy with their agreement may say more about the type of practice which has one than the actual wording). Salaried partners were less happy — 71 per cent in this position were either overseas male graduates or married females.

Clearly, for many trainees the problems do not disappear on getting a job and this is reflected in the rising number of Young Principal Groups throughout the country. The ex-trainee, weaned on peer group support, finds himself alone in an often unfamiliar environment.

The number of women entering general practice has doubled in the last 14 years and it is predicted that by the year 2000 over 50 per cent of principals will be women. The flexibility of general practice is a particular attraction. Many women patients prefer to see a woman doctor about certain problems.[6] Women doctors are more likely to have a part-time post (94 per cent in North's survey) which fits in with family commitments. Any group practice of the future wishing to offer patients a 'full' service should include a woman doctor, and changes in the regulations could allow the 'luxury' of a part-time woman doctor in practices in intermediate and restricted areas. This would help to improve the range of services to patients, the employment prospects of women doctors and reduce the average list size. The General Medical Services Committee (GMSC) has suggested a programme[7] to help the single-handed rural general practitioner with locums, which could be a starting point for such a scheme.

The policies of the Medical Practice Committee have been reasonably effective in creating an even distribution of general practitioners throughout the country outside London, but there are still doctors with list sizes of 3,500. In such practices, any emphasis on preventive medicine is precluded by the workload. A reduction in maximum list size would be beneficial in developing better services and would also mean more job opportunities for trainees. By creating posts for young doctors, there would also be opportunities for improving primary care in central London. A good working environment is necessary but prohibitively expensive for a young principal in central areas, and improved financial aid is essential.

Stocking,[8] looking to the future of general practice as an outsider, considered there were four options: (1) to dispense with the general practitioner (which she dismissed rapidly; (2) to have bigger lists, fewer general practitioners and more associated staff — at risk of losing individual and continuing care; (3) to have constant or smaller lists but at least as many general practitioners, to get to grips with the whole problem of preventive medicine and health education; (4) to muddle along — 'a well respected National Health Service activity'.

The best young graduates still see general practice as a satisfying career; we must use this resource of young idealists to raise the minimum standards of general practice. Unemployment of highly and expensively trained young doctors is unacceptable in a society whose population still has many of its health needs unmet — it is not enough just to 'muddle along'.

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# Affective learning: a new approach to medicine

ONE of the more controversial aspects of training for general practice is the half-day release case discussion group. Some of these groups take on the characteristics of a Balint group and have a strong psychotherapeutic approach to the case discussions. Trainees entering such a group are confronted with a new approach to medicine — one which entails them in affective learning, that is in the emotional as well as the intellectual acceptance of new knowledge. It involves the loss of status and identity as a hospital doctor and the taking on of the new professional role of general practitioner. For this to take place, the trainee may pass through the four stages of reaction described by Kahn.[1] His observations of medical students in small groups suggests that affective learning requires giving up old beliefs and behaviour and coping with the feelings of loss until reintegration takes place.

The four stages of feeling states postulated by Kahn include confusion, denial, anger and reintegration. Individuals pass through some of these stages in order to break with the past, relinquish an old identity and allow a new identity to emerge. The 'Balint style' case discus-

sion approach uses the trainee's own case as a means of examining the interaction in the doctor–patient relationship.[2] The group process involves comments on the case presentation and criticisms of the doctor's skill and of how he uses himself in conducting the doctor–patient relationship. The trainee gradually learns about his or her own personality and how he functions — a learning process which can be painful.[2]

Support for this descriptive model of the 'Balint style' half-day release scheme came from trainees and course organizers attending or conducting four half-day release groups in the London area who were studied in varying depths in 1978/79. In addition to interviews, observation of participants took place as the researcher sat in with some of the groups. The analysis of the study of the groups indicates that some of the trainees passed through at least some of the stages in the reaction model. Moreover, the trainees' differing levels of participation, involvement and investment of themselves in their training and the 'Balint style' seminars affected their experience of these stages of transition. The quality of comments obtained from the trainees was very much a reflection of the individual's insight into his or her feelings, awareness of his or her own reactions and responses to the group process and of his or her motivation for entering general practice. Some trainees were obviously more willing than others to articulate their feelings. Silence or less expansive responses can of course also be interpreted as an indicator of such feeling states as avoidance or denial.

As the model indicates, the initial reaction to joining a group was often confusion as to what the learning task was about. The ability to relinquish old styles of learning and functioning and to adopt a new approach differed. During this first confusional stage trainees were often non-responsive, silent and withdrawn, unwilling to present cases. One course organizer commented: 'They did not really understand what it was all about. About once a term there is usually a discussion about the value of the group. Sometimes it is necessary to have a go at them, stir them up; obviously this is an unpleasant task.' The reluctance of trainees to take part in the group reflects the uncertainty about the new approach to medicine which they were being offered, which included the opportunity to criticize and challenge and by implication to threaten self-esteem. Not only were trainees vulnerable in the conduct of their case but aspects of the 'self' seemed open to inspection.

The first confusional stage postulated by the model was followed by denial that any learning or change was taking place. Denial is the most difficult hurdle and perhaps central to the process of affective learning.[3] In one group in which there was a rejection of the 'Balint style' it was suggested that as an alternative the group task should be modified. It was then decided that instead of conducting the group weekly on the 'Balint style' where discussion is focused on trainees' cases, the group would meet on alternate weeks to discuss certain selected topics.

The next stage in the model was anger, which was reflected in the interaction of the group members. Some of the trainees labelled the outcome of internal dissatisfaction within the group as a 'revolt'. One speaker whom the trainees thought was patronizing became a scapegoat for the internal hostility. It was 'safer' to destroy this outsider, than to damage one another within the group. The anger directed at the visitor acted as a catalyst for a more cohesive group, which in turn may have enabled members to feel more supported during the process of change.

The final stage in the model was evidenced by the degree of professional maturity the trainees displayed. By this time, a well-integrated professional identity had emerged, earlier feelings had been overcome and adjustment to the loss of an old identity and acceptance of a new one had taken place. One trainee emphasized the similarity between the trainees in his group rather than the differences, and his own identification with them despite his previous antagonisms.

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# General practice and the undergraduate medical curriculum

ALL medical schools offering a course leading to a first medical degree must satisfy the General Medical Council (GMC) about the content and standards of the courses they offer. The GMC is the governing body of the medical profession, and the majority of its members are directly elected by all registered medical practitioners in the United Kingdom. However, despite this clear and formal relationship at the top, in practice universities and medical schools have in the past enjoyed a high degree of freedom and autonomy and as a result there are wide variations in the medical courses available.

One particularly important variation is the contribution made by general practice to the undergraduate medical curriculum. A variety of arrangements for teaching general practice is matched by a variety of arrangements for departments of general practice, ranging from substantial, relatively well-resourced departments with established chairs of general practice at one end, to