University departments of general practice: a changing scene

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Introduction

SINCE the establishment of the first chair of general practice in Edinburgh in 1963, there has been a steady growth of such departments.[1,2] General practice departments initially tended to be based on university practices but in the majority, clinical staff were linked to different practices.[3] The Association of University Teachers of General Practice was formed in 1974; in 1991 its name changed to the Association of University Departments of General Practice (AUDGP) and by 1994 there were 342 members compared with 80 in 1976. The recent rapid increase in members has largely resulted from additional National Health Service funding of posts via 'tasked money' from regional health authorities. Most departments now have non-clinical members, reflecting the widening remit of teaching and research.

Initially established for undergraduate teaching, often under the umbrella of public health, general practice has only re-cently achieved the critical mass for an academic discipline. This evolution has been made more problematic by the separate development, for historical reasons, of postgraduate training.[4] The pressures of research assessment and for more integrated undergraduate teaching are now making many medical schools seek broader groupings of departments. A study was undertaken examining the current situation and proposed organizational changes.

Method and results

In November 1994 a questionnaire was sent to all 32 heads of departments of general practice in the United Kingdom and Eire (all belonging to the AUDGP) exploring the present, planned and preferred arrangements for their departments within medical schools. A distinction was made between autonomous departments answerable directly to the dean and medical faculty, with responsibility for departmental budgets and staff, and departments which were part of larger groupings.

Replies were received from all 32 departments which were named as follows: departments of general practice (16), units or institutes of general practice (5), combined with public health or clinical epidemiology (4), primary health (or medical) care (4), general practice and primary care (2) and a school of postgraduate medical education (1).

The majority of departments were still autonomous within a traditional faculty framework (Table 1). Seventeen medical schools were organized along traditional departmental lines, nine had schools, institutes, divisions or autonomous groups and six had mixtures of departments and larger units.

Twenty respondents reported that their departments had no plans to change, seven planned to merge to form larger units and two planned to merge with public health medicine. One department planned closer links with public health and health service research, one planned to change its name to the department of social medicine and one department was scheduled to disappear when a new curriculum was introduced.

Of 21 respondents who were happy with their present arrangements, 15 were in autonomous departments, three were linked with public health medicine, two were in a larger grouping and one was in a postgraduate department. Five would have preferred a larger grouping, two a merger with public health medicine and one would have preferred a different grouping. Two would have liked to return to being autonomous, and one would have preferred a link with a community health trust.

The advantages of autonomous departments in traditional medical schools over larger groupings were the freedom to develop links and to have control over budgets. Decision making and strategy were considered to be more easily processed with less administration and better representation. The identity of general practice was considered important, both politically and for academic cohesion and accountability. One disadvantage was that there was often a lack of a critical mass, particularly for research-based skills such as statistics and computing. Other disadvantages were smaller budgets, more difficulties in cooperation and less communication with other departments for teaching and research, and a perception that external sponsors preferred wider groupings.

The advantage of larger groupings was multidisciplinary collaboration for teaching and research, which helped research assessment. The disadvantages were seen to be unwieldy structures with top-heavy administration and lack of direct access to a dean. There were added difficulties if groupings were geographically dispersed. There was also a perceived loss of understanding about the unique nature of general practice.

Discussion

The picture that emerges is one of diversity and change in university departments of general practice. Identity is important, but what is optimum depends upon local circumstances, particularly department size. Where this is small then larger groupings are an advantage, in particular mergers with public health medicine to provide research-based skills. Perhaps the optimum solution would be autonomous departments of general practice within

Table 1. Current arrangement of 32 departments of general practice.

Autonomous	13
Autonomous but:	
In larger groupings for research	3
Within school of health sciences	3
Within department of medicine	2
Within school of clinical medicine	1
Combined with public health medicine	4
Part of postgraduate medical school	2
Integrated undergraduate postgraduate department	1
Part of division with public health, child health and psychiatry	1
Unit in department of clinical pharmacology and therapeutics	1
Unit in institute of public health	1

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larger groupings, to provide collaboration for research and teaching in a way that complements rather than submerges the identity of general practice. This implies a matrix management structure in which the physical siting of larger groupings could be important. So far, only one department of general practice has formally integrated undergraduate teaching and postgraduate training.

References

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