THE DEVELOPMENT OF ACADEMIC GENERAL PRACTICE IN SCOTLAND

A Sociological Analysis

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Summary

This thesis examines the transformation of a generalism into a specialty. It takes as its example the branch of medicine known as general practice, and appraises its introduction into the university as an academic discipline. The study draws upon historical data, interviews with general practitioners, and participant observation of seminars in general practice.

The thesis is divided into four sections. The first, Chapter One, documents the theoretical orientation of the investigation. It reviews the sociological literature on professional structure but argues that while professional training is well covered in the literature, the subject matter of the training, the academic discipline itself, is seldom the focus of research.

The second section provides an overview of general practice. Chapter Two examines the development of that branch of medicine, in particular emphasising the relationship between the curriculum and the broader professional structure. Chapter Three outlines current general practice, and identifies two distinct perspectives held by general practitioners of their work.

Section three introduces university based general practice. Chapter Four reviews the emergence of the four general practice departments in Scotland, isolating the critical features associated with the birth of an academic department. The relationship between the service general practitioners and the academic members of an applied profession is the topic of Chapter Five. Chapter Six outlines the general practice courses of the four departments, and through an

analysis of their aims and teaching methods, identifies some of the problematic issues surrounding their presentation.

Section four examines different group perspectives on the teaching of general practice, and draws upon one example of general practice teaching. Chapter Seven compares and contrasts the views of the academic and the service general practitioners, while Chapter Eight introduces into the discussion the part-time teachers of two departments. Chapter Nine, the final empirically based chapter, uses material from an actual teaching situation. The first part of the chapter illustrates the teaching of one perspective to students; the second, related part uses the observational data to contrast the teaching of the subject with that more typically experienced in the undergraduate curriculum. The conclusion sums up the overall argument of the thesis, and lists some propositions about the future of general practice.

Overall, this thesis should be seen as a contribution towards a greater understanding of the processes involved in specialty development.

Section I

THEORETICAL OUTLINE

This first Section and Chapter outlines the area of study, and the theoretical underpinning of the research.

Chapter One

PROFESSIONS AND EPISTEMOLOGY

Introduction

This research concerns the development of academic general practice. In this work, the processes involved in creating academic departments and courses in a university context have been examined and analysed. At a more general level, the research may be seen as a study of the creation of a specialty within an occupational group. Although the process of specialisation is repeated many times over it is the focus of few studies. The research reported below aims to generate a fresh curiosity in the field.

Before the chapter outlines the theoretical approach taken in the thesis, it is worth emphasising how much the topic of discipline development lies outside the margins of accepted fields of study. The creation of an academic discipline, to some extent a body of knowledge distinct from its parent 'knowledge of practice', has been largely taken for granted by those concerned with studying occupations. Sociologists interested in professional groups have continued to focus upon issues concerning professionalisation (for example, Lewis and Maude, 1952; Goode, 1957; Freidson, 1970; Elliott, 1972). Despite the recognition that the development of a body of abstract knowledge plays a crucial part in the process, there has been little questioning over the manner in which this knowledge is formed, or of the role of academics involved in its formation.

The special contribution of interactionist thinking to this present research will be noted later in the chapter, but some of the earlier work, in particular that of Hughes in Men and their Work (Hughes, 1958), directed attention to matters of professional education and the role of new disciplines. The focus upon training into the health professions was pursued, but almost without exception through studies of student socialisation. In America the precedent was set by two now classic studies. The first in the field was Merton, Reader and Kendall's research at Case Western Reserve Medical School where they studied, in the functionalist tradition, students progressing through their undergraduate training (Merton, Reader and Kendall, 1957). The work of Becker, Geer, Strauss and Hughes (1961) at Kansas Medical School pioneered the research method of participant observation as well as adding to the growing debate over the nature of the socialisation process. Their work inspired a further number of studies into health professions training, all focussing upon the changing student identity (see Oleson and Whittaker, 1968; Miller, 1970;[1] Bloom, 1973; Shuval, 1975; while the work of Haas, Marshall and Shaffir at McMaster Medical School is a direct continuation of the approach adopted by Becker et al [Haas and Shaffir, 1977, and unpublished papers]).

In Britain, sociological research into the education of health professionals never inspired the same interest. Within the limited number of studies available, however, the student experience again dominated the literature. Johnson and Elston's study of medical

[1] This was paralleled in the functionalist school by Mumford's study of post-graduate medical education (Mumford, 1970).

careers (as yet unpublished but see Johnson, 1978) stemmed from an earlier interest in the characteristics of rejected applicants to medical school (Johnson, 1971). Atkinson, College and Dingwall all took aspects of students' training into the health professions as the topic for their post-graduate theses (Atkinson, forthcoming; College, 1975; Dingwall, 1977a). Whilst these latter studies reflected the influence of earlier American work, both Atkinson and Dingwall introduced an awareness of the curriculum into their studies (a perspective typically lacking in interactionist research on this topic). In neither case was this extended to a broader analysis of the respective discipline.

But those focussing upon professions and professional training were not alone in ignoring the topic of discipline development. Another literature drawn upon in this research has been that of curriculum studies. Here research falls crudely into two groups. Those sociologists interested in higher education typically studied the personnel rather than the pedagogy (for example, Halsey and Trow, 1971; Taylor, 1969; Startup, 1979). Others took as central to any study of the curriculum epistemological issues (in particular, the selectivity of curricula), but used as their empirical base the curricula of primary and secondary schools (Young, 1971a).

Two further works, as yet unmentioned, come closest to the perspective taken in this present research. The first, a collection of papers, is unusual in that it spans the fields of professions and phenomenology. In Professions and Professionalisation the editor, Jackson, and other contributors (for example, Jamous and Peloille), explored in a number of contexts, the inter-relationships between types of knowledge, training and occupational power (Jackson, 1970a).

The second work, that of Armstrong, is as yet unpublished in its entirety, but promises to be a structuralist analysis of the medical profession. Again, the central thrust of the research is an examination of occupational knowledge, structure and power (see Armstrong, 1979a, 1979b, for initial examples of his work). The kind of critical factors these researchers have isolated is reflected in this study where the concern is with the actors and the epistemology.

Thus the research takes as problematic both the inter-relationships between those involved in practice and academic institutions, and also the creation of the knowledge itself. Overall, the research contributes to our understanding of how a specialty arises within a profession. Although there is little literature to compare medicine with other professions, it is hoped that others may find parallels in different occupations.

As the above outline implies, the thesis draws upon more than one field of sociology. A major, although hidden part of the research has been to explore the possible contribution of different branches of sociology (notably medical sociology, the sociology of education, and sociological theory) to the research problematic. In practice, this has necessitated the researcher familiarising herself with a broad spectrum of debates.[1] Each branch of sociology has offered a different perspective and so this research has been involved in building bridges between the distinct fields.

Surprisingly, since to the researcher's knowledge other professions have not developed this area so extensively, members of the medical

[1] This is of course a telling comment on the fragmentation of sociological work, where each field tends to have a fixed agenda of topics.

profession have shown considerable interest in their own educational process.[1] Medical education has become a thriving field in its own right. It now has its own association (The Association for the Study of Medical Education), two journals (The British Journal of Medical Education, and the more recent Medical Teacher, founded in 1979), and at least one university department of medical education (Dundee). As one might anticipate, however, the interest is not with medical knowledge but rather with facets of medical education which can be brought under human control, quantified and tested. For instance, both journals carry articles on new techniques for examining and assessing medical students, developments in medical technology related to the teaching process, as well as including descriptions of new courses.

General practitioners, too, in the more recent years have shown an interest in academic matters. Influential here has been the Royal College of General Practitioners, which has monitored the development of the academic departments, while continuing to act as a pressure group for the furtherance of the academic branch. The journals of medical education and of the Royal College of General Practitioners referred to above have all proved to be useful sources of supportive material for this research.

This study takes academic general practice as its focus of interest, and studies the development of the general practice departments and their courses in the four Scottish medical schools, Aberdeen, Dundee, Edinburgh and Glasgow. That all four departments

[1] The major exceptions are teacher training and social work, both professions having started an educational journal within the last five years.

were based in Scotland adds a geographical tidyness to the study but is not significant in other ways. There is little evidence to show that academic general practice in Scotland is different from that of the rest of the United Kingdom. Certainly the Scottish medical schools were some of the first to gain departments - reasons for this will be discussed in the text. But from the available evidence there is little suggestion that these departments and the courses are atypical, and therefore their placement in the United Kingdom has not been treated as a significant variable.

The majority of the data collection for the research took place in the mid-seventies - from 1973 to 1975. Academic general practice was then very much in its infancy, and it is pertinent to ask in what ways it may have altered since then. Particular developments have been charted in the appropriate places in the text, while the thesis conclusions summarise the changes. Yet it is relevant to note that throughout the thesis reference is made to more recent general practice literature to support the hypotheses of the study. This in itself suggests that the underlying issues identified in the thesis are still the critical issues pertaining to academic general practice today.

The next part of this chapter outlines the theory and assumptions which guided the research. The chapter which follows introduces the empirical material of the thesis.

The Interactionist Contribution

Throughout the research, the theories and methodology of symbolic interaction may be seen to be dominant. Thus considerable weight is placed upon seeking out and understanding the actor's perspective, (gathered through interviews with the significant groups), and one section of the thesis is concerned only with presenting the reality of general practice teaching through the perspective of those involved. Yet the research steps outside the confines of a 'pure' interactionist approach through its insistance upon both a historical perspective (Chapter Two) and upon the importance of studying the pedagogy of general practice (in particular, Chapter Nine). Reasons for the researcher adopting a more eclectic approach to the collection and interpretation of the data will be spelled out later in the chapter, along with an outline of the other theoretical ideas which informed the research.

The theoretical starting point of this research was the work on professions which was a product of the Chicago School of Symbolic Interaction. The relevant ideas were first outlined by Bucher and Strauss in a 1961 paper entitled 'Professions in Process' (Bucher and Strauss, 1961). In the paper, they presented a view of professions as a collection of a number of groups or 'segments' with a diversity of interests and commitments, only loosely amalgamated into a coherent occupational group.[1] These notions about professional organisation fitted the researcher's first impressions of the medical profession as

[1] These ideas were developed in an empirical study of psychiatric institutions by Strauss and his colleagues (Strauss, Schatzman, Bucher, Ehrlich and Sabshin, 1964), and summed up (and modified) five years later (Strauss and Schatzman, 1966).

witnessed through the medical school, and the research was undertaken with these notions implicit within its structure.

To fully appreciate the distinct contribution to this research of interactionist thinking on professional organisation and structure it is necessary first to outline the broader debate on the professions. The study of the professions is now a sociological backwater. While still being recognised as forming a discrete sociological literature - the 'professions' - one finds that the majority of the debates and activities were engendered some decades ago. Since the nineteen thirties, two types of debate have taken place concerning the role and place of professions in Western industrial society. The first concerned the process of professionalising itself, a debate largely stimulated by the increasing division of labour brought about by the demands of industrialised societies. The second focused upon professional organisation and role. The first debate, which centred upon the definition of the essential characteristics of a profession (as distinct from an occupation), filled pages of many journals, but need concern us less here since there has never been any dispute over the status of medicine (indeed medicine was often taken as a blue-print for a profession).[1]

The second, inter-related debate to which interactionist thinking contributed so much, concerned professional organisation and professional role in society. Early accounts of professions stressed their presence as a conservative force in society (for example, Carr-Saunders and

[1] Johnson's critique of 'trait' theory approach provides an excellent summary of this debate (Johnson, 1972). See also Freidson's criticisms of the approach (Freidson, 1970, especially part 1), and Dingwall's spirited attack of Freidson's notion of professional autonomy (Dingwall, 1976).

Wilson, 1964 [originally published in 1933]; Goode, 1957). Functionalist accounts of professions thus emphasised the cohesion of the profession as a group, and their role in upholding the moral values of society. The tone of such writing is well illustrated by Carr-Saunders and Wilson. In their classic study The Professions, the authors wrote 'professional associations are stabilising elements in society. They engender modes of life, habits of thought, and standards of judgement which render them centres of resistance to crude forces which threaten steady and peaceful evolution . . . It is largely due to them and to other similar centres of resistance that the older civilisations stand firm' (Carr-Saunders and Wilson, 1964, p. 497).

Contrary to current wisdom, functionalist writers did recognise that internal divisions existed within professional groups, but ignored their significance. Thus the above authors discussed at some length various factors which brought about a 'multiple form of organisation' (within a profession). To quote again from Carr-Saunders and Wilson these various factors consisted of:

1. the presence of one or more distinct sub-crafts within a profession
2. differences of what may be termed 'professional status' among the practitioners
3. differences of economic status
4. the factor of common employment
5. the geographical factor
6. the antagonisms of 'insiders' and 'outsiders'

(Carr-Saunders and Wilson, 1964, p. 320)[1]

[1] It is instructive to contrast the above quotation with Hughes, writing on essentially the same topic, but from a different tradition:

> By the same token, only some small portion of medical knowledge and skill can be mastered by each member of the profession itself, which leads to there being sub-cultures within the greater medical culture. This is also more than a matter of technique and knowledge; it has roots in ideas and assumptions. One can, with some truth, speak of the medical philosophy, perhaps even on the moral, social or economic philosophy of various specialties; one can at least speak of a difference of emphasis among them (Hughes, 1971, p. 398).

Functionalist thinking, then, acknowledged some form of divisions within professional groups, but continued to stress the role of the group as a stabilising force within society. The literature of professions grew to considerable proportions; key issues which were developed over the decades were the maintenance of professional autonomy in bureaucracies, relations between the various occupations at the work place, and the effect of professionalisation of a number of occupations on the broader structure of society (see Vollmer and Mills, 1966; Lewis and Maude, 1952; and Wilensky, 1964, for discussion of these topics).

Questions concerning the internal organisation of a professional group, were seldom tackled, however, and it was this omission to which Bucher and Strauss's paper addressed itself. With an acknowledged debt to both G.H. Mead and Everett Hughes, the two authors raised a new set of critical issues pertaining to the study of the professions. While others had recognised, but ignored, the significance of intra-professional differences, Bucher and Strauss spent time acknowledging them, and indeed failed to do more than pay lip service to <u>shared</u> professional perspective and experience.

Instead, the authors focused upon internal divisions within a profession, stressing a 'process' or emergent view of the structure of profession. They suggested that a profession should be seen as a collection of 'segments' - groupings which emerge within the profession with common values, identities and interests. Segments, they argued, did not equate with specialties, for within one specialty one might find more than one segment, as Bucher's original work with pathology demonstrated (Bucher, 1961). Segments could be distinguished along a number of critical dimensions; these included work identity, mission, work activities, methodology and technique, clients, colleagueship,

interests and associations. Medicine was officially divided into specialties (for instance paediatrics or psychiatry) but also informally along various lines which constituted ideological divisions. Thus Bucher and Strauss stressed the fragmentation and inherent conflict as opposed to the cohesion, of the professional group.[1]

With the shift in perspective also came a change in research methodology, as divergence from functionalist ideas was further underlined by the emphasis symbolic interactionists placed upon process. This was largely engendered by the use of a research technique, participant observation, which allowed the researcher to gather qualitative data over a period of time, in contrast to the previously used 'one-off' methods such as the questionnaire or interview (for an initial statement on participant observation see Glaser and Strauss, 1968; and for elaboration of the method, Filstead, 1971).

The use of qualitative data, processually collected, became the hallmark of interactionist work.[2] Such material encouraged a different view of professions, for it allowed interactionists to understand the fluid nature of apparently stable institutions. Thus Bucher and Strauss argued that segments of professions, and hence professions themselves, should be seen as consisting of fluid boundaries, open to

[1] Although there has been widespread acknowledgement of the ideas of Bucher, Strauss and their colleagues, their exhortations for further studies in this area have, with few exceptions, been ignored. One of the few British studies based upon this thinking was Goldie's study of the mental health professions (Goldie, 1974).

[2] Two classic studies concerned with medicine are Fox's Experiment Perilous (Fox, 1974), and Roth's study of a tuberculosis sanitarium Timetables (Roth, 1963). After the mid-sixties few 'pure' observation studies were produced since as a method it was unusually expensive in researcher's time and resources.

negotiation, change, reshaping and possible disappearance. Thus emerged a 'relativist' view of professions:

> We shall develop the idea of professions as loose amalgamations of segments pursuing objectives in different manners and more or less delicately held together under a common name at a particular period of history.
> (Bucher and Strauss, 1961, p. 326)[1]

A further set of ideas presented (admittedly rather loosely) by Bucher and Strauss concerns specialisation. The authors noted in their paper that a segment was essentially a developing specialty, and that specialty status would be the goal of all social movements within an occupation. These notions were, however, developed no further, and no coherent theory of specialisation has emerged from the group. What they assumed was that the process of carving out a specialty involved some kind of symbolic boundary creation, definition of mission, and the creation of associations and a discrete occupational identity.[2]

This present study reflects the interactionist concern with intraprofessional divisions within medicine. Taking general practice as the field of study, the researcher focused her attention on the emergent branch of academic general practice. The university was identified as the key institution in the process, and on the basis of that, the researcher identified three groups in relation to their association with the key institution. The three groups of general

[1] It is worth underlining the point that although this approach has been identified primarily with Bucher and Strauss, many of the ideas stem from Everett Hughes. One can find the seeds of many of their ideas in the earlier writings of Hughes, and although he evolved no grand theory, his perception and understanding of professions and professional work was considerable.

[2] Hughes likens this process to that of professionalising, an idea which neither he nor others expand upon (Hughes, 1963).

practitioners whose perspective on the development of academic general practice was subsequently sought were the academic general practitioners (those full-time medically qualified doctors who taught in any of the departments studied), part-time teachers (those service general practitioners who carried out a small teaching commitment in the undergraduate general practice courses), and service general practitioners who had no involvement in teaching the subject, but who were representative of the large group of doctors who provided general practice care.

Chapter Three briefly reviews the literature on specialisation, but concludes that for the majority of writers, specialisation is treated as an unproblematic process (in this respect Bucher and Strauss are not alone). The thesis attempts to expand upon the important factors involved in the specialisation of a subject, in particular emphasising the central role of the university in the process, and within that, the manner in which the creation of distinctive courses shape the broader construction of the specialisation. From the interviews with service general practitioners and from the literature, it will be argued that two distinct ideologies emerge, identified as the 'clinical' and the 'social' ideologies of general practice. When the content of the general practice courses was examined, it was found that the courses reflected one or other of these ideologies in their orientation, although these courses were not a direct articulation

of these ideologies.[1] Discussion of this finding will focus upon the dialectical relations between the institution and the group ideology, and at another level, the relationship between theory and practice (see especially Chapters Four and Six).

It was said earlier that the ideas of Bucher and Strauss were used as guide-lines rather than a blue-print for a research design. 'Professions in Process' remains rich in ideas. Furthermore the authors were addressing similar questions as the researcher was ten years later. But this thesis cannot be perceived as a pure interactionist study. It steps well outside the bounds of the approach, and it is now time to document the limitations which led to the incorporation of other schools of thought into the research.[2]

The first major limitation of the approach[3] is that symbolic

[1] The concept of ideology demands a little elaboration, since it is a term with a number of meanings (Williams, 1976). Its use here refers to an ideology as a system of ideas, each system being as correct as another - thereby excluding the idea of falsification present in Marxist writing. This present usage equates with Mannheim's 'total' (as opposed to 'particular') conception of ideology (Mannheim, 1970). An ideology, then, is a set of ideas and values which knit into an overall belief system. An actor may hold a particular set of beliefs about the type of work they do, its purpose, their clientele and so on (cf. Bucher and Strauss, 1961) which taken as a whole, may be described as an ideology. This framework remains closely linked to a particular work situation and to work itself and does not extend to non-working life. Indeed the relationship between a working ideology and non-working life is not explored.

[2] This is in no sense an apology for having strayed outside the bounds of symbolic interaction. A number of researchers have done so, and the resultant study is often strengthened by so doing. Burns, in his study of the B.B.C., nicely combines a broader socio-historical approach with an interactionist's concern to present the actor's perspective (Burns, 1977).

[3] One could directly criticise the Bucher and Strauss paper, which has a looseness to it. For instance, it is unclear as to the status of the various rubrics the authors offered as forms of ideological division. Some are not mutually exclusive ('work activities' and 'interests and associations' overlap), and it is uncertain as to whether they felt the list was complete. Concepts like 'ideology' and 'identity' are used ambiguously; while it is suggested in the text that segments can be identified as 'ideological groupings' the authors also write that a segment is an 'organised identity'. For these kinds of reasons the development of their ideas has not been rigidly adhered to.

interactionists have preferred to take an 'emergent' account of reality at the expense of any broader socio-historical analysis.[1] They have chosen to study present day structural accounts of everyday life, emphasising the underlying similarities of varied situations while ignoring any historical factors in determining their present state. As Rock argues in his elegant critique of symbolic interactionism, they are 'committed to the exploration of social diversity' (Rock, 1979, p. 157). Thus 'The responses of a Samoan, a college teacher, a migrant farm-worker, a city policeman, an acrobat and a pimp must be functionally and structurally similar for imaginative acts of emphatic bridging to take place. In turn, those responses must be sufficiently free of context and biography to provide a workable similarity' (Rock, 1979, p. 169, emphasis added). This produces a sociology which is strongly non-deterministic, and where a relativist position is reached through breadth rather than through historical depth. The resultant accounts could at best be accused of ethnocentricity, at worst appear to be wholly unlocated in the broader social structure.

By contrast, this research begins its empirical analysis by presenting a long, historical account of the development of general practice. This serves to locate the position of general practitioners within the medical hierarchy, and is essential to an understanding of the heritage of academic general practice.

Secondly, by ignoring any historical dimension, symbolic interactionists present only one side of 'interaction'. Although it is argued that the actor and the institution form a dialectical relationship

[1] This is generally true for the tradition despite a persuasive argument for the necessity of a historical perspective offered by Strauss in Mirrors and Masks (Strauss, 1959, Chapter Six).

(for example, Strauss et al, 1964), at the same time they produce a unidimensional account of interaction which ignores both the historical features which have helped create the institution as it exists today (and which still influence the interaction), and also the other institutions to which a professional relates, (thus, medical academics relate and are influenced not only by the university and other members of the profession, but also the National Health Service, the Royal Colleges, other medico-political organisations if they belong, and so on).

But there is another sense in which symbolic interactionists may be seen to be unduly narrow in their focus. On maintaining an interest in intra-professional conflict, they ignore a further important set of questions concerning the role of the professional in a bureaucratising society. The rather simplistic polarisation of conflict and consensus among a profession hides a further concern of both professionals themselves and those interested in the study of professions. The increasing bureaucratisation of society meant that not only were newer professions from the beginning salaried employees, but that older professions too were unable to wholly maintain their independence when they were locked into an institution which in turn relied upon a wider economy. Mills, in his essay on the American middle classes, White Collar, concludes that 'In practically every profession, the managerial demiurge works to build ingenious bureaucracies of intellectual skills' (Mills, 1951, p. 115).

Central to symbolic interaction is the role of the self. Symbolic interaction, to quote again from Rock, 'urges the sociologists to turn in on himself, advocating an inward quest for existential essences' (Rock, 1979, p. 160). This has meant, and this is a criticism of all interpretive sociologies (cf. Giddens, 1976, Chapter One), symbolic

interaction is best at explaining 'subjectively meaningful action' and least good at explaining the objective world as it is experienced by the actor. Thus the final criticism of their work is that in studying educational institutions, interactionists have failed to consider as at all problematic the curricula and the pedagogy of these institutions. Instead, the thrust of the inquiries into professional socialisation concentrated upon studying the role and changes in the self of (primarily) the students, as the study of the Kansas medical students illustrates (Becker et al, 1961, or the later study by Bloom, 1973). Socialisation, not epistemology, was the focus of sociological activity.

This criticism, of course, may also be applied to other schools of sociological thought, which have likewise failed to study the curriculum in terms of its epistemology. Educational sociologists of the 'fifties and 'sixties (for example Musgrave, 1965; Banks, 1955, 1968) took a functionalist perspective, and like those interested in the professions at the time, concentrated their energies upon objective studies of education which never challenged the status quo and which took a conservative view of education (Gleeson, 1970a).

This research considers the self as important and the identity of the academic general practitioners is taken as the central topic of Chapter Five as their dilemma qua academic is outlined. The students' perspective, too, is represented in the final chapter of the thesis, where the research draws upon a small piece of participant observation of seminars and student interviews carried out early in the enterprise. But the lack of weight attached to the student experience reflects the researcher's desire to move away from the model provided by previous interactionist studies of medical education. This research also takes as problematic the construction of academic general practice courses.

Thus the research unites an interest in epistemology and pedagogy with the interactionists' concern over identity and the institution. In stepping outside interactionist thought, the researcher acknowledges the influence of another field of sociological thinking, that of the 'new' sociology of education.

The 'New' Sociology of Education

An attempt to redirect sociological thinking came at the beginning of the nineteen seventies when a group of British sociologists applied ideas from the sociology of knowledge to the field of education. Some of the initial work appeared in Knowledge and Control (Young, 1971a), an influential text which stimulated many researchers when it first appeared. Young and his colleagues took the curriculum to be socially organised knowledge - immediately a radical departure from previous approaches. They recognised that curricula were not impartial but selective, and argued that curricula were achieved through the conscious and unconscious selection of available knowledge (Young, 1971b).

The use of the term 'knowledge' is critical; as Esland (a former student of Young's and contributor to Knowledge and Control) points out, knowledge is not used in its usual meaning of truth or higher learning (Esland, 1971a). The Platonic sense of 'knowledge' as a higher status thought form which emphasises its objective quality is entirely absent in their writing. Instead, knowledge was referred to in its phenomenological sense, that each individual's everyday experiences

forms his stock of knowledge upon which he acts and to which he adds throughout his life. Thus knowledge becomes 'all thought forms which are used by individuals in a society as the basis to everyday life' (Esland, 1971b, p. 41), a definition which like many of his ideas derives from Schutz's work.

Schutz's phenomenology, crudely, focuses upon how the individual experiences the world in an intersubjective manner; the world is seen as jointly constructed by man, and needs to be sustained by continued work (Berger and Luckmann, 1971). Translated into educational concerns, this meant that of major importance was the manner in which the pupil experienced the educational process, and the relationship between schooling and the remainder of everyday life.

Although there is a tendency to contrast the 'new' sociology of education with functionalist thought, and compare it with symbolic interaction (cf. Gleeson, 1970b), it is worth noting one critical difference between these two interpretative sociologies. For interactionists, education was something the students reacted to but did not appear to influence to any extent; this, of course, is a classic 'underdog' position typical of Chicago interactionists, whereby the individual is seen as having little means by which to influence his fate. Phenomenology, on the other hand, allows the individual greater control in influencing his position in the life-world.

But the 'new' sociology of education drew not only upon the phenomenological tradition but was an attractive synthesis of ways of thinking which at first glance are quite disparate. Young notes in his introduction to Knowledge and Control his debt not only to Schutz but also to Marx and Mannheim, and his work and that of his students and colleagues illustrates how these thinkers can be successfully united

(Young, 1971b). Young himself was particularly interested in the application of Mannheim's ideas to education. But significantly in the new sociology of education it was the relationship between the curriculum and political ideology which became explicit. Thus the new educationalists were concerned with the manner in which the changing power relations were reflected in curriculum changes, and, more generally, how the dominant ideology was reproduced by certain classes and imposed on others (cf. Gramsci and Bourdieu who share these concerns).[1]

Although it has been implied that the authors of Knowledge and Control present a coherent perspective, like many other 'new approaches' there is in fact considerable diversity amongst the writers. Two distinct sets of ideas which have been important for the analysis of this research stem from the work of these educational writers.

The first set of ideas are contained in a paper of Bernstein's 'On the Classification and Framing of Educational Knowledge' (Bernstein, 1971). The ideas of this paper may be seen as an extension of Bernstein's earlier work on language and social class, and have been followed by a further elaboration (of the concepts of classification and framing) in 'Class and Pedagogies: visible and invisible' (Bernstein, 1980).[2]

[1] This shift to a more politically aware perspective is paralleled in other areas of sociology, for example, deviance. While retaining the heritage of earlier American interactionist work (Cloward and Ohlin, 1960; Cohen, 1966; Matza, 1969). British sociologists have more recently produced a number of critical texts constituting the 'new criminology' (see Taylor, Walton and Young, 1974).

[2] Bernstein, influenced by Durkheim, understands a moral order to exist in society. Education is the medium through which an understanding of the moral order is transmitted to, and internalised by a new generation. Education is thus seen as an indirect exercise in social control. Bernstein's self-elected task, to quote one reviewer, is to 'relate different educational forms to types of social order' (McDonald, 1977). Bernstein's work relates overall to the more general concerns of social reproduction, to issues concerning the perpetuation of the class structure, and to the role of the school in transmitting particular ideologies.

In 'Classification and Framing' Bernstein considers in detail the implications of different types of pedagogy. He outlines two conflicting educational codes, collection code and integrated code; collection code curricula are characterised by a 'closed' compartmentalised relationship between the subjects, integrated code curricula by an 'open' relationship. The former is sustained by stressing the theoretical diversity of the subject area, the latter by stressing its unity. In order to unravel some of the features of each pedagogical situation Bernstein introduces two concepts which refer to control over knowledge, 'classification', and 'framing', which refer to the types of control over knowledge exercised by those in power.

Although his ideas have an analytical nicety to them, they remain at the level of ideal-type statements, with little foundation in empirical studies. Attempts to apply them usually at a primary school or secondary school level (King, 1979; Hamilton, 1975) have begun to highlight their weaknesses.

Despite such criticisms (see also, Easthope, Bell and Wilkes, 1975), the ideas were found to be sufficiently illuminating to use as a device to examine the general practice teaching in the context of the medical curriculum. There were a number of reasons for their inclusion. Bernstein's ideas have seldom been applied to the field of higher education, and even less to the novel context of medical education.[1] The concept of educational codes is therefore introduced in Chapter Nine as a way of understanding the problems encountered by the academic staff

[1] Armstrong's 1977 paper on the structure of medical education introduces Bernstein's notions of classification and framing (Armstrong, 1977); however it was felt that he misunderstood Bernstein's basic intentions (see footnote, p 363, for discussion of Armstrong's interpretation).

in their teaching.

The second set of ideas elaborated by Young (1971b) and Esland (1971a, 1971b), and stated at its most simple, begins with the premise that curricula are socially organised. In keeping with the general proposition that knowledge should not be viewed in an objective sense, curriculum knowledge then becomes something which is arrived at through joint negotiation between what Esland calls the 'reality definers', and legitimated at an institutional level through the production of courses.

Thus curricula are not created or changed in a random manner, but a very deliberate shaping process is understood to take place by certain groups. These are the reality definers who essentially control the definitions of what counts as valid knowledge on the curriculum; an important part of any research on the curriculum must be to identify these groups and to delineate their notions about its central elements.

Underlying this argument is the notion already identified in interactionist thinking concerning the relativity of disciplines. Contrary to an 'objective' view of the world, where disciplines are seen to exist as permanent entities in themselves, the assumption here is that disciplines are of a transient nature. Once a discipline has merged with another it loses its special identity.[1] But while interactionists did little more than acknowledge this notion, writers concerned with curricula have put flesh to the arguments (see Interdisciplinarity [Group for Research and Innovation in Higher Education, 1975]). This approach allows us to understand that

[1] Associated with this is the idea that curriculum change affects professional identity. The merging or division of specialties creates a situation where the teacher must re-assess his or her own identity.

disciplines have a certain historicity, that permanence should not be assumed. The development of the medical curriculum since 1867 is an example par excellence of the transience of disciplines. Likewise, the development of general practice is understood in this thesis as one part of the larger 'natural history' of medical disciplines, and nowhere is it assumed that general practice is moving towards fulfilling any pre-ordained potential.

The emphasis on the social construction of curricula is therefore critical to this research. Two assumptions stem from this line of thought. The first is that general practice owes its characteristics as an emergent discipline to the time and period at which it emerges. Thus the two ideologies which have been identified as existing within general practice at the present time reflect the current split within the broader profession as to the role and function of medicine. At present they co-exist, and neither is identified as dominant. But a number of writers (for instance Armstrong, 1979b) have argued for the ultimate success of one or other of the perspectives within general practice. This research obviously contributes to this broader debate.

Secondly, it has been assumed that the particular ideas concerning high status knowledge within medicine were controlled by those with institutional power. That is to say, the characteristics of high status knowledge can be manipulated, that they are not fixed or permanent.[1] When reviewing the emergence of an academic discipline it is important to delineate what counts as significant and powerful knowledge. This

[1] This directly contradicts Young's argument as set out in his essay 'An Approach to the Study of Curricula as Socially Organized Knowledge' (Young, 1971b).

leads on to an analysis of what counts as high status knowledge within the medical faculty at the time of the research, and ultimately, to unravel the distinction between high status university-based knowledge, and knowledge of practice. We now turn to discuss this latter topic.

The Nature of Medical Knowledge

So far two sets of ideas have been introduced, the first concerned with professional structure, the second with curriculum knowledge. The last part of this chapter, and the latter part of the thesis is concerned with, not curriculum knowledge, but the knowledge used in professional practice. The literature of professional knowledge is limited (see Freidson, 1970; Bloor, 1976; Wright, 1978; Armstrong, 1979b). However, Freidson in Profession of Medicine does devote considerable discussion to an examination of the 'clinical mentality' (Freidson, 1970). Medicine, he argues, is an applied profession. By this Freidson means that in the course of practice, doctors would use knowledge based on experience which is contrasted sharply with the body of 'pure' scientific knowledge known by the profession at large (for example, theories of disease could constitute 'pure' knowledge [Freidson, 1970, p. 340]).

During the course of medical practice, Freidson argues that even in the absence of reliable knowledge the medical professional feels impelled to act, so that the doctor applies procedures to the particular problem with which he is faced. In the course of his application the pure knowledge becomes transformed (Freidson uses the term 'debased'),

into 'knowledge in practice'. Freidson suggests that medicine cannot be practised neutrally since 'It involves moral commitments and moral consequences neither justified by nor derived from the esoteric expertise which is supposed to distinguish the profession from other occupations' (Freidson, 1970, p. 346). The debasement is caused by the moral implications built into practice - applied knowledge, by definition, can never be pure.

The view that knowledge in any form is pure, that it can exist without moral content or connotation is one which has been open to recent criticism (for example, Wright, 1978; Elliott, 1974) for it denies the social element involved in the construction of scientific theory. Freidson is perhaps less open to criticism in his examination of the form that this applied knowledge takes.

According to Freidson, applied knowledge derives from personal clinical experience. The experience consists of an accumulation over years of practice of particular routines and ways of handling certain situations (what Schutz would call 'rules of thumb' and 'recipes of action'). Such knowledge is uncodified and by its very nature, individualistic or 'particularistic'.

As important as the form such uncodified knowledge takes is the question of why it exists. Some would argue that the professions retain uncodified, 'tacit' knowledge by default, since they have as yet found no way to codify it (Polanyi, in his elegant exposition of the notion of 'tacit knowledge', holds this position [Polanyi, 1974]); while a similar point is made by Fox concerning uncertainty in medical teaching (Fox, 1957). Freidson, characteristically torn between positivism and relativism, sidesteps the issue:

> Whether or not that idea [of the uncertainty in medical knowledge] faithfully represents actual deficiencies in available knowledge or technique, it does provide the practitioner with a psychological ground from which to justify his pragmatic emphasis on firsthand experience.
>
> (Freidson, 1970, p. 169)

An alternative (and to the researcher, more attractive) approach is taken by two French sociologists, Jamous and Peloille. In their paper 'Professions or self-perpetuating system? Changes in the French University Hospital System' Jamous and Peloille confront the issue of the nature of medical knowledge in a way which unites the study of knowledge to the study of professions, since they suggest that the maintenance of uncodified knowledge may be seen as a form of occupational control (Jamous and Peloille, 1970).

Briefly, they argue that knowledge could be placed along a continuum of, to introduce their terms, indeterminacy to technicality, and that a knowledge of the amount of indeterminacy an occupation claimed would tell one whether or not to allocate to it the status of 'profession'. Jamous and Peloille, then, are tackling in a novel manner, the old debate over when is an occupation a profession. Their argument has one weak point - when they introduce into the analysis the notion of a ratio with which an objective measurement of indeterminacy can be achieved.[1] But the paper is valuable in that it does address the topic of uncodified knowledge and to relate this to professional status.

Technicality and indeterminacy merit further exploration. Indeterminacy refers to the tacit and private knowledge that is the

[1] For a critique of the paper and two case studies using the concepts of indeterminacy and technicality see Atkinson, Reid and Sheldrake (1977).

personal property of the practitioner. It cannot be made wholly explicit, and it remains untranslatable into precisely formulated rules of prescriptions. Thus expertise which consists of such 'rules of thumb' and the performances based on them become refined as personal qualities of the practitioner. Technicality, on the other hand, is that proportion of the means of production which is entirely susceptible to codification in terms of explicit public rules, procedures or techniques.

Training for an occupation which was based entirely upon indeterminate knowledge would have to be carried out by apprenticeship or on-the-job practice, and recruitment would have to be on the basis of personal qualities. If an occupation was composed only of technical knowledge, however, then a novice could theoretically be handed a textbook on the first day and told to start from page 1. In practice, Jamous and Peloille argue, the work of occupational groups is composed of both technicality and indeterminacy.

The use to which these two concepts can be put is next tackled by the authors:

> Those who, at a given moment in history, thanks to their skill and their social qualities, control the system of evaluation, of sanction and control, impose their definition of the production(s), have a tendency to exclude or to place in a position of subordination those who could be brought by technical and scientific changes to redefine these productions. It is possible to say that the system includes dominant and dominated people.
>
> The former can perpetuate their definition only by emphasising the margin of indetermination inherent in the production process, and by the same token, the rules, the norms and the institutions which are their supports.
>
> (Jamous and Peloille, 1970, p. 130)

Thus the authors argue that indeterminate knowledge is of higher status,

and that the exhibition of indeterminacy is a deliberate strategy on the part of professional groups to maintain social control.

Chapter Nine deals with an examination of types of medical knowledge and introduces the notions of Jamous and Peloille. The question is posed as to whether academic general practitioners, in a profession where their work is possibly seen as the most 'technical' of all branches of medicine (in the Jamous and Peloille sense of the word), have deliberately set out to emphasise the indeterminate aspects of their work in the courses. It is suggested that while the courses could range over many aspects of general practice work, there is in fact considerable selectivity in what is presented to the students. These findings are finally related back to the theories of occupational control outlined earlier in the chapter.

Research Strategy

As the above outline implies, data was gathered for this research by more than one method. Documentary evidence provided the only support for Chapter Two, while virtually all the other chapters (Three to Nine) rely upon interview material, some documentary material (mainly from University Calendars and course syllabuses) and in the case of the final chapter, participant observation. Details of the data collection method appear in the relevant chapters, while the Appendix provides an analysis of the sample of general practitioners, together with an elaboration of the value of each of the research methods employed.

Section II

THE BROADER CONSPECTUS

This Section presents the broader conspectus of general practice both past and present. Chapter Two reviews the development of general practice until present times, while Chapter Three takes a broad view of current general practice, in particular highlighting the emergence of the two distinctive ideologies.

Chapter Two

HISTORICAL DEVELOPMENT OF GENERAL PRACTICE

Introduction

This long, historical chapter acts as a necessary fore-runner to the future debates of the thesis. It locates the place of general practitioners within the present medical profession, having traced over a period of two hundred years changes which resulted in general practice becoming an established branch - some would say a specialty - of medicine.

This, briefly, is the main purpose of the chapter. But there are a number of sub-themes which are important to the overall account. It is fitting that a thesis concerned with the academic branch should begin by outlining the broader field of general practice. In the thesis, the relationship between the academic branch and the changing character of general practice will be a recurrent theme.

Two other concerns are worth underlining at this stage. They are related, and involve the overall perspective of the researcher. The first concern is with the evolution of the curriculum into its present form, and the second, with the evolution of the broader profession. It is important to recognise, for this will be assumed thereafter, that the perspective taken here is that the boundaries of medicine are never fixed, and that the composition of that group of professionals is

likewise open to change. The curriculum, often seen as such an immovable force, has in fact responded to outside influences consistently and continually. The reasons for the changes, and the way the curriculum developed into its present shape, are important in the study of academic practice, and some attention has been paid to this issue in the chapter.

The profession, too, demonstrates these features of fluidity. Hughes described medicine as 'the constant sorting and re-sorting of the tasks involved among many kinds of people - inside the profession, in related professions and clear outside professional ranks' (Hughes, 1971, p. 401). The study of the development of general practitioners into a coherent group within the medical profession is an excellent example of this kind of occupational shuffling which is so characteristic of achieving society. It is argued here, like Wright Mills (1959), that such an historical perspective serves to underline the dynamic nature of present day structures.

What follows in this chapter may be understood as a short, selective history of general practice. The chapter does not attempt to compete in breadth or depth with existing sociological analyses of the medical profession, such as Stevens' Medical Practice in Modern England, (Stevens, 1966) or Parry and Parry The Rise of the Medical Profession, (Parry and Parry, 1976). The above sources have been drawn upon, heavily at times, but the boundaries of this chapter are set firmly around an overview of general practice of the last two centuries.

Significantly, histories of general practice are scarce, for the history of general practice has been little dwelt upon either by historians or by the membership itself. The twenty-six page (unpublished) bibliography by Hamilton, 'Scottish Medicine: the published literature'

is an indication of the proliferation of works in the general medical field (Hamilton, 1980b). But in the bibliography, general practice receives barely a reference. Medical histories tend to fall into the fallacy of elitism (Fischer, 1971) in which history is interpreted through the ruling classes; given this representation of medical history, it follows that the lower status branches, such as general practice, should be seen to play a less significant part in the formation of the present group of professionals.

The one notable exception to the general trend is Honigsbaum's recent contribution The Division in British Medicine (Honigsbaum, 1979). It spans the period 1911-1968 and brings detailed evidence to bear on the general practitioner/specialist relationship earlier this century. It remains analytically weak, however, and that, together with the lack of interest in the educational concerns of general practice, has meant that its recent publication has little affected the account which follows.

Similar reasons, an overconcern with detail at the expense of any analysis, likewise diminished the potential value of Franklin's thesis (Franklin, 1950). This antiquarian account addressed the topic 'Medical Education and the Rise of the General Practitioner 1760-1860' but despite the centrality of the topic, it offered little more insight than the more general histories.

Two authors deserve special mention. Holloway and Waddington, both sociologists interested in medical history, have provided short but valuable accounts of particular periods. Holloway's reinterpretation of the Apothecaries Act of 1815 is worth singling out as an article which challenged traditional thinking on the significance of the Act (Holloway, 1966a, 1966b); Waddington's study of the origins of the

general practitioner uncovered the de facto (as opposed to the de jure) organisation of medical practice last century (Waddington, 1977). These articles had a formative influence in the writing of the first part of this chapter.

As the research deals with the Scottish departments of general practice it was thought important that special attention should be paid to the developments in education in Scotland. However, curricula are not necessarily chauvinistic and whilst the Scottish influences in the curricula were strong in the eighteenth century many of the peculiarly Scottish innovations were ignored after 1858 when the medical profession in England and Scotland united. Thereafter the influence of English thinking dominated educational reforms throughout the United Kingdom. Certain aspects of Scottish education left their mark, however, and these will be dealt with appropriately.

The chapter has been organised around milestones in the development of general practice. Such milestones are purely a heuristic device, simplifying the complexities of history-tracing. They are sometimes legal, or sometimes socially defined. Some periods have been dwelt on longer because of the nature (and in retrospect, the importance) of the changes made. The chapter ends in 1970 following the publication of the Todd Report in 1968, and the introduction of the first general practice department in the United Kingdom. Since that date further developments have taken place, but this chapter is essentially concerned with the establishment of academic general practice, and the date seemed a suitable point of termination.

The 'Three Estates' - the origins of the profession in England

Traditionally the medical profession has been seen as originating in three 'estates' - three groups of medical men[1] whose position and work echoed the divisions of status in wider society. Of the three groups, the physicians, surgeons and apothecaries, the physicians had undoubted dominance. Since 1518, when the London College of Physicians was incorporated, physicians proved to be the influential model, offering a style of work later to be emulated by other specialties. English physicians were of high social class, usually the younger sons of the landed classes, whose family could afford to give them a university education at Oxford or Cambridge and a private income. These social links with the gentry gave the physician, once graduated, unique access to upper class clientele, for whom he often acted as personal physician (Stevens, 1966).

As befitted his status, the work entailed no manual work but merely comprised of diagnosis from history-taking and suggested treatment, the drugs for which his own apothecary (if he employed one) would compound. Indeed, the physician did not need to see the patient, because before the early eighteen hundreds, little attention was paid to the physical signs of illness. The dominant paradigm in medical thought derived from the humoral model of bodily processes, and no significance was attached to the individual organs of the body. Such a paradigm, which stemmed from the early physicians Hippocrates and Galen, regarded illness not

[1] Although women often practised as midwives, it was not until the end of the nineteenth century that women were allowed, legally, to qualify as doctors. Medicine is still dominated by men, and for that reason, doctors are referred to throughout the text as 'he'.

as a localised or specific event, but rather as a general disturbance of the organism (Jewson, 1976). Thus eighteenth-century pathology was monistic in form, constructed upon a single explanatory model. Significantly Newtonian physics, rather than changing the structure of medical thought, had been incorporated into it, allowing a more mechanistic interpretation of bodily workings, but still understanding the constitution as a balance of the humours. This kind of perspective, of course, gave continuing dominance to the physician, who need only diagnose the manner in which the humours were disordered and suggest a remedy. No recourse was needed to examine the body, and surgery was not a considered course of treatment. Discussing medical practice at that time, Jewson has emphasised the individualistic nature of the physician's work. Although common underlying theories about medical causation existed, each practitioner gave his practice a colourful personal slant in an attempt to convince the patient that it was his particular remedy to which the cure could be attributed (Jewson, 1976).

At this time, medicine was practised privately. In accordance with the ideas that existed amongst gentlemen of the time regarding money, it was accepted that the physician was merely paid an 'honorarium' for attending the patient (albeit a high one); until 1858 a physician could not sue for recovery of charges from a patient (Stevens, 1966).

Physicians were the only group in English medical practice who had a university education at Oxford or Cambridge.[1] Such a training was purely in the classics, the student taking a Master of Arts degree (M.A.), with no 'practical' or vocational implications. After gaining this

[1] Franklin deals with the education of the three 'estates' and her account, based upon many primary sources, is very detailed (Franklin, 1950). Stevens' account is more superficial but used here since it was felt that she covered the main points.

degree the student would then enrol for his Bachelor of Medicine degree, learning his trade in the newly formed London hospitals, and completing his training with an M.D. degree. He would then apply for membership to the College of Physicians. The exclusiveness of physicians as a group was maintained by the policies of the College; fellowships were only awarded to graduates of Oxford or Cambridge, who would then have the opportunity of being elected to the Council. Furthermore, membership with other medical groups was not permitted simultaneously with membership to their College. The College of Physicians examination covered only aspects of medical practice deemed suitable for gentlemen physicians, and subjects such as midwifery or surgery were not dealt with in the examination. A licentiate of England and Wales could not practise in Scotland, and vice versa.

Early on, then, the physicians established themselves in a position of considerable control. Through accident of birth, their social status within the wider social structure was secured and this position was reflected within medicine where the government of the 'profession' - such as it was - lay entirely with the Fellows of the Royal College of Physicians.

Surgeons formed the second category or 'estate' of medical practitioner. They did not equal the social background of the physicians; surgery was a well-established trade, surgeons and barbers being associated in twin corporations which flourished in London (the Barbers' Guild and the Fellowship or Guild of Surgeons). In 1745 an Act of Parliament established the separate Companies, and in 1800 the Company of Surgeons was reconstituted by Royal Charter into the Royal College of Surgeons of London. Surgeons rose considerably in status with the acceptance and level of more complex surgical techniques. Newman notes

that by 1800 surgeons in prestigious hospitals were drawn from the same social background as the physician (Newman, 1957). However the significant point was that surgeons in England did not have an academic background but originally gained their training through the traditional 'craft' method, apprenticeship. This meant that the actual training received was very variable, and dependent upon the master, and geographical location. A London surgical apprenticeship would, for example, be very different from an apprenticeship in a small shop in the provinces (Franklin, 1950).

The general practitioners of today, the third 'estate', originated as grocers, selling amongst other goods, drugs and herbs with reputed healing power. They were then tradesmen associated with medicine, socially far removed from the landed classes, and closely allied to other crafts and trades. Stevens tells us that in 1617 they broke away as a group from the 'Mystery of Grocers' and formed the Society of Apothecaries (Stevens, 1966). When physicians left London during the Great Plague in 1664, apothecaries stayed and established a precedent for treating the sick as well as compounding medicine. Until 1703 an apothecary worked for a physician or in a hospital, where his duties would spread more widely, allowing him to cut and bleed patients, do the accounts as well as mixing medicines. In 1703, the group was given the right to practise medicine and prescribe for a patient without the advice of a physician. However, an apothecary was only allowed to charge for the drugs he used, and not for advice - an indication of the low status of an apothecary's knowledge. This important point will be returned to later. An apothecary remained forbidden by law to practise as a physician, although some combined the work with surgery (after the College of Surgeons was founded, it was legally required to

pass the College of Surgeons examinations, in practice not necessary).

An apothecary's education was practical. It was necessary for him to read the latin prescriptions of the physician, and to acquire a working knowledge of the properties of the herbs. This he learnt, as did the surgeon, through apprenticeship.[1] The son of a well-to-do tradesman would be apprenticed, for an agreed sum, to a practising apothecary for a number of years, after which he could then set up in practice. In 1815 it became a compulsory feature of an apothecary's training. Later the concept of apprenticeship proved to be a thorn to this group of practitioners, for it had class-linked connotations from which they wished to be disassociated.

Early Medical Education in Scotland

Whilst in England training for medicine remained very distinct for each of the 'three estates', eighteenth-century Scotland was organised rather differently. Medical education was formalised in Scotland long before in England, and teaching took place in the universities (Aberdeen being the first) rather than, as was to develop in England, being based in a hospital medical school.[2] In England physicians alone

[1] Although apprenticeship suggests a form of training for non-literates, Franklin cites evidence which suggests that apprentices were expected to study books (Franklin, 1950, p. 66).

[2] Until 1826, there were only seven universities in the United Kingdom, and five of those were in Scotland, the most recent being founded in 1593: they were St Andrews, Glasgow, Edinburgh, and two at Aberdeen. Dundee separated from St Andrews in 1967, while the two Aberdeen universities amalgamated in 1800. (Moodie and Eustace, 1974)

had a classical university education. In Scotland education was perceived and organised rather differently. Aimed at the masses rather than the few, education was seen to be a means of producing the 'lad o' pairts', who having been given a broad philosophical training, would then specialise in one specific subject. Indeed, the contrast between England and Scotland can be quickly understood if we read the argument against education for the masses attributed to Andrew Fletcher. Learning in eighteenth-century Scotland, he said, was

> 'Under disgrace and contempt': it tends to 'unfitt a Scholar for a Gentleman and to render a Gentleman asham'd of being a Scholar . . . were learning taken out of the hands of the Vulgar and brought to be as Honourable and Fashionable among the Gentry, as 'tis now contemptible, I think it would be indeed in a fair way of prospering'.
> (Withrington, 1970, p. 172)

Also different was the organisation of vocational education. Teaching in medicine has a long history in Scottish universities. In Edinburgh a medical faculty was established in 1726, but in Edinburgh and Glasgow there are records of teaching since early sixteenth century.[1] In Scottish medical education, there was no rigid distinction between medicine and surgery as in the English training. Students learned both anatomy and the theory and practice of medicine, together with chemistry. In 1738 Edinburgh introduced lectures in materia medica and botany into the curriculum, and one year later midwifery joined the list of subjects available. Clinical instruction was made possible with the opening of a small city infirmary in 1729. Thus the teaching at Edinburgh was eclectic, and offered students comprehensive medical training in a wide

[1] For a discussion of early Scottish education see Kerr (1910), Comrie (1927), and Newman (1957). The first chair in the practice of medicine in Edinburgh University was established in 1685, in Glasgow in 1750, in Aberdeen in 1505, and in Dundee in 1889. (University Calendars)

range of subjects. By the middle of that century, the Edinburgh medical school was recognised as one of the leaders in Europe (Kerr, 1910).

Edinburgh was not the only town in Scotland to provide training for medicine. Glasgow too, advertised a similar curriculum to Edinburgh, while St Andrews and Aberdeen could offer teaching, although of a less structured nature. It has been said that degrees from these latter three universities (two at Aberdeen) were often bought in return for payment, the students not requiring attendance at classes (Kerr, 1910).[1]

Whilst these universities offered specific medical training, it should be understood that, because of the Scottish approach to education, this training was in fact of a fairly theoretical nature. In Scotland, philosophy was seen as a formative discipline and a broad philosophical approach shaped the teaching in the sciences as well as in the arts.[2] Thus even in medical teaching there was a tendency to discuss matters of theory and first principle to the exclusion of the factual details of the subjects (Davie, 1961). Discourse and argument between tutor and student were encouraged, as the students were led to understand and criticise the assumptions upon which the medical disciplines were based. The relation of different matters was important, then, and it is easy to understand how, in this kind of setting, surgery and medicine could be combined to form a general medical course.

[1] Franklin makes the similar point concerning students at Oxford (although less so at Cambridge). During the eighteenth century there were few teachers of medicine; students would gain their training elsewhere (possibly at Edinburgh) and return to Oxford only to graduate. The quality of the university was judged by the Master of Arts degree, which all students took before going on to take their M.B. (Franklin, 1950).

[2] In Aberdeen physics is still called 'natural philosophy'.

Typically, medical education took three years, and was completed by an oral examination before an array of professors. The oral, held in latin, covered every subject in turn; it was an occasion for the student to demonstrate his powers of reasoning and his skill at debating. Having received this training, qualified students were then equipped to serve an apprenticeship. Some emigrated south of the border to practise, combining the practice of medicine with some midwifery, surgery or apothecary, and causing great concern to the English physicians who found such open practice 'vulgar' and totally opposed to the cherished image of a single-minded gentleman physician (Waddington, 1973).[1]

And here the irony lies. For whilst in England the training of the three groups of practitioners was quite distinct, whilst the social implications of being a surgeon as opposed to a physician or an apothecary were clearly defined and well understood, in practice the distinction between their work was far from distinct. It now seems doubtful that members of each group in England did practise 'purely', but instead practised a combination of medicine, surgery, midwifery and drug dispensing, as the situation, and the public demanded (Waddington, 1977). Waddington cites evidence to show that physicians did 'general practice', and that in the greater part of England, as in Scotland, physicians 'practise everything that comes to them' (Waddington, 1977, quoting John Burns). Similarly few surgeons in London were deemed to confine their work to pure surgery, most dispensing medicines as well, and dealing in surgical and medical cases. Waddington notes: 'in 1834 when there were

[1] The 'real' issue concerned membership to the College of Physicians which was intent on maintaining the distinction between physicians and lower status practitioners, and which the increasing number of Scottish graduates prepared to practise 'generally', threatened. (Waddington, 1973)

some six thousand members of the College of Surgeons practising in England and Wales, the President of the College estimated that only two hundred of these confined their practice to surgery: the rest were general practitioners.' (Waddington, 1977, p. 167, emphasis added)

The case holds equally for the apothecaries. Evidence is offered by Waddington of apothecaries who never had any training in surgery, yet who would engage in surgical work as well as drug dispensing and practising general medicine. While many surgeons and apothecaries practised with the license of the Apothecaries Society (some holding it jointly with the surgical qualification), many held neither. The main explanation for this direct flouting of the law was a practical one. There were not sufficient numbers of wealthy people who could afford the high fees charged by surgeons and physicians. The elite, the well-off, who could afford a private physician or surgeon, were small in number. Hence doctors worked for the increasingly large middle class, a section of society which was expanding during industrialisation, and who could afford to pay modest sums for the services of the doctor. In this changed structure of society, the arrival of the general practitioner can be anticipated, the family doctor who worked neither as a physician, a surgeon nor an apothecary, but who would competently cope with all these aspects of medical work. This kind of explanation probably comes nearest to answering the question 'how did the "general practitioner" arise?' He was someone who, although trained in the particular branch of medicine, through choice or necessity, practised more general medicine. It is interesting to note that at the time the term 'general practitioner' literally meant that; only later doctors in this branch of medicine would argue that general practice was rather more than the simple combination of various forms of medical practice.

Such practice was seen by the physicians to go against the natural order of medicine, however, and Scottish trained physicians, who admitted a knowledge of such subjects as midwifery, further challenged the physicians by attempting to gain a measure of control of the College through entry into its governing body, the Council. Their efforts were finally in vain, but the Royal College could not undo the effects of a Scottish education (Waddington, 1973). Scottish trained doctors felt that their wide education was something to be proud of, rather than the opposite.

To anticipate the future, however, towards the mid-Victorian period greater importance was attached to experimental work associated with medicine, and gradually (although not without considerable debate), the medical curriculum in Scotland changed, it became more pragmatic and didactic.* After 1858, education in England and Scotland came under the aegis of the newly formed General Medical Council; one of their first jobs was to begin to standardise curricula in all establishments of medical education. Thus much of the early influence of Scottish education became overshadowed by the English model.

* by, for example, attaching increasing importance to scientific data and through the widescale use of lectures as a form of teaching.

The Apothecaries Act (1815) and its Implications

Any writer of general practice history finds the first part of the nineteenth century dominated by the Apothecaries Act. Passed in 1815 after heated discussions, the Apothecaries Act has been interpreted both as a major advance and also as a retrogressive step for the apothecaries of the time. Historians, by their very discussion of the Act, however, all agree to its importance (see Newman, 1957; Stevens, 1966 and particularly Holloway's analysis of this Act 1966a, 1966b).

The Act brought into the open the situation which had existed de facto for a long time, by underlining the ill definition of the boundaries of medical practice. Ostensibly designed to clarify the position between apothecaries and other traders in herbs and medicines, the whole group of medical practitioners was drawn into the debate by the wording of the final Act of 1815. How did such a situation arise?

The controversy which resulted ultimately in the passing of the Apothecaries Act arose initially over the duties of the apothecary. Whilst the apothecary formed one of the three estates, and was thus seen as associated with the medical profession, there were surrounding him a number of other trades, the chemist, the druggist, 'worm and water doctors, bone setters and others whose name is Legion' (origin of quotation unknown). The occupational distinctions between these groups were unclear, as many would practise as an apothecary, while at the same time the apothecary himself might carry out general surgical and medical work. This was true in rural areas, where, with the apothecary away visiting patients, his former tasks and skills of prescribing and dispensing were managed by the chemist, a situation which the apothecaries interpreted as one of occupational encroachment. In towns, too, a similar situation was found, although for a different set of reasons. Industry required large numbers of labourers to work in urban areas, especially in the north of England. This gave the urban apothecary more patients than he could deal with, and hence the chemists began to take away an amount of trade, dealing with minor complaints of the urban dwellers. The question of adulteration of drugs, and payment also intruded. The apothecaries accused the druggists of adulterating their drugs (traditionally apothecaries would use expensive, but pure drugs) while the druggists criticised the apothecaries for their 'overpriced'

drugs (which they argued, contained a hidden 'fee').

Antagonism between these two groups was considerable. After much pamphleteering, and accusations, a group of apothecaries formed a society in 1793, 'The General Pharmaceutical Association of Great Britain'. Their intention was to appeal to the Government to legalise a situation which would give them monopoly of practice, of compounding and prescribing drugs and to this end, they collected evidence from the College of Physicians, College of Surgeons, and the Apothecaries Society. Two points can be made. First, while this is often interpreted as a 'progressive' step for apothecaries, in fact they were not attempting to increase the boundaries of their duties, but merely to gain exclusive right of their present work. Second, (and this can only be appreciated in retrospect), Holloway argues that apothecaries were only able to concentrate on the more directly medical aspects of practice if they could rely on druggists and chemists to carry out the very necessary duties of dispensing (Holloway, 1966a).

The confusion which existed with the world of dispensing reflected that of other branches of medicine. In London, physicians, surgeons and apothecaries' practice was regulated by three corporate bodies, but in the provinces there was almost complete disorganisation. There was no control over the practice or the education, and as already noted, the actual work of the various medical groups was often indistinguishable. Quackery was rife and numerous practitioners had received no formal training at all. One solution to the problem of maintaining some kind of control over the various medical groups was put forward by the College of Physicians, in a Bill published in 1804. The Bill covered not only the physicians but also surgeons, apothecaries, chemists and druggists. Control was to be in the hands of the College, who offered

to supervise all medical practice in England and Wales. It was discarded, but ideas first articulated here later became law.

At about the same time, another group of (mixed) practitioners was meeting under the title 'The Associated Faculty', again drawing up proposals to regulate the whole field of medical practice. Their Bill, put forward in 1806, concentrated primarily on essential education for different medical groups, with a register of practitioners to be kept. The Bill also emphasised the need to reserve the practice of medicine to 'youths of reputable birth and liberal education' and 'to prevent the admission of mean and low persons' (quoted by Holloway, 1966a, p. 116). Likewise this plea would be echoed for many decades.

The most significant feature of this Bill was its attempt to break down the barriers between the different medical groups to form one 'profession'. The Bill made provision for practitioners to extend their sphere of activity in any direction, and to transfer to any branch of the profession. It was intended that practitioners would register under one group but could then branch out according to their capabilities or intentions. This Bill was in fact arguing for the very opposite to that of the College of Physicians, who wished the branches of medicine to be kept socially and professionally distinct. This second Bill, rather than preserving the 'natural orders', suggested that such barriers should be completely broken down. Significantly, this latter idea came from men of lower standing who would benefit the most from such a re-categorisation. Significantly, too, the Bill received considerable opposition from the Royal College of Physicians and was abandoned.

In 1813 the apothecaries however, strengthened by their new alliance with surgeons, drew up a further Bill which was intended as a compromise of the two previous Bills. Again, reference was made to some kind of

professional control over the lower orders of medicine - the apothecaries, surgeon apothecaries, midwives and compounders of medicine. Discussion of educational provisions, too, was introduced. Appeal was made to public interest, with the insistence that such measures would ensure 'none but intelligent and well-educated individuals would be found in that profession' (Holloway, 1966a, p. 120). The Bill progressed to the House of Commons whereupon not only the College of Physicians openly opposed it, but also the chemists and druggists. The Bill was withdrawn, and offending items renegotiated, reworded and reinserted. The College of Physicians exerted considerable influence to have additional clauses inserted, and the druggists' request to exempt the chemist from the operation of the Bill was also granted. After a hasty reading, the Bill was eventually passed and received Royal Assent on 12th July 1815.

The Apothecaries Bill was originally put forward by the apothecaries themselves as a means of more clearly distinguishing the boundary between them and other groups associated with the mixing and compounding of drugs. What was the final outcome? Briefly, the Act allowed examination of the work of the apothecary in compounding medicines by specially appointed inspectors. All practising apothecaries should have served a five year apprenticeship, and produce testimonials of a sufficient medical education and of good moral character; no one could practise without this, and suitable penalties were introduced. An annual list of all licensed that year would be published. The Act would not fit chemists or druggists, and the privileges of the Universities of Oxford and Cambridge and the two Royal Colleges would not be affected by the Act.

It can be seen, even by this short resume, that the concluding Act was very different in form and content to those original ideas of the

Associated Faculty, and the disappointment of the reformers has been well documented (Holloway, 1966b). Yet historians themselves are divided over the merits of the Act. Newman, one of the more widely cited medical historians, reports the outcome of the debate as a great victory for the apothecaries, the first step on the ladder of the medical profession (Newman, 1957). On the other hand, Holloway, in a persuasive analysis of the Act, highlights the disadvantages of maintaining apprenticeship, a tradesman's training, as the main form of education for an apothecary. He argues that instead the Act should be seen as a triumph for the College of Physicians, for the legislation served the purpose of maintaining the apothecaries 'in their rightful place' in society (Holloway, 1966b).

Why was the Act so important, and what were its implications? First, the apothecaries were the first medical group to introduce an examination which members had to pass before they could be licensed to practise. Previously, the Apothecaries Society had required an apprenticeship training of five years, but exceptions were tolerated and apothecaries did practise without completing the five years. The 1815 Act made the examination compulsory (and prosecutions were made against those practising illegally, the first being in 1818), (Holloway, 1966b). As well as setting an examination, the Apothecaries Society set out in detail a curriculum, which they broadened as other subjects were deemed as relevant; in 1816 physiology and botany were added, and eleven years later a training in midwifery further increased the syllabus. With the increasing availability of hospital teaching, one year's study

in hospital became compulsory.[1] A course of lectures became necessary, and examiners were apparently quite scrupulous about approving hospitals and medical schools as suitable establishments for teaching.

The examination, then, became a definite hurdle to be overcome - and served its purpose as a selection procedure. The Act now separated apothecaries from druggists and chemists, and a sharper distinction than before was made between those licensed to practise, and 'quacks'. By implication, too, the examination defined certain knowledge as elite knowledge, gathered only through a particular medical training. Previously physicians and Scottish trained doctors had access to such knowledge through a university education; now, through the Society's training programme, the apothecary's expertise could be legitimised. One could argue that because of the Act the apothecaries had joined the medical elite.

The requirement of an apprenticeship, however, remained a problem. Today apprenticeship forms only one part of the lengthy medical training, however, and the 'tradesman' image of the concept has dulled. In the nineteenth century however, apprenticeship was the only form of a vocational training for tradespeople, with little or no reading requirements, and no examination at the end. To continue to be tied to this practical form of training was seen by the apothecaries as a failure, a mark of their low status with other medical groups. A five

[1] Newman gives the full curriculum of the Apothecaries Society in 1835 (Newman, 1957, pp. 107-109); briefly it consisted of anatomy, chemistry, materia medica, therapeutics, botany and vegetable physiology, surgery, medicine, forensic medicine, chemistry, morbid anatomy, dissection. Later midwifery and diseases of women and children were fitted in, and with the increase in curriculum, the fulfilment of five years apprenticeship was progressively modified (Newman, 1957, p. 108).

year education, too, was seen to be a waste of time. Hodgkin, writing after the Act, argued that the apothecary's work was previously more complicated and five years might have been justified. However:

> The case is, at present, widely different; the Apothecaries' shops are encumbered with fewer articles - most of these are generally supplied, ready prepared by the wholesale Druggist, and a very few months, at the utmost, would suffice for the acquisition of the art of combining them in extemporaneous prescription.
> (Hodgkin, 1828, p. 6)

Some argued that apprenticeship was a means by which apothecaries obtained unqualified assistants on highly favourable terms (an argument now extended to 'trainees' in general practice).

One particular aspect of the Act warrants mention. At no time did the Act specify the work of, or define, an apothecary. At the time of its passing, the apothecary was permitted by law to charge only for medicine (the fee for attendance being implicitly counted in the high cost of the medicines). Such a method of payment had undertones of 'trade', where the goods, rather than the expertise, was the product paid for. Reformers who had hoped the Act would change this were disappointed. It required two legal precedents to specify the distinctions between the services of an apothecary and other compounders of drugs. In 1829 it was held that an apothecary could charge for either his attendance or the medicines he prescribed. The following year Lord Penterdon ruled that an apothecary might recover for a reasonable attendance as well as for medicines (Stevens, 1966). This may be seen as an important date, for the ruling recognised the 'professional' status of an apothecary's services.

Finally, the Act provided grounds for discontent, this time not from the apothecaries but from other medical practitioners As laid

down, it prescribed that all who practised as an apothecary in England and Wales must have served a five year apprenticeship. As already noted, however, the de facto distinction between the work of different medical groups was less clear than those de jure. Under the Act every physician or surgeon who included the practice of compounding his own drugs in his work must, to practise legally, submit to a five year apprenticeship. This demand of the Act caused considerable grievance to other practitioners - especially those outside London who were more likely to practise generally. Scottish physicians, ('the chief sufferers from the 1815 Act', Holloway, 1966b, p. 225), already having completed a three year training, were also loath to spend another five years in apprenticeship. Of course many did not pass the examination (or even sit it). They went back to their home town and practised as chemists, druggists, surgeons, apothecaries and man-midwives. If the Apothecaries Society heard of this, they could be barred from practising as an apothecary but not as a surgeon, for the College of Surgeons had no such similar powers. The Apothecaries Society had shown itself to be conscientious in carrying out its duties; failures of the examination were known, increasing from 5-6% to 15%. Over the period 1815-1834, 7,028 candidates were examined, and 795 were rejected (Reader, 1966).

It is reported that the other branches of medicine were impressed by the work of the apothecaries, and indeed, even had to look to their own entry procedures (Stevens, 1966). These changes will be discussed in the next section, for they were closely connected to the development of the 'new' medicine .

The 'New' Medicine

The early eighteen hundreds was a period of dramatic change for medicine.[1] The structure and thought of current medical thinking was challenged from abroad and resulted in what would be in Kuhn's terms a paradigm change (Kuhn, 1974). At the same time, the medical curriculum expanded to incorporate these ideas. The new medical cosmology gave greater emphasis to surgery, and the power structure of the group changed. Previously, physicians held control over the various medical groups, explicitly through their Royal College, implicitly through the paradigm of medical thought which allowed greatest credit to the physician's skills. Innovations came from abroad, however; from Germany new ideas about medical education, and from France, sustained attempts at classifying disease.

Post-revolution in France provided a unique environment for challenging the accepted order. The shift from a generalised to a localised pathology was first discussed in the Paris schools during the period 1800-1830. Innovators in medical thought, the 'Ideologues' as they called themselves, insisted that methods of research in medicine should resemble those of the natural sciences. They argued that symptoms could be understood only by tracing their development back to their sources in the organs of the body, and that the monistic explanation of disease should be replaced by systematic studies of the phenomena of disease. Their preliminary researches in Paris hospitals related symptoms with their associated lesions. Later postmortem examinations were added to the formation of discrete disease entities (Jamous and

[1] This period of medical history has been dealt with in considerable detail by a number of writers - for example, Jamous and Peloille (1970) and Foucault in The Birth of the Clinic (1973).

Peloille, 1970).

The Paris hospitals offered excellent facilities for systematic studies of illnesses, for the thirty hospitals housed numerous beds, and thus many thousands of patients were available for such research. The increasing importance of the internal workings of the body was no doubt due in part to their surgeons, who, for the first time, worked alongside the physicians. Extensive, and intensive research took place; medical instruments were invented (the microscope, for example, was first used in this potent environment) which opened up fields for further study. Results of the findings, of the new categorisations of disease and their diagnoses were published in medical journals. These developed from the desire to spread information more accurately; findings were made available internationally since they were now couched in 'scientific' terms.

This kind of medical upheaval had profound effects throughout Europe. Such discoveries could not be ignored. In Britain medical scientific societies were formed, for example, the British Association, and the Provincial Medical and Surgical Association. And medical education changed to incorporate not only the new ideas but also the new subjects. Holloway notes that the teaching of these new methods and techniques, and their application to the classifications of disease became the main subject of medical education after 1830; (as he puts it, 'The library medicine of the physician and the bedside medicine of the apothecary, were discarded in favour of the new hospital medicine' [Holloway, 1964, p. 305]).

This paradigm shift of medical explanation proved to be an important 'milestone' for future general practice for it signified the beginning of a difference in status between hospital medicine and medicine

practised in the community. From this period until the present day, prestigious appointments would be made within the hospital where, together with research funds and teaching facilities, technically 'good' (high status) practice was made possible. General medical work in the community could not compete, since the changed value system devalued community practice. The distinction between the surgeon and apothecary, so often united in one person in the past, was also more clearly made. Surgeons rose to positions of considerable power. They were a major force in establishing provincial medical hospitals and along with them, medical schools, thereby decentralising medical education from its previous London base. Medical schools were set up in Manchester, Bristol, Liverpool, Leeds and Birmingham, and provided teaching for surgery and the Apothecaries Hall examination (Stevens, 1966).

The enhancement of the social status of surgery was a reflection of the recognition that students would be required to possess greater surgical knowledge to practise the 'new' surgery. The Anatomy Act, passed in 1833, allowed corpses to be made available for educative purposes, and the Royal College of Surgeons also reviewed their training requirements. A two tier system was introduced. The lower rung, the surgery diploma, held by many surgeon apothecaries, became demoted to a general 'all-purpose' qualification. The higher qualification, the Fellowship of the College (F.R.C.S.) was conferred on successful candidates after a two-part examination in theory and practice. In future good London posts required this. The Royal College of Physicians followed suit by instituting a similar 'fellowship'. Together these moves constituted the beginning of 'post-graduate' training, with specialty qualifications which would be a necessary later addition to an undergraduate general medical degree.

Reforms in medicine echoed many of the changes taking place during this time in other spheres of life. The first Reform Bill was passed in 1832, the New Poor Law in 1834. Some social historians have pointed to the seeds of a nationalised health service in the Poor Law Board, created in 1834 (for example, Fraser, 1973). Free medical services were thought by some to encourage idleness and bad moral character, seen at that time as a 'natural' characteristic of paupers. State aid through the Poor Law also meant that medical care was offered to one group in society while the urban working class had to pay for their medical attendances. To counter these objections, early medical provision made qualifications for free medical care strict, as a form of deterrent. Nevertheless, many qualified, and the work of the Poor Law Officer (who would sometimes combine this with general medical work in the community) was considerably increased. Because of this work, he became seen as the 'general practitioner' for the poor. He would also undertake care of the poor in the workhouse hospitals, and carried out vaccinations, the first medical service provided by the Poor Law for all members of the community. This combined role was the first link between the State service and medicine. Further, and more substantial links were made by subsequent legislation.

Important changes took place in the public medical services. In 1847 the first Medical Officer of Health was appointed in England and Wales. In 1872 the Public Health Act of England and Wales (1867 in Scotland) made the appointment of medical officers of health compulsory in local sanitary authorities, thereby creating another 'tier' of the medical profession also concerned with the community rather than hospital. Subsequent Health Acts affected many health measures concerning infectious diseases (for example, the creation of fever hospitals) and environmental health.

The First Recorded Attempt to Found a College for General Practitioners

One can only speculate on the reasons why an attempt to found a College for general practitioners should have been made in 1840, documented by McConaghey (1972). Two possible reasons are the lack of success of the surgeon/apothecary groups (now increasingly called general practitioners) in previous legislation, together with the knowledge of the growing demand for general practitioner services. The other Colleges had created a monopoly in medicine, and controlled all decisions about education and employment. The Colleges were now the examining boards for the Fellowship examination whilst the rulers of the Colleges and the teachers at the medical schools were one and the same people. A College for general practitioners would offer representation for what was at the time, the largest group of medical men; (Reader tells us that according to the census of 1841, there was in the United Kingdom 1,776 physicians, 19,106 surgeons and surgeon/apothecaries, and 2,152 medical students totalling 23,034 [Reader, 1966]). The attempt by the general practitioners to found a College failed, despite concerted action by the 'National Association of General Practitioners' (McConaghey, 1972). Their College was to be called the Royal College of General Practice in Medicine, Surgery and Midwifery. Opposition to the idea was strong, the surgeons and physicians accusing the general practitioners of professional encroachment. Although steps were taken to meet the criticisms, the Bill was finally shelved in 1845. No further attempts were made for another hundred years.

One of the proposals in the Bill was that of a united medical profession, united through an examination common to all three groups. This notion had been raised in various contexts for at least thirty years.

The physicians always interpreted such an idea as a challenge to their supremacy, and appealed to notions of the 'professional good' to maintain the status quo.

> It would be the downfall of all three . . . it would reduce those which are professions now to a mere trade, and would be very fatal to the character of the whole medical profession and very injurious to the public.
> (quoted in Reader, 1966, p. 60)

Yet all three groups had a vested interest in changing the present situation. Although medical education and entry requirement had tightened up considerably, there were still practising in the United Kingdom a large number of 'quacks', unqualified doctors whose practice was not based upon the sound training which qualification assured. At the same time the Apothecaries Society still demanded their five year apprenticeship, an annoying requirement for many practitioners. Reports on medical education (for example the Select Committee on Medical Education of 1834), revealed gross deficiencies in the various training schemes, and it was the Royal Colleges who came in for many of the criticisms. Given these factors, it is not surprising that the various medical groups were all willing to discuss changes to the present situation. Many ideas were floated, with the critical issue turning on the system of control of the profession through examination and registration.

The debate crystallised around two alternatives. The first was to offer one official council to supervise existing separate examining bodies, the second, to create and supervise one single examination for all groups of practitioner. After a total of fifteen Bills had been put to, and rejected by the House, the sixteenth Bill was passed and the Medical Act of 1858 came into being. The solution acceptable to all

parties was inevitably a compromise. An official council (now the General Medical Council [G.M.C.]) was created to supervise medical education but not to examine or compel changes. The Council was to be independent of the Royal Colleges, the medical schools and the universities, but made up of representatives from these groups, together with six members nominated by the Crown. The Council had a considerable degree of autonomy, being answerable not to the House of Commons but directly to the Privy Council. The Medical Act required a register to be established which would list all qualified doctors, with severe sanctions for the unregistered; the register also provided the means of self-discipline for the profession, failure to act accordingly to professional standards leading to the striking off of the practitioner from the ranks of the qualified. Finally, the Council was expected to define suitable qualifications, appoint examiners and expect examining bodies to co-operate.

With the passing of this Bill, provincial medical schools became independent of London examinations, and the universities were given greater autonomy. However, interestingly, the Act did not prohibit unqualified practice, but merely restricted the work of such a practitioner by making it illegal for him to sign a statutory certificate or prescribe dangerous drugs. Neither did the Act produce a uniform medical qualification, nor did it change the distribution of power throughout the profession. The power of the profession was still invested in the upper echelons of medicine and surgery.

Educational Changes

One of the main tasks of the G.M.C. was to reorganise the educational structure of the profession. The overriding aim of the period was to gain respectability (for example the Provincial Medical and Surgical Association, later becoming the British Medical Association [B.M.A.] dedicated itself to 'the maintenance of the honour and responsibility of the Profession generally in the Provinces'.) Education became seen, together with general qualities of character, as the feature which best characterised the professional man, and which set a fine contrast to the other major life style of the middle class of this era, business (Rothblatt, 1968). In this context the values of professionalism mimicked those of the educated gentleman, disdaining the acquisitive aspects of industrialism, fired by a vocation for his work, and the common good. This idea of the working man as a learned man proved to be an extension of the life style cultivated originally by the physicians, and now emulated by the other medical groups. Thus education became doubly important, not only for the very necessary task of imparting knowledge to students, but also for the image it carried with it.

The substantial increase in demand for medical services by the middle classes (who were as a class expanding and becoming increasingly affluent) during the century had important consequences for medical education. With a wider range of clients, the general practitioner - as he was now termed - was more or less assured of an income, and more willing to tailor the charges according to the ability of each client to pay. With the prospect of stable and lucrative practice after qualifications, more time and money could be spent on training. Students whose families paid for the education through private income were beginning to

be joined by sons of the successful business and tradesmen who saw a medical education as a major road to social mobility. Licensing authorities could afford to raise the standard of entry into the profession and still attract increasing numbers.

The minimum essential requirements as defined by the General Medical Council in 1867 encompassed more than just medicine and surgery. The subjects for the curriculum were as follows:

1. anatomy
2. general anatomy
3. physiology
4. chemistry
5. materia medica
6. practical pharmacology
7. medicine
8. surgery
9. midwifery
10. forensic medicine

To cope with the increasing number of students taking medicine written examinations were introduced and less emphasis was placed on the oral examination.[1]

The first basic curriculum, placed in some logical order by the Report in 1869, contained none of the liberal subjects which earlier Scottish university curricula had held so important. Instead, the emphasis was on purely medical knowledge with a grounding in the 'preliminary sciences' - chemistry and physics. The latter group was introduced to establish in the students a method of approach which they could subsequently apply to the study of medicine. Newman quoted the explanation offered by the Education Committee of the Council in 1890:

[1] Carr-Saunders and Wilson describe the twin functions of the written examination system as a way of raising the standard of education within universities, but also as a means of testing competence in those in public service and in certain professions. Interestingly, they single out the Society of Apothecaries as one of the earliest groups to adopt this new mechanism for examination (in 1839-40) (Carr-Saunders and Wilson, 1964, pp. 310-314).

> A year spent at a School of Science or School of Medicine where such sciences are taught, in acquiring a practical acquaintance with them and the habits of observation and reasoning which such studies foster may be regarded not only as well-spent but as essential to a just comprehension of the phenomena of disease.
>
> (Newman, 1957, p. 209)

The necessity to complete a five year apprenticeship changed to allow the student to complete the lecture course and practise at a recognised medical school; apprenticeship no longer had such relevance in a system of medical education which emphasised the transference of specific, documented, theoretical expertise. Nevertheless, as a method of learning vocational skills, apprenticeship is still a potent concept for the general practitioner of today.

Thus medical education at an undergraduate level became organised around an 'omnicompetence' ideal. The basic training was thought to be suitable to create a 'safe general practitioner' who could then, without further education, take up a career in general practice. For those who wished to specialise in medicine or surgery, this basic training provided an educational base prior to further qualifications. Thus the hierarchy in medicine between specialists and general practitioners, which has extended into this century, was incorporated into the initial training provision of the united profession. Provisions for the curriculum changed in subsequent Acts, but the reasoning behind the original construction of the curriculum did not alter until the middle of the twentieth century. Until then, there was no suggestion from others that general practitioners should take part in the teaching, or that they should have special needs for the practice of their work.

Hospital Practice - the Creation of Specialties

Hospital based medicine expanded throughout the second half of the nineteenth century; more hospitals were built, and the numbers of doctors employed in hospital services increased considerably. Medical research made discoveries which significantly altered medical practice. The revelation of sepsis and antisepsis, together with an understanding of germ theory, made possible hitherto radical surgical techniques and surgical possibilities, as well as improving recovery rates of many infectious diseases. Consultants in hospitals held on to key positions, both as practitioners and teachers, whilst the general practitioners were gradually excluded from first the voluntary hospitals and later the urban hospitals through the appointment of other hospital trained personnel. Only in rural areas did the general practitioners maintain access to hospital beds (indeed, they had a central role in the creation of cottage hospitals).

In her description of the profession in the mid-late Victorian period, Stevens emphasises the competition for clients which existed between the general practitioner and the hospital consultant (Stevens, 1966). Both aimed at the same middle class market, and practised the same kind of work. By the end of the century, however, special hospitals had been founded which concentrated on one specific area of medicine. Particularly in London, hospitals were founded specifically for treatment of the eye, ear, nose and throat, and obstetric problems. The more well-off patients would attend the outpatients department for treatment, completely by-passing the general practitioner. This caused concern with the community based doctors, who envisaged their clientele being reduced to only those who could pay little or nothing for medical care.

Specialism also formed a threat to the 'generalists' in hospital medicine by offering success by other means. The modern instruments used by specialists, were difficult to work with and required training and practice; general consultants, then, could not easily make the transition to specialty work. Eventually, specialists who had trained in specialist hospitals were appointed to jobs over and above those who received a general training, and one could say that the specialisms had become institutionalised. The London special hospitals retained their position as post-graduate teaching centres unconnected to the under-graduate hospital schools. Provincial special hospitals became integrated with the rising university departments.

The General Practitioner and the State

Whilst it may have been still acceptable to practise general rather than specialist medicine in a teaching hospital at the end of the last century, the allure of generalism did not extend to general practice. The former links which general practice held with surgery were finally severed with the introduction of particular surgical techniques (for example, anaesthesia) which rendered general surgical tasks less available to the general practitioner. Similarly, the sterile conditions which were beginning to typify hospital practice meant that amongst other work, obstetric work was beginning to be seen as necessarily taking place within hospitals. The general practitioner found much of his work taken over from him by consultants.

The general practitioners themselves were becoming increasingly involved in the social welfare system. Already mention has been made of

a number of general practitioners who worked with the Poor Law and Local Government Board, carrying out medical treatment for paupers and the poor. By 1910 about one sixth of all general practitioners (about 3,700 doctors) were working at least part-time in the Poor Law Service (Stevens, 1966). Most of them were also public vaccinators, and many in rural areas also worked as part-time medical officers of health. General practitioners were also becoming involved in certification of births and deaths, notification of infectious diseases, and other duties under acts relating to factories, child health and housing. The doctor, but especially the general practitioner, fast became a central figure in the administration of public health and preventive medicine. This type of bureaucratic work, however, was not to be equated with the prestigious medical work carried out in hospitals; it was seen by other members of the profession as low status, clerical, and 'non-medical' in nature.

With the changing emphasis of a general practitioner's work, the organisation of general practice also changed. His clientele was now largely drawn from the working population, whose medical expenses were covered by various arrangements with 'sick clubs', friendly societies and provident societies. Indeed, it has been argued that this form of care was encouraged by the Government as a way of relieving the State of the burden of covering such expenses (Parry and Parry, 1976). However, the practitioner's involvement with the friendly clubs was to lead to conflict. Service for the workers took the form of worker-control, the doctor being employed by that particular organisation, and therefore, under control of their committees. Doctors disliked this shift in control, arguing that it was 'unprofessional'. With the support of the B.M.A., general practitioners attempted to redefine the

situation regarding both the payment and the working conditions of the family doctor. A G.M.C. committee investigated the situation and reported in 1893 that the situation was reprehensible for the general practitioner; they made a number of recommendations which the G.M.C. did not adopt, and the situation worsened. Continuing their support, the B.M.A. carried a motion in 1903 to investigate 'contract practice' as it was called, the result of which appeared in their journal two years later, in the form of a publication on contract practice. The document argued strongly that 'contract practice should be arranged by and under the control of the medical profession'. Ideas later found in the Act of 1911, which introduced the National Health Insurance Scheme, were originally outlined in this document (Little, 1932).

The Webbs took up the theme of the organisation of the medical services in their memorandum to the Royal Commission on the Poor Law submitted in 1907 (Webb and Webb, 1910). Campaigning for a unified medical service and against 'the chaos into which the whole subject of public medical attendance has been allowed to fall' their report offers one of the few descriptions of general practice at that time. The friction between the medical clubs and the practitioners is clearly documented:

> The doctors allege that the remuneration allowed them is so insufficient as hardly to cover expenses, whilst many persons of substantial means take advantage of the society membership. The members of the friendly society, on the other hand, complain that the doctor favours the committee men or other influential members, and that he seeks to recoup himself by charging fees for all the other members of the family.
>
> (Webb and Webb, 1910, p. 137)

At the time medical treatment for non-working people, or workers who did not join a club, could be sought from several sources, the

outpatients department of voluntary hospitals (dismissed by the Webbs as 'positive dangers to public health' because of the hurried treatment and overcrowding); from free dispensaries; and from Provident Medical Associations which differed by their organisation from the contract practice of medical clubs. (Here a group of doctors would join together locally and offer the patient a choice of doctor, sharing the work and contributions of the members. As a form of medical care, it apparently made little headway in the towns because of the competition from the voluntary hospitals [Webb and Webb, 1910].) Interestingly, the Webbs condemned a state-subsidised health insurance system, with free choice of doctor; this, they felt, would merely perpetuate a situation whereby the patient would be treated for his symptoms and not the 'disease' which too often simply could be solved by better housing, food and sanitary conditions.[1, 2]

The Webbs' memorandum was ineffective, however, and the National Health Insurance Act came into being four years after their submission.[3]

The Act satisfied the demands for a State subsidised system of health care, although it only provided (as did the Clubs) for the working population. The six 'Cardinal Points' of the Act are set out

[1] They were, then making the case for a more preventively orientated medical system - an idea which recurred through socialist writing and eventually came to form part of the ideal of the National Health Service.

[2] At this time various Acts were passed, concerned with preventive medicine and the improvement of the community's health - for example, Development of Midwifery Services (1902), Development of School Health (Medical) Service (1908), the introduction of free school meals made compulsory in 1914.

[3] Honigsbaum offers evidence which suggests that the Webbs played an influential role in the formation of later health reports, however - for example in the 1920 Dawson Report (Honigsbaum, 1979, Chapter 5).

below:

1. upper income limit of worker (£2 per week)
2. free choice of doctor by patient subject to the doctor's agreement
3. benefit administered by local health committee, and not friendly society
4. choice of their method of remuneration by doctor in each district
5. medical remuneration to be adequate for work performed
6. adequate medical representation among insurance commissioners

State control of the friendly societies was thus instigated, whilst the general practitioner also began a relationship with the State through capitation payment - a relationship and system of payment still in operation today, although both have changed in nature. Capitation payment was, and has remained, the general practitioner's prerogative, although its advantages are still much debated. It allows the doctor payment according to the number of people on his 'panel' (signed up on his list); it ensures a steady income but obviously encourages larger lists (in those days some doctors built up very large lists[1] of more than 4,000 patients [average size last decade was around 2,000]). Capitation also meant that the general practitioner maintained independence from the Government; he was still free to withdraw his services and practise privately as before.[2]

[1] A weighting system was introduced in 1953 after the Danckwerts Award which gave additional payments in respect to the 501st to the 1,500th person on the general practitioner's list, to discourage large lists.

[2] This has always proved to be an important negotiating tool for the practitioner who has used it on occasion to make a political point although in fact the demand for private general practice is not so great as to allow the majority of doctors to work effectively outside the N.H.S.

The informal division between the general practitioner and the hospital doctor now became legal through the referral system. Hospital doctors became, by the nature of their work, specialists, to whom the general practitioner would consult for a 'learned' opinion. The referral system also implied that the hospital should be primarily the place of work of the specialist, with the general practitioner remaining in the community to work, using the hospital only as a special resource. The N.H.I. Act thus legitimised the status of hospital (specialist) expertise as superior to that of 'generalist' practice.

An important feature of the Act was that through its organisation it gave general practitioners representation at a number of levels. Such representation was gained through participation on various committees (for instance the local insurance committee, the medical services committee, which were set up to ensure protection for the practitioners from complaints by other practitioners, or friendly societies via Insurance Committees). When in 1919 the administration of the scheme was placed in the hands of the Ministry of Health general practitioners then had representation direct to the Government through the Central Advisory Committee.

It has been argued that 1911 'ushered in a period in which the general practitioners collectively consolidated their control in the medical market place and improved their status position in society' (Parry and Parry, 1976, p. 195). Their control of the medical market place was, however, limited to community based medicine, and not the more prestigious hospital based medicine. What appeared to happen was that through panel organisation, general practitioners became more self-conscious, cohesive and politically strong, rather than being fragmented by the various systems in which they had previously worked. Their

services were demanded by increasing numbers of the population and the split between 'panel' and 'non-panel' doctors declined in importance as more doctors joined the scheme. By 1938 40% of the population of England and Wales were covered by the scheme, and 90% of all general practitioners were involved in it (Stevens, 1966).

Stevens suggested that at the time about one third of a doctor's income would derive from panel work, and that under National Health Insurance the general practitioner became a 'well-established figure, not well-to-do, but comfortably situated' (Stevens, 1966, p. 57). It seems more likely, however, that as in the previous century (see Waddington, 1977) income of practitioners would vary widely.[1] The following description of a general practitioner of the 'twenties who practised in a rough-shod fashion, illustrates what have been described as 'Robin Hood ethics':

> He kept neither day-book nor regular accounts. This was another habit that got him into trouble for he was assessed by the Inland Revenue at a fantastic figure and he had no books to prove them wrong. It cost him a lot of money. He sent no bill in until and unless the patient died. Then there took place a mental calculation of the work done, sometimes over many years, and the resources of the deceased. The result, on occasions, caused some alarm and surprise among his wealthy clients but never did the poor have reason to complain.
>
> (Rees, 1956, p. 307)

[1] See A.J. Cronin's novel The Citadel for an account of the uncertainty attached to general practice at this time (Cronin, 1937), also see Hale and Roberts (1974) for some recollections of general practice (especially chapters 3 and 4).

Specialisation and Medical Education

Some general practitioners were also becoming specialists in one particular aspect of their own work, for example, in E.N.T., where ~~can~~ conditions would need immediate treatment with certain drugs. They had access to cottage hospitals, and to second 'specialist' opinions. Some general practitioners thus formed what was essentially a second group of specialists, lower in status than hospital doctors, yet with some acknowledged specialist expertise. It was quite acceptable to start one's career in general practice, work for a number of years as a consultant, returning before retirement to general practice.

Partly as a means of ensuring competence in these specialist fields, a number of post-graduate diplomas were introduced (for example, Diploma in Opthalmic Medicine and Surgery, 1920, or later, the Diploma in Child Health or Diploma in Anaesthetics, 1935). The above mentioned diplomas are significant of an increasing specialisation (some would say, fragmentation) of medical knowledge which had repercussions in many areas of medical life. Specialists from new areas of medicine requested training appropriate and relevant to that branch of medicine and they wished representation within the profession. Until the 'twenties the two Royal Colleges achieved total control of hospital medicine. In 1929, however, a group of obstetricians and gynaecologists formed an autonomous College, successful in their attempt (according to Stevens) because the government of the day was concerned over the high maternal and infant mortality rate.

The undergraduate curriculum, too, reflected the growth in medical specialties. From the first standardised curriculum in 1867, it had expanded to include first the laboratory sciences and pre-clinical

subjects (for example, physiology, embryology) and later the clinical specialties such as E.N.T., diseases of the skin, diseases of women. The expansion of the curriculum (in Glasgow it had doubled by 1906) caused some concern amongst the profession and those involved in medical education. From America came the publication of the Flexner Report in 1910, highly critical of American medical education, with a number of directives about the future of medical education in America. In Britain the Haldane Commission was set up, reporting in 1913. A number of themes of the Flexner Report are reflected in Haldane, the overarching concern of both being a rationalisation of medical education within the universities. Haldane made a number of recommendations concerned with creating a more 'academic' medical education. Medical education should, Haldane argued, be a university education, there should be a close association between undergraduate and post-graduate education, and distinguished clinicians should teach undergraduates. This would be accomplished through the introduction of professorial units into the hospital medical schools, which would be linked to the general hospitals. Haldane further argued that too great an emphasis was placed upon examinations, and too little upon creating flexibility in the curriculum (Cohen, 1968). Both reports stressed the importance of a scientific education, and because of this, were seen to be opposed to apprenticeship as a major form of training for medicine.

Many of the concerns of the day over the curriculum are still contemporary themes, for example, overcrowding of the curriculum, the role of examinations, the relationship between pre-clinical and clinical subjects. At the time, there was no mention of general practice teaching, although it would not be true to say that the idea that general practice could or should be taught either at a post-graduate or

undergraduate level, had never been raised. The idea of a training school for general practitioners was brought up by James Mackenzie (1853-1925), a most successful general practitioner whose career spanned both general practice and hospital medicine, but who was one of the few prepared to speak out for general practitioners.[1] When his career was at a peak, Mackenzie wrote to the Medical Research Council requesting money for an institute for training general practitioners. Mair, one of his biographers, quotes the reply to this letter:

> The aspect that chiefly strikes me both for novelty and germinal importance is your Institute as a training school for practitioners. There is nothing like it, I think, elsewhere, and I hope from this seed will spring a training system all over the country. I think that is your best gospel - that present medical education does not educate practitioners.
>
> (Mair, 1973, p. 313, emphasis in original)

Money was forthcoming, since the Institute came into being in 1919, in Dundee. In its early days, it was seen to be well staffed and active. By 1939, however, it was wound up, its closure symptomatic of the lack of concern and funding for general practice education at the time. The notion, along with other of Mackenzie's ideas, still has a topical ring to them today.

While hospital medicine and general practice might offer a confused situation, certainly this was no more so than the administration of the medical services during this period. It has been argued that only World War Two fully revealed the weaknesses of the system (Titmuss, 1950). The 1911 Act did nothing to distribute medical services evenly throughout

[1] Two biographies of Mackenzie exist, McNair Wilson (1926) and the more recent one by Mair (1973).

the population, either geographically or functionally. Some (working class) areas had no hospitals and few general practitioners. Given the preference for private practice both hospital doctors and general practitioners preferred to work in areas where the number of middle class patients would offer a secure living (this, in spite of the Insurance scheme). Organised around municipal and voluntary hospitals, the administration of the whole system became increasingly problematic. There were for example, huge disparities in spending between local authorities. The unevenness of the services was brought home to the London based specialists at the beginning of World War Two; hospital doctors were quickly organised into the Emergency Medical Services, and senior and influential specialists (amongst others) were moved from their London hospitals to provincial hospitals to await the war wounded.

With the emphasis during war on providing medical care for the injured, general practitioners tried to refer fewer patients to hospital than before, and a system of priorities was drawn up for hospital bed usage. Many newly qualified doctors went straight into service while others left general practice and joined up. Of those who remained, 10% were over the age of seventy, and elderly doctors struggled with lists of 4,000 - 5,000. Women graduates, often hitherto denied control in a practice found themselves organising and running large practices (Titmuss, 1950). By the end of the war civilians had access to only two thirds the number of general practitioners as before. It could well be argued that more than others, civilians suffered a loss of medical care during the war, and that this helped in their acceptance of the idea of a comprehensive health service.

However, the concept of a nationalised health service did not spring only from the conditions of the War but was itself the cumulation

of suggestions and proposals made throughout the early decades of the twentieth century. Indeed, one can trace through various reports the introduction of ideas which came together to form the service in its finally agreed form.[1]

While both the profession and the public seemed desirous of State support for health and the social services, and whilst the Government became committed to such a move, the details involved in implementing a national health service proved considerably more troublesome. Already well documented and discussed,[2] a short account is offered here to indicate how the role of the general practitioner was reshaped. The account also illustrates the continued lack of power of general practitioners within the profession by highlighting the discrepancy between the reported wishes of general practitioners for the service, and the final outcome of the negotiations.

The Introduction of the National Health Service

Direct negotiations for the National Health Service (N.H.S.) began with the White Paper produced in 1944 by Churchill's coalition government. It was committed (read the introduction), to 'establish a comprehensive

[1] Reports came from a number of sources; for example, the Ministry of Health, the Hospitals Committee, the B.M.A., the Socialist Medical Association, and various *ad hoc* committees such as the Medical Planning Committee, set up by the B.M.A. in co-operation with the Royal Colleges and the Scottish Medical Corporation. The Beveridge Report also came out at this time (1942).

[2] For example, Eckstein (1959), Stevens (1966), Forsyth (1973), Parry and Parry (1976). For a more personal, but revealing account, see Foot's biography of Aneurin Bevan (Foot, 1975, Vol. 2).

health service for everybody in this country' and wished that in 'future every man, woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health' (Ministry of Health, 1944, p. 5): need would be in no way related to ability to pay. The White Paper showed careful consideration of the inter-war reports, and fully acknowledged the value of their recommendations in aiding the White Paper. The new health service was to be centrally funded, being financed out of general taxation and local rates. Neither patients nor doctors were to be compelled into using the public services, but doctors who did join were to have more choice than now in method of remuneration. Most important was the shift in emphasis on hospital and general services. The general medical services were to be moved into the 'front line' of the service; that is, they would be the first source of help available to the public, with specialists providing a separate back-up service. The question of geographical maldistribution was tackled by uniting administratively the municipal and voluntary hospitals. The concentration of hospital staff in teaching hospitals was to be diluted, with more moved to work in regional peripheral hospitals. Consultant staff would be salaried, part- or whole-time, according to their commitments. General practitioners would have the choice of working in a health centre for a salary, or separately in grouped practice paid on the usual capitation basis. However, whatever form of practice they chose, public funds would have to be sought for their remuneration. The implications of this to the profession was spelled out in the report: 'The State must, therefore,' the report read, 'take a greater part in the future in regard to general medical practice' (Ministry of Health, 1944, p. 26). All doctors taking part in the service would be under a Central Medical Board, although

health centre doctors would hold a joint contract with local government authorities.[1] Henceforth all would be unable to buy and sell the goodwill of practices, but the Government would undertake to recompense the doctors. Finally, there would be a 'negative direction' of labour to achieve a more even spread of manpower in general medical as well as hospital services.

The report is detailed and thorough in its discussion of the service, showing for the first time how such a nationalised service could be administered, run, and controlled. It invited constructive criticism, but expressed the wish that such proposals could be made law as soon as possible.

The behaviour of the B.M.A. to the White Paper is worthy of note as it typified the manner in which they were to negotiate the rest of the proceedings. Shortly after the publication of the document the Independent Polling Organisation, acting for the B.M.A., sent out a detailed questionnaire to all members of the B.M.A. The results are shown on Table 2.i, and indicate features of the White Paper supported by the various groups. Whilst the overall percentage of doctors in favour of the service was slightly in the minority (39% to 53%), all voted in favour of health centres and a salaried service within them, a fully comprehensive service, the abolition of the sale of practices and control over the distribution of general practitioners.

The reaction of the B.M.A. was striking. They ignored it. Arguing that the rank and file of the profession did not fully understand the

[1] The administration of the services was to be organised hierarchically, with Local Health Services Councils reporting to the General Health Services Council, who would work alongside, but independently of, the Minister for Health.

Table 2.i

Response to the B.M.A. Questionnaire on the White Paper (in percentages)

Questions	All		Service Doctors		Consultants		G.P.s		Salaried Doctors	
	Pro	Con	Pro	Con	Pro	Con	Pro	Con	Pro	Con
For or against White Paper	39	53	53	41	36	58	31	62	60	33
A 100 per cent service (free, comprehensive)	60	37	73	26	54	44	54	43	74	23
Free and complete hospital service	69	28	79	19	58	40	66	32	84	15
Central administration by Ministry	33	51	45	41	30	47	29	57	49	39
Larger areas for hospital administration	63	24	67	23	64	27	58	26	74	17
'Joint authorities' for hospital administration	13	78	13	81	9	84	11	79	24	69
Remuneration of oonsultants by local authorities	37	40	40	40	50	34	30	41	39	44
Central Medical Board for G.P. services	55	31	62	25	50	31	54	35	64	21
Control over G.P.s' distribution	57	39	68	28	56	38	51	45	71	25
Health Centres	68	24	83	13	67	23	60	32	84	11
Health Centre practitioners under contract to local authorities	31	53	35	50	29	48	23	63	45	30
Salaried service in health centres: full or part	62	29	74	20	73	25	53	38	79	22

Source: Eckstein, H. The English Health Service. Oxford University Press, London, 1959, p. 148.

hidden implications of the document, they continued to negotiate with the Government Minister of Health (Henry Willink) along their policy lines - against a salaried service, for example. According to Forsyth, Willink was agreeable to concede to the 'profession's' wishes, and had circumstances not changed, the majority of doctors may have found themselves working in a service they far from approved of (Forsyth, 1973).

Before the Bill could reach Parliament, however, the 1945 General Election was held and a Labour Government returned. Mr Aneurin Bevan was made Minister of Health, a politician of considerable standing and experience. The success of the Bill in achieving fruition was undoubtedly due in large part to his skill in dealing with the medical profession, and to his style of negotiation, which medical representatives found so impressive. One B.M.A. official of the time suggested why:

> He knew his subject in a very short time. He was extremely efficient. In all my forty years of dealing with Ministers he was the only one who ever argued, never referring to his staff, always having the answer himself. All that really mattered we settled with him. He knew what he wanted and so did we.
>
> (Quoted in Foot, 1975, p. 120)

Foot's account of Bevan's role in the passage of the N.H.S. Bill through to law offers an excellent view of the machinations necessary to introduce such a scheme. Bevan, with all the astuteness of an accomplished negotiator, quickly courted the leading members of the Royal Colleges, the Presidents, who were by their own account, charmed by the man. These three leading men, politicians in their own right, acted as Bevan's allies throughout the negotiations. Bevan also understood the structure of the profession; he played on the split which existed between specialists and general practitioners, and chose the

politically more powerful group to befriend.

The National Health Bill drawn up by the Minister of Health, passed through the two Houses and became law in 1946, all with little apparent discussion at that time. Much remained the same as the White Paper, the major change being that the hospitals were now placed under the ownership of the Minister. Dealings between the B.M.A. and Bevan changed, however, after the Act was passed. The B.M.A. became more vocal in their quarrel with particular aspects of the system, and the situation which ensued has interesting parallels with that of 1911, when doctors were then urged not to join such a service.

It is significant that the debates focussed upon the provisions made for the general practitioner rather than the hospital doctors. This reflects, one might suspect, Bevan's more successful dealings with the hospital specialists. They (the latter group) stood to gain enormously, and to lose little. Private practice was allowed to run concommitant with the service; and a salaried service for hospital staff allowed greater specialisation for the hospital doctor, as well as a cessation of dependence upon the general practitioner for patients. University teaching hospitals were given special concessions and an independent status, and in all specialties less interesting work could be potentially delegated to a junior with no loss of income.

Despite initial resistance to the Act, as in 1911, general practitioners did not hold out their resistance for very long. By the inception of the scheme 90% had joined and months later 97% of family doctors had enrolled, a figure which stabilised thereafter (Stevens, 1966).

Little has been mentioned about the Scottish Act, passed independently

on 21st May 1947. The outcome of the Act was the same for the day-to-day practice of doctors in Scotland, although the organisation and administration of the Scottish Act was moulded in the features peculiar to Scottish characteristics of geography and government and 'certain equally marked characteristics of the Scottish mind and character' (Ross, 1952, p. 336).

Intraprofessional Comparisons

Whilst the introduction of such a scheme of nationalised health care obviously affected every branch of the service, the implications of the scheme for the general practitioners are what is of interest here. In bringing general practitioners into the 'front line' of medical care, the scheme again altered the relationship between hospital doctors and general practitioners. It now seemed that family doctors would be exposed to a greater number of consultations from patients, each of which they were to deal with either themselves, or if necessary, send for specialist treatment in hospital. They themselves were no longer to deal with the patient within the hospital but should use the 'back-up' services of consultant staff. All competition between the two had apparently been removed. Instead, it was imagined that the two streams of medical staff should work in tandem, each complementing the other's task. Administratively, hospital and general medical staff were united for the first time under the State, although each had formed a different bond; hospital staff were now salaried while general practitioners remained independently contracted. This new relationship, intended to act as a unifying force, in fact caused continuing dissatisfaction

amongst the general practitioners. Some of the problems revolved around the difficulty in co-ordinating treatment of patients who required both hospital and general practice services. Much of the debate although ultimately concerned with work conditions and status, initially focussed on payment of general practitioners. As full State involvement with general practice certainly affected their structural situation, it is worth investigating the remuneration question a little more closely.

Prior to the introduction of the N.H.S., payment of the doctor had been largely a private matter between him and the patient. Most general practitioners had received part of their income from panel patients and from friendly societies. However, this comprised only a percentage of their total income, the rest coming from private practice. The result, as the Spens Report on remuneration of general practitioners (1946) made clear, was a wide spread of income within general practice, the most marked being between rural and other areas. How much a general practitioner might earn in a year, then depended upon the area in which he practised, his choice of patients, the manner in which he demanded payment (whether he accepted credit, hired a debt collector, and so on). Certainly no guarantee existed that he should earn a consistent amount over the years, or that if he bought equipment or hired a receptionist, he would find reimbursement from his annual income. The N.H.S. changed the situation by offering an assured income through capitation payment for larger numbers of patients but still no guarantee of a fixed yearly income. General practice now compared less well with the newly salaried hospital specialties, which began to attract more graduates away from general practice. This point was emphasised in the Spens Report when they described the necessity to raise the average income of the general

practitioner if the profession wished to continue to maintain recruitment and status. They well predicted the situation to arise when they wrote:

> We consider, however, that unless the financial expectations in general practice are substantially improved the great majority of abler men will seek to become specialists, in view of the fact that as specialists they have an equal outlet for their interests in medicine, can more easily keep close contact with hospitals and with medical progress and will have a less arduous life.
> (Spens Report, 1946, p. 5)

The change from a private to the more public nature of the payment for medical care meant, as the Government pointed out at the time, the increasing State involvement in such matters. Even more than in 1911, the State now played a central role in negotiations over what was now a nationalised concern. The Spens Reports (a second came out in 1948 relating to the remuneration of the hospital sector) are in themselves indicative of such involvement, for they were the first Government Committees to look into and report on the income of the medical profession. Henceforth, issues about pay would be dealt with by a Review Body, or on occasion, a Royal Commission. The profession, too, would have to take stock of the situation; if income levels were to be raised, they would have to negotiate accordingly through their union, the B.M.A. Although doctors traditionally eschew the rhetoric of industrial bargaining, it is interesting to see their action henceforth became increasingly phrased in the language of industrial relations.

Such Commissions or public reviews were also to involve the comparison of salaries between the professions (for example, the Pilkington Report, 1959) or within the profession (for example, the Dankwerts Award, 1951). This latter comparison leads on to a third and

related point about the income of general practitioners, one which proved a central element of future discontent. Within the N.H.S. system two frameworks now existed, two distinct career structures which overlapped only at the undergraduate level. For the first time direct comparisons could be made about the work, the conditions of work and the relative income of the two groups. General practice did not emerge well from such a comparison. Summarising the two Spens Reports, Stevens notes that 'Figures in the Spens Reports indicate the consultant might expect to earn almost twice as much as a general practitioner. They recommended a median net income (after practice expenses) for a general practitioner aged forty to fifty years of £1,300: a whole-time specialist was to receive a salary of at least £2,500 at about age forty' (Stevens, 1966, p. 128-129).

Why was salary so important? In any situation where the nature of work can be compared, salary becomes one measure of the social worth of that occupational group. It becomes a key criterion through which society can express the value it attaches to certain types of work. Regardless of the fact that overall, doctors' salaries were high compared with other professionals, general practitioners felt that their social worth was being undervalued against hospital doctors - especially since the N.H.S. placed such emphasis on the central role they were to play in safeguarding the nation's health. Matters of remuneration and work conditions recur in disputes of the late 'fifties and 'sixties.

Medical Education - the End of the 'Safe General Practitioners'?

Although the question of medical representation has been considered mainly from the viewpoint of general practice during the 'forties it also became a domain question for many of the minor specialties in medicine. Negotiations for the N.H.S. had brought home to many the weakness of their position within the Royal Colleges. It was noticeable that the older and more prestigious branches of medicine and surgery (for example, orthopaedics, urology or plastic surgery), had drawn a large share of the committee men from their ranks, and were not dissatisfied with their position. But others were not content to accept the situation, for, as Stevens explains, the meaning of specialties as social groups was subtly changing.

> Specialties were no longer merely indications of scientific interest, marked by attachment to a special hospital and attendance at after-dinner discussion clubs or the appropriate section of the Royal Society of Medicine. They had become professionalised groups, each conscious of its own particular needs; inclusion of their subject in the undergraduate curriculum, raised standards of training (and simultaneously the status of the specialty) and representation on appropriate administrative and professional bodies.
> (Stevens, 1966, p. 50)

Dissatisfaction now led to action, which manifested itself through the 'generalist' / 'specialist' debate. In the 'forties and onwards, a strain existed between these two groups, the latter pushing for greater representation within medicine, on the College councils, for example. Between the years 1944 and 1946 Societies of ophthalmologists, otolaryngologists, radiologists, anaesthetists, dental surgeons and obstetricians all requested representation on the Council of the Royal College of Surgeons, a request granted in each case. Some groups also

formed semi-autonomous faculties within the College, with their own (post-graduate) fellowship examination, geared not to general surgery but to their own specialty. The only specialty to make a complete break from medicine, however, was pathology, which in 1962 founded its own College after a long 'by no means harmonious' campaign.

How did specialisation affect the curriculum? Two reports which came out in the 'forties, the influential Goodenough Report (Goodenough Report, 1944), and the B.M.A.'s own report on medical education, in 1948 (B.M.A., 1948) reflect the then current debate. Regarding post-graduate education (the focus of the specialist/generalist debate), Goodenough placed conflicting demands on the Colleges. They were pressed firstly to maintain their general approach in training and examinations, while at the same time to incorporate the demands of specialist education into their remit.

But specialists were also seeking representation on the undergraduate curriculum, a move which the generalist argued distorted the student's clinical experience by emphasising the rare and difficult cases, at the expense of gaining breadth and variety of knowledge. Further it was claimed that the introduction of these subjects would erode the apprenticeship system. Because of the increasing complexity of techniques used by specialists, the student was cast into the role of passive observer, learning didactically, and uncritically the theory of the specialties (Ellis, 1956). This trend was sanctioned severely by both Reports as the following example indicates:

> It has, however, steadily kept before it the view that the aim of medical education is not to impart to the student a mass of factual information in each branch of medicine, but to equip him with sound basic principles, including the scientific outlook and method, a knowledge of the fundamentals of medical sciences. . . The

> pressure of interested specialist groups to include more and more of their branches in the curriculum must be resisted, for there is a limit to the burden which a student can be expected to sustain in any formal educational programme.
>
> (B.M.A., 1948, para. 19)

One way of diverting the curriculum from overspecialisation was to concentrate more extensively upon the training of the general practitioner, a move in keeping with the change imminent in the health service. The curriculum, reasoned Goodenough, should now show a definite bias towards future needs of the general practitioner. Medical developments like the successful drug treatment of acute illnesses, better surgery, the lowering of infant mortality and achievements with preventive medicine all resulted in the general practitioner dealing with an increasing range of chronic diseases, and conditions of old age. The curriculum should reflect these changes, and acknowledge the importance of psychological and social factors in diagnosis and treatment. Thus social medicine, paediatrics and psychology were all given special mention in the Report, and the orientation of the teaching encouraged towards the environment, or community, rather than being purely hospital centred. It was suggested that the teaching of social medicine should be carried out through lectures, with additional practical visits with supervision from general practitioners, almoners or social workers.[1] However, there was no suggestion that general practitioners should gain university teaching posts. Instead, Goodenough recommended that someone involved in social medicine, or a

[1] It is worth noting that Goodenough has linked, as branches of medicine concerned with 'the community', social medicine and general practice. This link subsequently proved important, although problematic.

'well-trained young physician' with an interest in a relevant subject would be most appropriate.

The Goodenough Report also suggested that the days were over when a basic undergraduate education would produce the 'safe general practitioner'. This proposal was elaborated upon in the B.M.A.'s report in 1950 on 'General Practice and the Training of the General Practitioner' (B.M.A., 1950). Here one finds explicitly stated the idea that the general practitioner has a special set of skills and expertise to learn for practice in that branch of medicine - and that a good general undergraduate training is insufficient. The assumption was made that the undergraduate curriculum should become non-vocational, that it should continue to offer a good general medical education, and that all students should seek specialist, vocational training in post-graduate years. The B.M.A.'s report may be seen as a landmark in general practice history, for its implications were that general practice was indeed a specialty.

> The discussion in the previous chapters has led to a view of general practice as a special branch of medicine with its own approach to health and disease, using its own methods and techniques, and requiring in the practitioner particular qualities of outlook and temperament.
>
> (B.M.A., 1950, p. 85)

They elaborated a three year training scheme of post-graduate education for those wishing to take up a career in general practice. It was based upon a mixture of apprenticeship and training through short-term hospital appointments in different subjects, although no examination was planned for the end of the training. This scheme signified the beginning of post-graduate education in general practice, because from it blossomed the three year vocational training scheme

made compulsory by the Vocational Training N.H.S. Act 1977.

The Report, then, had powerful implications for both the standing of general practice, and also for the internal balance of the undergraduate and post-graduate curriculum. At the time, however, the notion of general practice having special skills (and therefore requiring students to undertake 'speciality' training) met with severe criticisms, and was not implemented, although a voluntary one year 'trainee practitioner' scheme came into being (essentially a one year apprenticeship). When compared to the hospital specialties, general practice was seen as a branch of medicine whose light had dimmed. The 'fifties brought little encouragement.

1950 - The Decreasing Status of the General Practitioner

To some still practising today, the nineteen fifties may be remembered as a bleak time in general practice history, a time of wavering fortunes, of emigration and of pay disputes. To others it may seem memorable, but for other reasons, a time of criticism, self-reflection, but also of new ideas and new projects, which came to have considerable influence on the future direction of general practice. It is the latter view which is taken here.

First, the criticism, which arrived unasked for, and unwanted in 1950. It appeared in the Lancet in the form of an evaluation of general practice, the result of some research carried out by an Australian doctor, Joseph Collings (Collings, 1950). It is, by his own admission, 'indeed a condemnation of general practice in its present form' (Collings, 1950, p. 555). The 'Collings Report' as it became

known, ignited general practitioners into a blaze of resentment, anger, and most important, action.

Collings studied a number of practices throughout Britain, sitting in with doctors, listening, watching and evaluating their work, their methods, their approach. He divided practices into three types, industrial, rural and urban-residential. The first category was by his reckoning run on an appalling standard, little removed in its attitude from practice fifty years previously. Emphasising this point by first offering Flexner's account of general practice in the late eighteen hundreds as primitive, unhygienic and superficial, Collings notes that 'Flexner's description of medical practice in the last decades of the nineteenth century is almost a perfect word picture of general practice as I found it in the industrial areas of England in 1949' (Collings, 1950, p. 558). Rural practice was described as superior in its quality while urban-residential surgeries varied considerably between areas and practices.

The research was carried out too quickly after the introduction of the N.H.S. to appreciate what would be the long term effects of such a reorganisation. Collings merely mentioned that through various expressed opinions it seemed that the increased work load feared by doctors had not come about, although the demand rose for minor medical appliances, spectacles and so on. However, doctors had already begun to appreciate some of the difficulties which their new situation would bring. Bringing the general practitioner into the front-line meant that he could no longer work with the 'back-up' team. Collings summarised what was still to be contentious twenty years later: 'it further implies the employment of many junior specialists, <u>often with no experience of general practice</u>; and it closes the already half-shut

door on the general practitioner's chances of entrance into the realm of the specialist' (Collings, 1950, p. 570, emphasis added). The understanding of each other's situation, which previously existed between hospital doctor and general practitioner, had gone, as new entrants knew nothing of the work of the other.

It is interesting to note Collings' comments about Scottish general practice. Although some of the rural practices were seen as bad as poor English practices, Collings was clearly impressed by the conditions in Scotland, and describes what he felt was to be a basic difference in attitude of Scottish doctors. 'In Scotland I found much more spontaneous interest in professional issues such as the quality of medical service, the relation of general practice to hospital and specialist services, and the development of health centres' (Collings, 1950, p. 579). In his view, specialist and general practitioner had formed a better relationship, the former being noticeably more respectful and sympathetic to the latter. He reported (although gave no explanation for the fact) that he thought general practitioners worked more conscientiously, examined their patients more often and resorted less to prescribing 'tonics'.

Although the Collings Report is lengthy, detailed and with an appearance of 'thoroughness' his evaluations are largely impressionistic, relying on opinion of the privately sampled doctors. Indeed, one of the main criticisms of the Report was that Collings had not sampled his practices at random, but merely studied 'the unsatisfactory quarter, which Dr Collings equated with the whole' (Taylor, 1954). Nevertheless, regardless of its defects or merits as an academic piece of work, its impact on general practice cannot be ignored. It provoked two kinds of reactions. The first, essentially a denial of the validity of the work,

lead to a series of researches into general practice, often using the technique of Collings. Hadfield's study, published in 1953, (Hadfield, 1953) and Taylor's work on 'good general practice' in 1954, (Taylor, 1954) are two of the more well known studies. While each acknowledge their debt to Collings as 'the most potent single stimulus', their findings often directly refuted his, revealing perhaps a quarter of general practice which Collings missed.

The second reaction to the report was to implicitly accept Collings criticisms, and look for ways of improving the lot of the practitioner. Thus his report contributed to the renewed interest in the idea of a College for general practitioners. After a hundred years of silence on the matter, there had again been talk in the late 'forties of founding such a body, talk which became more optimistic with the founding of the American Academy of General Practice in 1947. Negotiations for the N.H.S., together with a tightening of post-graduate training within the Royal Colleges of Surgeons and Physicians, had revealed general practitioners as politically ineffective and academically isolated. They had little representation in any field, and still little joint 'identity'. A College, it was reasoned, would provide the means to put forward the case for the practitioners in political and academic circles, as well as providing the focus for a stronger and more cohesive group. The College was founded, and later played an important role in stimulating undergraduate teaching in the subject. At present, its founding and intentions of the practitioners will be briefly dealt with.

At the time that specialisation in branches of hospital medicine was occurring, there was mention made of a College for general practitioners, and the title 'Royal College of General Practitioners'

was occasionally used gratuitously in letters to medical journals. Interest became more intense, however, after the unsatisfactory negotiations for the N.H.S., and the publication of the Collings Report, factors which were seen as symptomatic of the falling standards of general practice.

In June 1951 a resolution was passed at the Annual General Meeting of the Medical Practitioners' Union urging the development of a 'College of General Practice'. Later that year the fortuitous meeting of two doctors willing to take the initiative led to the publication of a letter in both the Lancet and the British Medical Journal (B.M.J.) on October 13, 1951:

> There is a College of Physicians, a College of Surgeons, a College of Obstetricians and Gynaecologists, a College of Nursing, a College of Midwives, and a College of Veterinary Surgeons, all of them Royal Colleges . . . but there is no College or Academic Body to represent primarily the interests of the largest group of medical personnel in this country - the 20,000 general practitioners. Many practitioners sadly felt the lack of such a body when negotiations about the National Health Service were taking place.
>
> (Rose and Hunt, 1951, p. 908)

The letter concludes by requesting comments and suggestions to help this proposal, and signed by two general practitioners, Fraser Rose and John Hunt. A beguiling account of the ensuing battle between the antagonistic Royal Colleges (of medicine) and the small group of general practitioners is given by Sir John Hunt, one of the two authors of the original letter, speaking eleven years after the event (Hunt, 1973). Drawing from both personal memories and relevant documentation, he describes the ire of the Royal Colleges (the 'Giants', as he calls them), who wasted no words with his opinion of such a venture. Sir Russell Brain wrote to him:

Dear Hunt,

> In view of our talk and your recent letter in The Lancet I think I ought to make it quite plain that this College, and I am sure I can speak for the other two Colleges as well, would not be able to support in any way an organisation which aimed at establishing another college or which it seemed to us might seek to do so at some future date . . .
> (quoted by Hunt, 1973 pp. 10-11)

Brain's suggestion was to deal with general practice as he had with potential divisions within the College of Physicians. The Three Royal Colleges, he wrote, would view most sympathetically the establishment of a Joint Faculty of General Practice (which would remain under the aegis of the Royal College).

Dismissing this possibility, a Steering Committee of general practitioners was formed, chaired by Henry Willink. With some encouragement from various sources, and good legal advice, the Committee found that it was not illegal to form an unincorporated association which could call itself a College. This they did, and the College was officially founded on 19th November 1952, with the first report and public acknowledgement of the Steering Committee's activities published one month later (C.G.P., 1952).

Support and donations immediately came in. Applications for founder membership (every general practitioner in Britain was initially invited to join) showed considerable interest in the project, with 1,655 members by 1st January 1953 to rise to 6,200 members and associates a decade later (1970 figures still fairly similar).

The Steering Committee's report reflects the hope and optimism of the founder members for general practice; they wished that 'the founding of such a body will do much to help general practice in the immediate future and during the next twenty years or so; and it will pave the way

for their satisfactory representation in a British Academy of Medicine if, and when, this is formed' (C.G.P., 1952, p. 1321).

The aims of the College were set out as primarily educational (both post-graduate and undergraduate). Other functions included the encouragement of research in the field, and an improvement of material conditions of practice. The hopes of the founding members were spelled out with frankness:

status

> By its very existence a college will raise the status and enhance the prestige of the general practitioner amongst medical students, specialists, and the public (C.G.P., 1952, p. 1325)

Undoubtedly the College has done much to enhance the field of general practice, although twenty years later it still had a minority membership and has continued to be viewed by some doctors (within and outside general practice) with scepticism. The immediate hope of the founder members was certainly not fulfilled during that decade. Lord Moran's annihilating remarks uttered at the end of the 'fifties exemplified the gulf in status which still existed between the specialist and the general practitioner.[1] When asked if he agreed with the view that the two branches of the profession, general practice and consultancy, were not junior and senior but level, he replied 'I say emphatically, no'. He elaborated his opinion by describing the ladder of achievement which he said as existing in medicine:

[1] A new entrant to general practice illustrates this gulf; at the time he wrote 'Right away I had the feeling of being on the other side of a barrier - the barrier separating "The Doctors" from "The Specialists"' (Alexander, 1956, p. 200).

> All of the people of outstanding merit, with few exceptions, aimed to get on the staff (of the hospital). There was no other aim, and it was a ladder off which some of them fell. How can you say that the people who get to the top of the ladder are the same as the people who fall off it? It seems to me so ludicrous.
> (Minutes of Evidence, 1958, p. 1030)

Whilst these may be regarded as extremist views, Moran was a most influential man, moving from one powerful position to another. His perception of the profession could find political reality where others could not.

There were other indications that general practice failed to improve its standing, and maintain its 'market value'. Government spending on general medical services fell compared to other services. Whilst never at any time equal to spending on hospital services, the proportional figure decreased steadily whilst hospital spending rose. To put it in real terms, in 1949 expenditure on general medical services was £65 millions: by 1966 it had doubled to £108 millions. But, as a proportion of the total N.H.S. Bill, these figures represent a fall from 12.5% in 1949 to 7% in 1966 (O.H.E., 1974). Thus although the share of the national income absorbed by the general medical services appeared to rise, in real money terms and of particular importance, in comparison to the hospital services, they received a decreasing share.

Late 'Fifties - More Pay Disputes

The initial fear of the doctors, however, was not realised at the time of the introduction of the N.H.S. List sizes did not expand enormously, largely because until 1958 the number of doctors entering the service was increasing at a rate which more than kept pace with the growth in numbers of patients. Thereafter the actual number of doctors began to fall, the population continued to rise, and list sizes did grow. Only in the 'sixties, then, did doctors begin to meet the volume of work they had predicted would be theirs at the beginning of the service. Matters were made worse by the fact that they argued that their work gave little satisfaction.

The final decades of general practice history must take in the lengthy disputes over remuneration which began soon after the introduction of the N.H.S. and lasted, intermittently, for fifteen years. The debates are complex, with many dimensions to them. To begin with, because of the relationship which general practitioners now held with the Government, each debate was conducted in a public form. Decisions made were influenced not only by the profession and the Ministry, but by the media, the public, and the interaction between these and the Government in power. In the last phase of the debate, for example, doctors actually sent undated resignations to their union.[1]

These pay disputes originated over the question of capitation

[1] Marmor and Thomas argue (in a critique of Eckstein's model of medical negotiations) that at this time the Government was never worried that mass resignation would come about, but rather that the country as a whole would be faced with a crisis of medical supply which would reflect badly on a government which held only a bare majority (Marmor and Thomas, 1972).

payment, that is, the unit of payment, but later involved a wider range of grievances related to the bases of differentiating doctors' payments (which in turn had implications for the type of work general practitioners carried out). Capitation was initially related to the number of general practitioners serving the total population - a system of inbuilt competition for doctors, as the greater the number of general practitioners the smaller would be their average income from capitation. Doctors were more interested in tying the size of the central 'pool'[1] to the number of doctors in the service - a more 'expensive' method from the view point of the Ministry of Health. Deadlock was reached, and the question of payment submitted to arbitration in 1951 by Mr Justice Dankwerts.

The subsequent proposals from the Dankwerts Committee were accepted by the Government in 1952. The total pool should be dependent upon a nationally agreed income for the 'average' doctor (and thus the size of the pool should increase as the number of doctors rose). Payment to general practitioners was doubled - an approved post-war translation of their earlier income, but total income was now to be derived not only from capitation but (often largely) from outside sources (for example maternity work, local authority work). This meant that the difference between the average income of the general practitioners and the consultant decreased, but that the general practitioner gained proportionately less

[1] The Pool was computed from a capitation rate of £X a year multiplied by 95% of the population of Great Britain. From that was drawn first mileage allowances, then the fixed annual payment of £300 to those entitled (usually doctors beginning practice). The remainder was then paid to doctors according to the numbers on their lists. The Pool system was never seen as very satisfactory and was abolished, although capitation remained.

from his work as a general medical practitioner and more for peripheral work.

The final stages of this series of disputes was still to come. The focus was firstly on differentiation between general practitioner and consultant, and second, between practitioners of differing ages and experience. The dispute ended in an undoubted victory for the general practitioner, and most important for this thesis, resulted in a significant redefinition of the nature of general practice and the constituents of the work of doctors in that branch of medicine.

The catalyst to this latter struggle, was a further Review Body award of 1963, wherein a 14% pay rise was granted to all doctors in the N.H.S. When details were sorted out through the Pool system, more general practitioners received less than 14%, often not more than 5%, a trivial increase for work which as seen by general practitioners was becoming unsatisfying, with lengthening lists and growing administrative burdens (Forsyth, 1973). This situation, which the Review Body appeared to condone, looked like worsening, for fewer doctors were entering general practice, and the 'boom' in scientific advances made hospital medicine appear more attractive and worthy of State finance. Discussion between the practitioners' representative committee of the B.M.A., the General Medical Services Committee (G.M.S.C.), and various consultant Committees led eventually to agreement that general practitioners might warrent special consideration in this instance. On 13th February 1965, the subsequent Review Body Award was published.

The report stated that it saw the issue as one of status differences between hospital doctor and the general practitioner but implicitly condoned the situation by advising an award which in no way reduced this disparity. It did not consider the practitioner's work had become more

complex and would not award money on those grounds. The £5.5 million which it did feel justified in giving was offered because general practitioners were decreasing in number having to deal with an increasing work load. The money was given, however, with the proviso that most of it must go towards a partial reimbursement scheme for practice expenses. The Review Body agreed that some outside work should not be included in Pool calculations, such as local authority and hospital work, but defined maternity work and eyesight testing as part of the general medical services. The report rejected payments for seniority on the grounds that the general practitioner's relationship with the Government was 'contractual rather than professional salaried' but suggested instead that a small sum should be set aside for merit awards.

Reaction to the award was strong. The Lancet, typically a journal of the consultants, offered very different views from their general practitioner/colleagues. In their leader the week of the Review Body report, they supported the award suggesting that it had 'taken the first steps towards reducing some of the worst anomalies in the method of remuneration', and adding that the general practitioner should be 'grateful'. The Times (9th February 1965) also gave support through both its leader and various letters published. The recommendations, it said, 'if looked at temperately, are sound' and would reward good and enthusiastic medicine. The letters in the correspondence column tended to emphasise the difficulties of the general practitioner, both in their duties and through lack of pay: 'No other profession or trade is called upon to make a comparable number of important decisions every day and for a comparable fee per item of service' (Lancet, 13th February 1965), and 'In a specialist and treatment-conscious world . . . not only is he

overburdened with dull chores of certificate and prescription signing, he is also often divorced from taking his place as of right in the work of the hospitals and their specialists of all kinds' (Lancet, 14th February 1965). Many letters, however, did not support the resignation but involved constructive criticism, giving alternatives of how they might organise their work, giving their own personal re-definition to the situation.

By the beginning of March the B.M.A. had received 17,000 resignations, and was thus assured of the support of the majority of general practitioners. An alternative contract was drawn up by four members of the G.M.S. Committee, but using the vast numbers of reports which the profession had received from practitioners at all levels in the hierarchy. The opinions and criticisms of all general practitioners then was meant to be represented in the 'Charter for the Family Doctor Service' which was published on 9th March (B.M.J., 1965). The Charter did what previous reports had failed to do, and that is to offer a completely new definition of General Practice. The Pool system was no more, and the pay structure was more closely related to the amount and type of work each general practitioner carried out - although capitation was maintained. The amount of administration was cut down by, for example, reducing the amount of certification the general practitioner should be liable for. General practitioners were offered a 'mini-hospital situation' allowing Government money for auxiliary staff, nurses, secretaries and so on, and it was also suggested that money for practice equipment should be reimbursed. The personal service of the general practitioner was emphasised, and the experience of the general practitioner as a family doctor who offered a very special one-to-one relationship over time, was central to the Charter. 'If General

Practice is to stay a worthwhile branch of medicine it must enable doctors to use their skills to the best advantage of their patients. It must also ensure that their energies are not wasted on work that can be done by others' (B.M.J., 1965). Further, the general practitioner was encouraged to continue his training through attendance at refresher courses and vocational training. To maintain his independence, the Charter writers suggested that an independent financial corporation should be set up to deal with money lending for surgeries, equipment, etc.

The Charter was offered to the Government as an alternative contract for general practice. With the B.M.G. holding now over 17,000 undated resignations, the Minister of Health reported back to the G.M.S. Committee within a fortnight that he would accept the Charter in principle, although he wanted to negotiate each suggestion separately. Thus began another series of negotiations which were finally completed in 1966. This 1966 Review Body again concerned the payment of the general practitioner, and there were marked departures from the original charter (for example concerning the responsibility for providing full-time coverage of services, which were returned to the profession). This seventh report of 1966 decreased the gap between consultant and general practitioner's pay - offering the former group a 10% pay rise while seeking to increase the income level of general practitioners by one third (Forsyth, 1973). The award became fully operational only from April 1967.

It was only by manoeuvering themselves into a politically dominant position that general practitioners were able to redefine general practice so as to make ideology and practice more congruent. Once in this position general practitioners were able to attack the assumption,

imposed by others, that they were an inferior breed of clinician. Educationally, too, their position was stronger by the end of the nineteen sixties.

General Practice in the Medical Curriculum

Since 1935 general practice had appeared in the curriculum of a few university medical schools. St Mary's in London claims the first formal teaching, with a series of lectures starting in 1935 (Barber, 1952). More usually, teaching undergraduates general practice took place on an *ad hoc* basis; students were attached to a general practitioner for a short period, during which they accompanied the doctor on his rounds, and sat in on a number of surgeries. As such, the arrangement was informal, unstructured and voluntary, and regarded as a marginal addition to the student's education.

The circumstances leading up to the creation of the first department and chair in general practice in the United Kingdom are dealt with in a later chapter. At present it is sufficient to record that in 1957 an important precedent was set. The teaching unit in general practice in Edinburgh, one of the few units of its kind, was converted into a general practice department of the university medical school and the course for undergraduate medical students made compulsory. Five years later the former director of the unit was appointed to hold the first chair in general practice in the United Kingdom, and indeed, the first in Europe. General practice had become truly institutionalised.

The future of academic general practice was further assured by

the publication of the Royal Commission on Medical Education, the 'Todd Report' (1968). The Report was wider ranging, tackling issues extending from a review of current student intake to advising on the centralising of undergraduate teaching in urban hospitals. One of the major curriculum proposals was that the G.M.C. recommendations of 1967 should be followed by abandoning wholly the 'safe general practitioner' concept and introducing instead two tier education for all branches of medicine. The Report, of course, could be seen as merely responding to ideas which had been proposed by various groups for at least twenty years. General practitioners themselves had continued to argue for changes outlined in the BMA document of 1950. The three year post-graduate training scheme was still seen to be viable, and indeed necessary, for those wishing to enter the field, while evidence to the Royal Commission from the College of General Practitioners contained a principle which they wished to have accepted, that 'general practice . . . [has] its own clinical and logistic problems that require to be evaluated and taught' (College of General Practitioners, 1966b, p. 17). The seriousness with which these ideas were taken can be judged from those paragraphs within the Report which concern undergraduate general practice. Here the subject was listed in the clinical years along with hospital specialties. Perhaps the thinking of the Commission on the subject can be gained from quoting one statement:

> The undergraduate medical student should, in our view, learn about general practice not as a preliminary training for a career in that field but as an educational experience whose purpose is to give every student some understanding of problems which are of major importance in themselves and should not be thought of as variants or minor subdivisions of the problems raised in hospital practice.
>
> (Todd Report, 1968, para. 278)

One might be justified in pausing here to reflect on the radical nature of such a statement.[1] The Commission argues strongly for specialty status to be granted to general practice, the key argument being that its inclusion within the undergraduate curriculum is justified because it has certain skills which will be of benefit to all students.

Interestingly, there was little discussion of the implications of this part of the Todd Report in any of the major journals, although the practical problem of how every student should receive tuition in general practice did not escape the attention of at least some doctors already involved in teaching (B.M.J., 1968).

The Todd Report remains the most recent major statement on medical education. In general practice, as in other areas, its recommendations are still to be implemented in some medical schools. Departments of general practice are now found in a number of British universities. Scotland quickly gained three by 1970 although it was not until 1972 that England gained its first. However, the attraction of 'senior academic appointments' in general practice departments, seen by Todd as appropriate for the teaching, remains elusive to many doctors, while the recommendation that the subject is unsuited to formal lectures, has generally been followed. Departments are still experimenting with syllabi and, as future chapters will reveal, the subject is still easing itself into the academic mould. Nevertheless, general practitioners now have representation in many universities, a place on the university faculty and often a department to back them. From such a position

[1] These ideas are certainly radical to current medical education but one wonders to what extent they were implicitly incorporated into the thinking of practitioners pre N.H.S., where many doctors were likely to experience both hospital work and general practice.

within the university system it is easier to argue for more resources and teaching time. The subject has received formal acknowledgement as a university discipline. Whilst informal acceptance may take longer, one may not question the considerable achievement of general practitioners to reach their present situation.

This chapter has described the development of general practice until contemporary times, and in so doing, has introduced the reader to the empirical substance of the thesis. Later chapters will focus specifically upon present day general practice work, and the development of the academic departments within the university. The overall purpose of this chapter was to inform the reader of changes which proved influential in shaping the current situation, and at another level, to underline a number of themes, identified theoretically in the previous chapter, to be explored throughout the remainder of the thesis.

Thus the chapter reflected the repeated debates over the boundaries of general practice, and the role of the general practitioner. The Apothecaries Act was the first cited instance where the predecessors of general practitioners were concerned to protect their work, and in that case, were moved to take legislative action to resolve the issue. But this chapter also provides an excellent illustration of the transience of professional (or indeed intra-professional) boundaries, and although the role of the general practitioner has undergone a number of changes it remains a controversial topic.

One other important theme raised in this chapter in the first of a number of instances, is the relationship between medical practice and medical education. The fragmentation of general medicine and general surgery was directly reflected in the curriculum, which multiplied in the number of subjects it included at each of the periods of growth.

A later chapter will review both the literature on specialisation and the factors associated with specialisation; throughout the thesis, too, this theme will be pursued specifically in relation to general practice, where the beliefs and ideas of service general practitioners about their work are seen to articulate with, and influence those of the academic segment.

Finally, an important feature of this chapter is the identification and impact of the scientific model on medical thinking and medical education. The increasing gulf between hospital-based medicine and community-based medicine - notably general practice - which this paradigm shift brought about is clearly shown in the legislation of this century. General practitioners continue to reflect considerable ambivalence towards the scientific model, and this ambivalence is illustrated in the bifurcation of ideologies which exist in current general practice, and in the academics' attitude towards the model of teaching associated with hospital medicine.

The chapter which follows introduces present day general practice. It begins with a review of specialisation at a general level, and then explores the particular and problematic instances of the specialisation of general practice.

Chapter Three

GENERAL PRACTICE WORK AND ORIENTATIONS

Introduction

The previous, historical chapter cited evidence to suggest that in official reports general practice was increasingly becoming considered a specialty. This is correct. Such a statement, however, fails to reveal the heart of the debate, which was over the characteristics of the 'specialty' of general practice.

The chapter explores the issues concerning the claim of general practitioners to specialty status. It briefly documents official views on the matters, and in more detail, analyses service general practitioners' views over what is special, or characteristic about general practice. The chapter concludes with a discussion of two orientations to general practice, two distinct perspectives, each of which offers a different justification for general practice being considered a specialty. Later in the thesis it will be argued that courses from the four Scottish departments show a marked similarity to one or other of these two perspectives.

Specialisation

How does specialisation within a profession occur, and when? Although histories of a discipline are available in the literature, particularly referring to the natural sciences (for example, Coleman, 1979; Hodgkin, Huxley, Feldberg, Rushton, Gregory, McCance, 1979), it is difficult to find any theoretical discussion of the processes involved.

Bucher and Strauss, whose arguments in 'Professions in Process' are directed towards a consideration of internal professional developments, disregard the actual stages or processes through which a subject may pass to become considered a specialty. They maintain that their interest is with 'segments' of professions, which should not be equated with specialties; 'Specialties might be thought of as major segments, except that a close look at a specialty betrays its claim to unity, revealing that specialties, too, usually contain segments, and, if they ever did have common definitions along all lines of professional identity, it was probably at a very special, and early, period, in their development' (Bucher and Strauss, 1961, p. 326). Later in the paper, however, they argue that the goal of segments is to develop into specialties so it is not unreasonable to look to them for some more detailed statements concerning specialty development. Bucher and Strauss merely identify segments and specialties through a consideration of a number of values held by the members - these include a sense of mission, work activities, methodology and techniques, clients, colleagueship, interests and associations, but the authors make no claims for the exclusiveness of the list. While a careful reading of their paper reveals little

about how a segment should develop, in essence the authors are suggesting that in order to isolate and study segments and specialties, one should delineate the boundaries of group membership. Thus one would seek out issues which would unite or divide apparently homogenous groups, and debates which would firmly locate an actor within or outside the membership.

The important concept above is that of boundaries. Transferring it to a 'knowledge' perspective, to begin to understand specialties one should seek out the boundaries of a subject, the characteristics which distinguish it from others as a specialty. Successful specialisation may then be understood as a claim to particular knowledge and expertise which has been accepted by other members of the profession. Following from that, the development of a specialty can be understood by studying the manner in which a group attempts to lay claim to a particular territory, or an area of expertise. An important consideration of this 'institutionalisation of territory' is that the claim should present a world view, a complete perspective with which to view the world (cf. Berger and Luckman, 1971).

The acceptance of a claim, often in the face of competition from rival segments or subgroups can be charted through a number of procedures; the establishment of a Society or Association, the setting up of entry qualifications, and the creation of a university department for recruitment purposes are commonly regarded as public forms of legitimation (Bucher and Strauss, 1961; Stevens, 1966). The significant role of the university in this process has been noted by Jackson, who outlines the benefits of placing the training within a university:

> The setting of the training process within the environment of an academic community with primary concerns in the dispassionate profession of knowledge itself serves to extend the range of legitimation, to add lustre and supra-authority to the ideals of detachment, public rather than self-interest, service to an ideal and an ethic.
> (Jackson, 1970b, pp. 4-5)

The fragmentation of medicine and surgery into specialties has attracted attention from writers of varied disciplines and schools of thought, (for example, Rosen, 1944; Stevens, 1966; Daniels, 1972; Armstrong, 1979a, 1979b). In their respective studies, typically although not always of one discipline, a variety of explanations are proposed (or implied) as to how or why specialisation took place. The variation in approach can be better understood by briefly examining two different studies.

Historical accounts of specialisation are characteristically rich in detail and dates, but thin on analysis. Stevens' work, Medical Practice in Modern England, while being immensely useful as a description of change in the organisation of medical services and the overall structure of the profession, does not attempt any theoretical analysis of the processes involved in specialisation. One is left to refine her theoretical approach from diffuse statements throughout the text. Early on she discusses the division of subjects which occurred in the first half of the twentieth century.

> Medical practice between the two world wars reflected the struggle between the Royal Colleges which wanted to retain medicine as a unified whole, with the emerging groups which wanted to raise standards in their own special fields and to advance their own status. Many specialties were gradually evolving from a peripheral interest in a particular sphere of general medicine or general surgery to bodies of knowledge in their own right.
> (Stevens, 1966, p. 38)

and more explicitly:

> In general, a specialty was born when practitioners interested in that field formed a specialist hospital or society, consolidated by the foundation of a specialist section of the Royal Soceity of Medicine and the B.M.A.; and academic respectability was added when a university chair was named.
> (Stevens, 1966, p. 39)

In the above quotation, Stevens proposes personal interest as a significant force behind specialty development; this is fairly typical of her account which leans heavily upon the 'great man' explanation of causality, although she does refer at times to political and economic factors - for instance she mentions the role of politicians in helping to establish obstetrics as a specialty. But the issue of specialisation is, on the whole, dealt with in an uncritical fashion.

An altogether different analysis of medical specialisation is Armstrong's, although his final analysis is still to be completed (Armstrong, personal communication, 1979). In contrast to the personalised, or 'great man' theories of specialisation proposed by Stevens and others, Armstrong instead focused upon the knowledge base of the specialties, drawing inspiration from Kuhn's work on scientific revolutions (Kuhn, 1974). In one of his case histories, entitled 'The Emancipation of Biographical Medicine', Armstrong studied the relationship between general practice and hospital medical knowledge. He argued that general practitioners challenged the dominant paradigm of medical nosology by introducing a new system of criteria with which to categorise illness - Armstrong called this the 'biographical approach' (Armstrong, 1979a). He suggested that as with any paradigm

shift a change of power within the occupational group took place, which in this instance, resulted in general practitioners gaining more professional control. But just as Kuhn identified the technical break-down as the core of the crisis, with external factors (political or economic, for example) as of secondary importance (Kuhn, 1974, p. 69), so too does Armstrong propose that only through an understanding of medical knowledge can the process of specialty change and control be understood.

Without offering a detailed criticism of specialty studies, it was felt that none were wholly successful in outlining and articulating the process of specialisation, largely because they regarded the overall process as unproblematic. One further study will be introduced at this point, since it underlines the weakness of a number of the studies in this field. In a recent paper, 'Boundary Encroachment: pharmacists in the clinical setting', Eaton and Webb explicitly confront the question of why specialisation is only successful in certain instances (Eaton and Webb, 1979). The paper uses as a case study pharmacy, an occupation outside, yet concerned with, medicine. Eaton and Webb's thesis is simply put; specialisation occurs when a particular aspect of medical practice is threatened by encroachment from a group or groups outside the profession. The authors elaborate:

> We would hypothesise that those who are in positions of power to influence such decisions are more willing to grant specialty status to a group or segment among medical practitioners claiming specialised areas of knowledge and skill, when that area overlaps with one to which some nonclinical group outside medicine also lays claim. An added impetus is provided if it is an area in which the media, the public and the government have also expressed some interest and concern.
>
> (Eaton and Webb, 1979, p. 82)

This view of specialisation is viewed sympathetically for two reasons. Firstly, Eaton and Webb recognise that all attempts at specialisation are not successful. Thus theories of specialisation should be able to explain the unsuccessful instances as well as the successes, an apparently simple demand which is ignored by many writers. Secondly, the authors' understanding of specialisation unites a good understanding of the political and professional factors involved with an appreciation of epistemological factors as well, the latter by emphasising the importance of professional boundary maintenance. Eaton and Webb stress that specialisation requires not just the personal commitment of individuals but also professional support by those who have access to resources necessary to found a specialty. At the end of this chapter their thesis will be applied to general practice; it will be suggested that if one takes their argument seriously then general practice is more likely to develop as a specialty along one particular direction. A later chapter, too, refers to their work.

General Practice - A Specialty?

General practice has had a long history of unsuccessful attempts to define a special field for itself. It has suffered from the implications of its title - 'general' practice. Specialised knowledge, as we have been discussing it, implies knowledge outside the common stock of knowledge. Within a system of medical education which allows any doctor to make a career in general practice without further training, general practice knowledge <u>is</u> seen by members of the profession

to be the common stock of every doctor's knowledge. By definition, it is 'general', rather than 'specialised' knowledge.

Moreover, there is another, related sense in which general practitioners have difficulty in claiming specialised knowledge. The theories and ideas which practitioners draw upon in a day-to-day sense are seen to be more closely related to lay knowledge than is specialty medical knowledge (Jackson, 1970b). This relationship has been demonstrated in studies of general practice; a fine example is from Helman, himself a general practitioner, who illustrates how general practitioners draw upon lay conceptions of the common cold when prescribing treatment (Helman, 1978).

Doctors in general practice, then, have had difficulty creating an image of that branch of medicine as a specialty, in having its claim to a specialised stock of knowledge accepted by other members of the medical profession. But many attempts have been made. Armstrong documents proposals made in 1925 that a general practitioner could become a 'consultoid' (Armstrong, 1979a). Throughout the following decades others continued to see general practice as an inferior version of hospital medicine, and specialty status remained elusive. The 'safe general practitioner' concept, which assumed that general practitioners needed only a superficial knowledge of each specialty to practise, continued to dominate medical education until very recently. Titmuss's notion of the generalist 'uneasy because he was to spread himself so widely and has no special role to perfect' (Titmuss, 1963, p. 191) was one shared by many members of the medical profession.

Official Views

Reports in the 'sixties and 'seventies reflect a continued concern over the direction of general practice; questions over the nature of its knowledge were addressed in a number of reports. The Gillie Report, for example, with dubious logic noted by Jefferys (1970) stated that the general practitioner's specialism was that he was not a specialist (Gillie Report 1963). In the mid-sixties, however, a more fully developed idea concerning specialism emerged within general practice. Set in the context of group practice, which by then was the most common form of practice organisation, the proposal was that each doctor in practice should specialise in a particular age group or branch of medicine (for example, paediatrics, or obstetrics) with a small number of 'general' doctors also at the practice. Patients with problems falling into the relevant category would consult the doctor possessing the respective expertise (see McKeown, 1965, ch. 11 for a fuller discussion). Exactly how it would work out in practice was never specified for the proposal was never implemented on a large scale. Politically, it was a weak idea, for it did nothing to alter the perception of general practice as a mere accumulation on a minor scale of all hospital specialties.

Although the argument of 'mini specialties' within general practice did not come to be fully realised,[1] the notion that general practice was merely hospital medicine practised in a different setting continued to be powerful. The Todd Report (1968) supported this approach. The

[1] Although in practice general practitioners may read up on one or two specialties.

Report presents no definition of general practice, but from it one can discern the Commission's view of how general practice should develop. Discussing the 'Future pattern of primary medical care' Todd advocates practice from health centres with good routine diagnostic equipment, increasing delegation of certain tasks, and a strong link with a district hospital with opportunities for practice therein for the practitioners (Todd Report 1968, para. 41). Later it outlines the role of the general practitioner, emphasising the clinical features of the work:

> Professional training in general practice should, we think, aim at producing a first rate clinician in the field of internal medicine, with a good knowledge of preventive medicine and with special knowledge of the problems - both clinical and organisational - associated with family doctoring and with the role of the general practitioner as 'doctor of first contact' in the community.
>
> (Todd Report, 1968, para. 119)

Discussion over general practice continued in the 'seventies; the reorganisation of the National Health Service brought about a further series of working parties over the future of the health service. The view of the general practitioner as 'clinician in the community' was reinforced by two documents from the Scottish Home and Health Service (Joint Working Party, 1971, 1973). In both, repeated reference is made to the clinical responsibilities of the general practitioner, health teams, health centres related to hospitals, and to access to the facilities and opportunity to practise in the latter. All suggest a particular orientation of general practice, one which emphasises the clinical aspects of general practice, and which attempts to close the gap between the work of the practitioner and the hospital specialist.

(On both Working Parties, general practitioners were in a minority.)[1]

At the same time that these statements were being presented, the Royal College of General Practioners produced the following job description, which since formed the basis for a definition adopted by the European Union of General Practitioners:

> The general practitioner is a doctor who provides personal, primary and continuing medical care to individuals and families. He may attend his patients in their homes, in his consulting-room, or sometimes in hospital. He accepts the responsibility for making an initial decision on every problem his patient may present to him, consulting with specialists when he thinks it appropriate to do so. He will usually work in a group with other general practitioners, from premises that are built or modified for the purpose, with the help of paramedical colleagues, adequate secretarial staff and all the equipment which is necessary. Even if he is in single-handed practice, he will work in a team and delegate when necessary. His diagnosis will be composed in physical, psychological and social terms. He will intervene educationally, preventively and therapeutically to promote his patient's health.
>
> (Royal College of General Practitioners, 1972a, p. 1)

Even a quick reading suggests a very different orientation to general practice work to those outlined earlier. There is little mention of the role of the hospital, and the term 'clinical' does not appear at all in the job description. Instead, there is more emphasis upon personal care provided by the general practitioner, and work shared with the paramedical team. Diagnosis is explicitly seen as comprising of three components; physical, psychological and social. Breadth of task is suggested not only through clinical diversity but

[1] On the 1971 Committee were 26 members of which four were G.P.s.
On the 1973 Committee were 20 members of which four were G.P.s.

also through the inclusion of non-medical tasks.

These official views of general practice may be understood as statements made by interested parties as to the direction general practice should take in its future development.[1] They represent attempts to draw the boundary around certain tasks, and delineate these as the remit of the general practitioner. They are essentially concerned with territory. But the views are significant not for their unity of vision but for their internal variation. How clinical should general practice work become? To what extent should a doctor see non-medical complaints as part of his role? The future of general practice, even at an official level, is still open to debate.

Unofficial Views

But these are only official views. Unofficial views concerning features of the social world are typically more difficult to delineate than are official ones. Unofficial views do not present themselves as neat, articulate statements; indeed the opposite is often more characteristic. People may have difficulty in expressing their views, and they may hold views which contradict others expressed on the same occasion. One way round this methodological dilemma is to seek out views and opinions by asking a variety of questions, thus approaching the core issue(s) from a number of angles.

In this research, the researcher was interested to find out

[1] See Hicks (1976) for an extended discussion of this topic.

among other issues, what doctors thought about their work, and what they thought was special about general practice. A number of questions were asked from which it was hoped to gain some understanding of general practitioners' orientations to their work (see Appendix C for questions). From the responses given it will be argued that their perceptions of general practice did form a coherent perspective. Their responses could be allied to one of two perspectives which emerged from the interviews - the 'clinical' and the 'social'. The doctors did not necessarily agree that general practice was a specialty, however. Before these two orientations are discussed more fully, the sample's attitude to aspects of general practice will be explained to show the reasoning which led to the two orientations becoming identified.

Variation in General Practice

An initial review of the general practice literature is enough to convince the outsider that it is difficult to seek underlying trends or orientations since the variation possible in the work is considerable. This notion of variation was reinforced by the general practitioners interviewed, although it was expressed slightly differently, as the individuality of the practitioner. 'There is no typical general practitioner' was a favourite sentiment, and a sociologist who wishes to categorise such doctors has a hard time; (what unfortunately remains unrecorded systematically in the fieldnotes were the numerous instances when, on leaving the interview the doctor would make a remark such as 'well, good luck with the research, but you can't fit us into

boxes, you know'. A certain amount of scepticism was held about the success of research which attempted to do so.)

Thus the range of work might initially be seen to detract from the notion of group orientation to work. Variation in practice is supported by the general practice literature along dimensions which can be readily quantified. For instance, basic variation is seen to exist between rural and urban practices (McIntosh and Horobin, 1978), or between middle and working class practices (Hart, 1975). List size varies, Scotland remaining consistently lower than in England (the Scottish average in 1974 being 1,991, to 2,373 in England and Wales). Within the practice consultation rates vary between doctors, over the time of year, the type of practice, and the social class of the patient (Cartwright and O'Brien, 1976; Howie, 1978).

General practitioners themselves are acknowledged as varying in the amount of time they may spend on a consultation (the average is taken to be five minutes), and within that time, time spent on the different activities (for example, history taking, examination [Buchan and Richardson, 1973]). Similarly variation exists in referral rates, techniques used, investigations made and use of the night service (see Howie, 1978, for a more detailed review of recent literature on patterns of general practice work). No details of figures are given here; the important point is that such variation is seen to exist.

Apart from direct patient care, general practitioners themselves may engage in a wide variety of outside work, some paid, other voluntary. Irvine and Jefferys' postal study of general practitioners throughout Great Britain offers some detail here (Irvine and Jefferys, 1971). Of their respondents, 80% had non-hospital appointments, while 33% of the doctors had paid or honorary hospital appointments (these were more

likely to be young doctors). Doctors also reported an involvement in professional affairs - 42% took an active role in the B.M.A., the R.C.G.P., or on executive councils, health boards, and so on; 30% were engaged in some form of teaching activity, while 33% of the respondents had been involved in some kind of research activity in the past three years (see Table 3.i).[1]

Clearly then, these general practitioners felt they could justifiably argue that there was an element of individuality in the way they used their time, and the particular emphasis they placed on the different aspects of their work. At the same time, however, such arguments for individuality can be countered by evidence from two groups. Evidence from general practitioners themselves suggests that there is some convergence towards the 'average'. For example, while list sizes vary considerably, they are grouped towards a particular range (1,500 - 2,500), (the figures between which practices maximise the incentives offered by the Government). Single handed general practitioners decrease yearly (from 43% in 1951 to 18% in 1974), while the trend is towards group practices of three doctors and upwards to six (Fry, 1978). The Royal College may be understood to have produced an element of standardisation by requiring a membership examination, and also through the introduction of a (post-graduate) vocational training scheme, with specified criteria for trainers. Group practice appears to have increased the amount of colleague control within a practice.[2]

[1] This is in no sense meant to represent a review of the literature on general practice work. Hicks' review of general practice is a fairly comprehensive overview of a large but very fragmented literature (Hicks, 1976).

[2] A small number of doctors in the sample reported having case conferences in the practice, and/or practice policies over certain issues.

Table 3.i

Teaching and Research Commitments of General Practitioners in Irvine and Jefferys' Study

Research:	33% respondents involved in research in last three years. Details as follows:		
	Therapeutic trials		23%
	Clinical research		13%
	Epidemiological studies		14%
	Practice organisation		15%
	Patient care		11%
Teaching:	30% respondents involved in some form of teaching activity. Details as follows:		
	Medical students teaching		13%
	Medical graduates		4%
	Voluntary organisation workers		19%
	Nurses or health visitors		7%
	General health education (rural areas)	Adults	7%
		Children	2%

Source: Irvine and Jefferys, 1971

Evidence against the notion that every doctor is individual and therefore his behaviour defies any kind of classification also comes from sociological work on general practitioners. Findings indicate that doctors do not treat every patient 'individually', as they would suggest, but develop strategies for routinising their work. These may be in the form of classifications of patients, problems, or formats for offering advice or help of some sort. Fletcher's observational study of routines in a surgery well illustrates the patterns of practice into which the doctor slips over time (Fletcher, 1974). Months and years of coping with a range of conditions in a situation where time is at a premium results in the doctor developing categorisations for patients, conditions and treatments. These may be changed, updated, modified (as we would do with our other everyday classifications): such systems may be crude or 'unelaborated', to use Comaroff's terminology (Comaroff, 1976), or may incorporate a wide range of potential courses for action. On the whole, doctors do not (and cannot) articulate these conceptual strategies; in the researcher's interviews a rare example arose with one doctor involved in teaching undergraduates on a part-time basis. He claimed that his method of assessing patients was as follows:

> First you look at their folder, if they're thick or thin and that tells you half, then you look at their address and by then you're three quarters of the way there, and then whether they're one [floor] up or three [floors] up and you have it.
>
> (G.P. 12)[1]

Thus while variation <u>does</u> exist in general practice, it is also

[1] Throughout the thesis doctors are identified by their sample number.

a central part of the general practitioner's ideology to believe in 'individuality'. This concept is employed to cover both the variation which exists between style of practice, and also in the doctor's handling of each patient.[1] Through observation, both Fletcher and Comaroff were able to study underlying similarities in general practitioner's work behaviour. While this present research is more concerned with the views and opinions of the doctors it, too, sought out similarities which served to unite the apparently disparate group of doctors calling themselves general practitioners.

General Practice and Hospital Medicine

In order to find out what aspects of general practice were seen to be special to that branch of medicine, all doctors were asked the question 'What ways, if any, does general practice differ from hospital medicine?' Findings are set out in Table 3.ii.

Table 3.ii

Sample Perceptions of Whether General Practice Differed from Hospital Medicine

No difference	4
Little difference	4
Considerable difference	28
Total	36 *

* n = 40. Four answered the question too indirectly to be classified

[1] This discussion ignores the question of whether other branches of medicine equally emphasise 'individuality'.

Of the four who argued that there was no difference, each made the point that the practice of medicine was the same. Two of these doctors had an unusual way of understanding the relationship between general practice and hospital medicine:

> All other branches of medicine are branches of general practice as we are at the centre of things. There's no difference between hospital medicine and general practice medicine.
>
> (G.P. 31)

> General practice is medicine, and hospital medicine is services rendered to general practice . . . without sounding arrogant, general practice is medicine; the consultants are technical experts, but the patient remains my patient.
>
> (G.P. 41)

But even the responses of the eight doctors who felt that there was little or no difference between general practice and hospital medicine were not qualitatively different to the responses of the twenty-eight who answered more adamantly that general practice was 'completely different' to hospital specialties. Some doctors suggested that the medical side was similar but that the emphasis in general practice was different; ' . . . but we are more involved than the hospital doctor' (G.P. 46) or 'the basic approach is the same but general practice is more personal' (G.P. 50). Other doctors stressed the distinctive nature of general practice: 'There's no comparison between general practice and hospital medicine. Doctors in hospital see cases that we think are outside our scope, really sick people, clinical medicine. We see a mixture, much of it "social" people who shouldn't really come in' (G.P. 59).

From the responses of the sample, a typology can be built up of characteristics which general practitioners saw as distinguishing

general practice from hospital medicine (see Table 3.iii).

Table 3.iii

Perceptions of General Practice and Hospital Medicine

General Practice	Hospital Medicine
Not specialised (therefore variety)	Specialised
Clearing/sorting function	Filtered cases
Trivial medicine	Serious/acute cases
Much administration	Little administration
Psychological/ non medical problems	Clinical (medical) cases
Environment important	'Context free'
Continuity	One-off
Patient important	Disease important

It is worth mentioning that virtually no doctor attempted to specify particular hospital specialties but talked about 'hospital medicine' or 'hospital practice'; secondly many offered a comparison in their answers ('general practice is . . . , not like hospital medicine which is . . . '). These features of the responses were no doubt in part due to the format of the question, but if that had not been consonant with general thinking, then it is unlikely that there would have been such consistency in the responses.

Two notions about general practice were recurrent in the responses. The first was that rather than general practitioners possessing special

medical knowledge, general practice was different from hospital medicine for structural reasons. Some general practitioners felt that administratively and professionally they were separated from hospital specialists by the referral system. This meant that they 'sorted' patients and were left with minor complaints, sometimes termed 'trivia'.

The second notion, raised in a more positive sense by the doctors, was general practitioners were geographically distinct. Because of their position in the community (as opposed to hospital) they saw the patient in his or her environment, and this was seen to add an extra dimension to the understanding of the patient and the condition. These notions, the trivial or minor medicine of general practice, and the importance of the environment, warrant further consideration.

Before we explore these issues, however, it is worth reviewing answers to a further question, 'What is the most important part of your work?' This question elicited at times rather clichéd answers, and not too much importance has been attached to them. However, the responses can be grouped as follows in Table 3.iv.

Table 3.iv

What is the Most Important Part of Your Work?

Type of Response	No. of Doctors
Primary diagnosis/ not missing anything	10
Doctor-patient relationship/ education of patient	9
Availability Reassurance Chatting	12
General service to patients	11
No part more important	2
Total	44

n = 40, more than one response possible

Responses have been grouped very generally into those who mentioned clinical factors, those who mentioned 'social' factors and those who gave 'general' responses. Two doctors answered that no part of their work was any more important than another, while a minority offered more than one response. Overall, responses reveal an emphasis on the non-clinical tasks associated with general practice, eight doctors alone specified early diagnosis, although no doubt at least some doctors who mentioned 'offering a good service' would include such a task in this category. But given that the lay person may well associate doctors as those who cure disease, it is interesting that some family doctors, at any rate, attach such importance to other

aspects of their work.

So far no attempt has been made to distinguish different orientations between the practitioners. But we may now begin to tease out two distinct orientations along which the general practitioners in the study aligned themselves. Such orientations are significant because they represent at grass roots level the formation of a particular world view of general practice. They have a direct influence, therefore, on the future development of the specialty of general practice.

Clinical and Social Orientations

From the interviews one of the main ideological divisions which emerged was between those doctors taking a 'clinical' perspective and those taking a 'social' perspective.[1] The difference may be characterised as that between 'primary medical care' and 'family doctoring'; the polar positions can be seen in the statements of G.P.s 46 and 69. G.P. 46 represented those adopting the clinical perspective when she responded to the question 'Is general practice more of an art than a science?':

[1] McIntosh and Horobin have elaborated these two dimensions at greater length than is done here (McIntosh and Horobin, 1978b). No attempt is made here to quantify the number of doctors adopting each perspective. Rather, the perspectives or orientations are offered as two ideal types.

> It is an old adage . . . I've heard people say that there should be two tiers of G.P., one for the hospital and one for practice. The danger comes in diagnosis. A G.P. must be an expert diagnostician, he needs very good training for this and a certain amount of hospital training. This is first in importance. The art is not the diagnosis, the doctor must know what he's doing . . . Being a pleasant, social caring person this is important but second to diagnosis. Doctors are useless in general practice if just caring for people - a neighbour can perform this function.

This perspective can be contrasted with that of G.P. 69, who clearly saw general practice as meaning something very different. He represented the 'social' perspective when he replied:

> I'm old fashioned, of course, but I think that this important knowledge for a doctor can be learned by going about patients, knowing them, you could go through general practice without knowing any medicine at all.

Later he defined the most important part of his work as

> Reassuring people, tiding them over bad times, acting as a prop which they can turn to, helping them over the illness, whether psychological or social in origin. I don't see it as curative, nature cures things. Students in universities are taught to ask what's wrong with the patient, when you come into general practice you must ask 'is anything wrong with the patient?'

This practitioner did not necessarily mean that he could practice without medical knowledge, but rather that he felt that his work relied less heavily upon medical knowledge and rather more on non-medical or 'social' knowledge. But these two perspectives, clearly important to our discussion about specialty knowledge, require more expansion.

The Clinical Perspective

The first perspective, the 'clinical', is characterised by the term 'primary medical care'. To engage in this form of practice, doctors are urged to form group practices, to specialise within practices, to use diagnostic aids, to do minor laboratory work, and to delegate tasks to paramedical staff and to the social worker (if one is attached). Thus they are encouraged to build up a 'mini hospital' situation where their clinical work has as much technological support as is possible outside hospital, and where the emphasis is on the clinical, rather than psychological or social. This form of practice has been encouraged through a number of Government reports (for example, Dankwerts, which encouraged group practice), the B.M.A. (for example, B. M. A., 1970), interested parties such as the Office of Health Economics, who make their preference for the type of medical care they would like to see general practitioners dispense quite plain: 'But it is very questionable whether the family doctor and his medically oriented team are the right people to intervene directly in any but the strictly medical aspects of such [i.e. "social"] cases' (O.H.E., 1974, p. 28), and of course, general practitioners themselves (for example, Thomas and Croft, 1976).

A general practitioner adopting this perspective would thus emphasise his clinical, diagnostic work. This does not mean, however, that he would, or could, wholly ignore social or psychological features of the patient, and their contribution to illness. Indeed, very few of the sample doctors could be seen to be approaching the ideal type; rather it is a question of emphasis. Doctors who could be characterised as adopting this orientation made statements concerning the priority of

practising good clinical medicine. The focus on clinical conditions, albeit in a different, community setting, therefore remained. The distinguishing features of general practice for these doctors were firstly, the task of primary diagnosis, and secondly, the type of condition that they encountered. Of the latter, the most frequently cited were the early stages of (major) illness, and chronic conditions. Yet although doctors in the sample argued that care of these conditions was special to general practice, only a very few extended the argument to this expertise constituting specialty knowledge. G.P. 32 was one of the few who did talk of this:

> You must train people for it if general practice is to be a true specialty - its specialty is primary care and the treatment of early conditions.

Our understanding of this work orientation can be heightened if we now reconsider some of the responses to earlier questions. Doctors adopting this perspective tended to refer to the first three items on Table 3.iii, and to the first or third group on Table 3.iv. That is to say, they were more likely to suggest that general practitioners played a sorting or shifting function which left them with the 'trivia', and to make either general statements about the most important part of their work, or to refer to primary diagnosis as the key task.

It was essentially doctors from this orientation who raised the topic of 'trivia' in the interviews, a concept which will be elaborated on in more detail as a way of illustrating how each perspective affects the doctors' approach to their work.

Trivia

Traditionally, of all complaints general practitioners see, about one sixth are categorised as major, that is, immediately life threatening situation, while about one fifth are chronic conditions with permanent disabilities (R.C.G.P., 1973). The remainder, the minor complaints, form over sixty per cent of the doctor's daily work. But 'trivia' is a relative judgement. Whether the majority of this sixty per cent is seen to be trivial or not depends upon with whom the doctor is comparing his work.

Every specialty probably has its category of 'trivia'. Jeffery, writing about admission procedures in an accident and emergency department, titles his paper 'Normal Rubbish' (Jeffery, 1979), while in one American study of the socialisation of medical students, the term 'crock' was used by the students for a patient who had no value as a teaching example (Becker et al, 1961). The general practitioner's complaint of trivial medicine thus serves generally to establish him within an occupational group which has special expertise, special skills. In effect, the general practitioner is saying that although he may deal with daily coughs and colds he is capable of dealing with other more demanding clinical tasks.

But the concept of 'trivia' was used discriminately by doctors in the study. Some conditions may well be regarded as trivial by all general practitioners - conditions such as badly cut knees, or other external, minor injuries, for instance. But some doctors felt that over and above this patients were continually presenting with a range of non-medical complaints which they defined as unnecessary, or outside their remit, and that the opportunity to practise good clinical medicine

was limited. The following doctor certainly felt this to be the case:

> Hospital medicine is so complex and specialised. General practice is a gross irritation at present, gross trivialities taking up so much time. The N.H.S. has taught young people not to use their heads - a grandmother could teach them what to do. They phone up and ask whether to give a child an aspirin. They have no resourcefulness at all. The old people don't expect the doctor to come, or to use the doctor for anything. Young people automatically reach for the phone.
>
> (G.P. 56)

As already mentioned, this feeling was typical of those who maintained that their priority was the practice of clinical medicine, and who espoused the clinical perspective. But this kind of attitude is very similar to that noted by Mechanic in his study of English general practitioners (Mechanic, 1975). Doctors in his study who felt frustration at the kind of non-medical problems patients presented with were the most unhappy with their work. Mechanic argues that those doctors who came out highest on 'social orientation' reported a more favourable attitude towards general practice in particular and the health service in general.

There may be other variables influencing the situation. A number of the doctors complained that they were being presented with problems about which they could do little (for example, concerning unemployment), or with a volume of non-medical, administrative tasks. There is some evidence that working class patients do consult their doctor slightly more often than do middle class patients (Cartwright and O'Brien, 1976). It also seems likely that doctors working in a large urban area (such as the doctors in the sample) were more involved in dealing with non-medical tasks which they were not able to delegate (for example,

writing notes recommending [council] re-housing, social security and so on). The quantity of these consultations is likely to be higher in an area of high density population, of working class employment, and with a large proportion of the population housed in council housing. Thus although this study has emphasised the importance of the doctor's orientation to his work, context no doubt influences his attitude.

This latter factor has been recognised by other researchers. In a study of rural practitioners in Scotland, there was a general acceptance of trivial conditions, which led the authors to argue that trivial illness should not be necessarily seen as a category of illness but rather as a product of pressure of time and inadequate resources (Horobin and McIntosh, 1977, 1978). In other words, whether or not the doctor defines a condition as 'trivial' in part depends upon his work context, i.e. particular workload, consultation rate, practice facilities and so on. In a further paper Horobin unites both the importance of orientation and context in his discussion of trivia (Horobin, 1978). Some doctors in their study regarded minor complaints as a nuisance, or trivial, because they wasted time which could be spent on more demanding clinical work; thus the doctor who says that he has no time to be bothered with trivia is essentially saying he would rather spend time on other tasks.

The Social Perspective

The alternative ideological position which some general practitioners espoused centred around a greater emphasis on the social and psychological aspects of general practice work. The definition here is the general practitioner as a family doctor, as G.P. 44 illustrates:

> Do you see general practice as different to hospital medicine?
>
> Yes, the new term 'family care' is correct, seeing the mother/child/husband/wife together. So many of the G.P.'s duties are done by the nurse, or ancillary worker but in the general practitioner they are all together in one person.

Here the rhetoric emphasises amongst other things personal care, knowing one's patients, availability, 'whole person' medicine. This perspective has been championed by the Royal College of General Practitioners (Armstrong, 1979a), and members of the College make their position clear, as one wrote: 'He would rather be recognised as the most versatile of medical-social workers than the least of medical men' (Norell, quoted by Honigsbaum, 1979, p. 311). Sponsorship of this kind of practice has also come from amongst others, sociologists (for example, Jefferys, 1970), and novelists (for example, Berger and Mohr, 1969), a finding which supports the disdainful comments of two senior medical protagonists writing about the 'pastoral fallacy':

> Pervaded by an excessive belief in a unique therapeutic relation between doctor and patient, they aim to substitute a pastoral role for technical care, which is assumed to be necessarily impersonal or even inhumane. This approach is often sympathetically received by laymen . . .
>
> (Dornhurst and Hunter, 1967, p. 667)

When asked about the most important part of their work, a number

of doctors responded in ways which would align them with this perspective. To return to earlier responses, doctors adopting this approach tended to give responses which fell into the last four categories of Table 3.iii - that is to say, to suggest that the distinctive features of general practice lay in a non-clinical direction. They were also more likely to argue that the most important part of their work was 'non-medical' or 'general' - see Table 3.iv. Thus availability, reassurance, continuity, chatting and doctor/patient relationships were repeatedly mentioned as most important. These notions, critical to this perspective, are worth discussing.

Doctors adopting this perspective emphasised the role of themselves as 'a friend to turn to'. Availability was valued highly and talking was also seen as important, both therapeutically for the patient, but also as a form of insight into the patient's 'real' problem. However, as will be indicated, the rhetoric and the reality of general practice have difficulty in meeting.

When asked about the most important part of their work, a number of doctors felt that availability of their services figured highly. Availability typically meant, as G.P. 37 said, 'being around the district with patients I know, if anything goes wrong we get it sorted out - being available'. Some doctors saw availability in more personal terms.

> I think it is important for every practice to have a woman doctor . . . I get many female patients who come to me with all kinds of female problems they wouldn't tell a male doctor. So I think being available as a woman doctor is of prime importance.
>
> (G.P. 43)

Some doctors also thought that it was important that the patients could come along and chat about their problems, 'giving them [the patients] time to talk about what they really want to talk about' (G.P. 65). This was mentioned by a number of doctors (about a quarter) as the most important aspect of their work. Some referred to themselves 'acting as a prop', others mentioned the therapeutic value of a good chat:

> The more I go on the more I recognise its value, allowing people to come in and chat and go away, often without medication, but somehow they feel better. I'm less interested in the dramatics now. I think that there is more recognition of the tensions and depressions now and that G.P.s try to help them. I've learnt to listen better.
> (G.P. 70)

The final aspect of the 'social'orientation which demands a little more attention is the doctor-patient relationship, singled out by a number of doctors as the most important part of their work. Throughout medicine, the doctor-patient relationship is talked of in hallowed terms: 'the magical and mystical relationship between doctor and patient which contributes so much to the healing process' (origin of quotation unknown). Despite suggestions that the status of the general practitioner may be dropping with members of the public, doctors still believe in the charisma invested in themselves. Part of the doctor-patient relationship is, then, the belief the patient is thought to attach to the doctor. Thus a personalised service is seen as important, while the doctor feels that he may delegate certain aspects of his work, he nevertheless would argue that he is offering something special, and that a visit to him gives the patient reassurance (Balint termed this 'the drug "doctor"'). One doctor explained:

> Ninety per cent of my work is not therapeutically beneficial. I give 'cough bottles' and so on, but I do question their actual importance vis-a-vis the gesture of seeing the doctor. Out of the thirty people I saw in the morning surgery, twenty had colds and if I were honest I was not required at all . . .
>
> (G.P. 45)

Titmuss well understood the importance of the person in general practice when he wrote, 'His [the doctor's] specialism lay in his own personality, the use he made of it, and the way he handled his self-conception of role in his day-to-day relations with his patients. He was better able to be himself . . . He was an individual, a character' (Titmuss, 1963, pp. 191-192). Although Titmuss was arguing that the person was becoming less important in general practice, it is interesting to note that some doctors continued to echo these sentiments. For example, one practitioner described the difference between general practice and hospital medicine as 'in general practice outside, your personality, it is very important, you must be natural and not be putting on airs and graces'. He adds, 'it helps when dealing with people and in turn they will tell you about problems not strictly medical' (G.P. 58).

This latter point was taken up by other doctors who felt that people would tell the doctor more if they knew him personally. The doctors saw it in terms of a 'trusting relationship' which the patient had with the doctor, and it formed a powerful argument in favour of dealing consistently with a doctor's 'own' patients (cf. Gray, 1979).

They talked with pride about knowing their patients - 'one is kept on one's toes remembering them all'. 'Knowing' here does not necessarily mean that a doctor could name all of his two thousand patients, although a study of general practitioners suggests that doctors would recognise about three-quarters of their patients if they met them in the street (72% working class patients, 80% middle class patients), (Cartwright and O'Brien, 1976). 'Knowing' could also mean possessing a brief outline of the patient, biographical details - the same study reports that doctors knew with whom 85% of their working class patients lived, and 96% of their middle class patients. And, one could possibly speculate, the doctor no doubt comes to 'know' in a little more detail, a select group of regulars (although one doctor, already quoted, suggests that this can prevent the doctor from noting changes in the condition of her chronic patients, just as in everyday life, one may be less aware of changes in people one sees on a regular basis).

But knowing one's patients has other benefits. Doctors <u>do</u> use prior knowledge of the patient when dealing with the patient's complaint on a new occasion: doctors themselves give elaborate examples of this (often in connection with showing the importance of 'social aspects' of practice). One doctor reported that a patient complained of stomach-ache every time their son was in trouble with the police, another always reacted in a certain way just before her husband returned home on leave. In that situation, having ascertained that the son was indeed in trouble with the police again, or the husband's leave imminent, the doctor chose to ignore the physical symptoms thereafter in the consultation. A doctor unfamiliar with the patient may handle the complaint very differently. It is not being argued here

that the first doctor handled the patient better, or indeed that he should know the physical symptoms, but rather that from the point of view of the doctor offering this example, he felt that he had handled the situation correctly.

While this latter perspective may have always been important to some practitioners it received theoretical legitimation in the 'fifties through the work and publications of a psychiatrist, Michael Balint (1896-1971). Balint's contribution to general practive is assessed by an editorial from the Royal College of General Practitioners as of considerable significance:

> His emphasis on the continuity of care illustrated by his analogy of 'a mutual investment company' led inevitably to new emphasis on the significance of the doctor-patient relationship and on whole person medicine or holistic care - which only a generalist can provide. He directed attention away from details of anatomy into the developing field of human behaviour - both of patients and doctors.
>
> (R.C.G.P., 1972a, pp. 133-134)

It may be that his ideas about general practice were not new; indeed, he developed them from a series of seminars which he ran with general practitioners. But the articulation of such ideas was novel, and Balint was able to set them into an already existing theoretical framework borrowed from psychiatry. The importance which the Royal College attaches to Balint's work is indicated by the following remark; 'what Freud became for psychiatry, Balint will become for general practice' (R.C.G.P., 1972a, p. 135).

In this 'social' perspective 'trivia' takes on another form. Doctors adopting a social orientation tended to tolerate minor

complaints to a greater degree.[1] They regarded them as legitimate, and felt that the patient had a right to seek help or reassurance about them. One indicated the tolerance with which such complaints were viewed, 'they are maybe important to the patient even though we see tham as "trivial"' (G.P. 65).

Others, more directly influenced by Balint, would take the argument further. Lane, writing in The Longest Art, talks of the significance of trivial ailments:

> There is one essential question that the doctor must ask himself at any consultation over a trivial complaint. Does this patient really need my help - consciously or unconsciously? If the doctor fails to look beneath the surface, he will become a very poor general practitioner.
> (Lane, 1969, p. 31)

Thus in a curious way the 'trivia' of general practice can indeed become the most professionally challenging for those doctors who adopt this perspective.

To date, the term 'social' has been used without additional explanation. But potential confusion rests in its usage. The literature reveals a diversity of meanings. The term loosely refers to the relationship between the complaint and the patient's background (whether economic, geographical or family). The term remains ambiguous, however, a point which seems to be ignored in much of the discussion about 'social factors' (for example, Cartwright, 1967; Mechanic, 1975). For some doctors it means interpreting unidentified complaints as being social in origin, that is, with no physical aetiology. Alternatively

[1] In fact doctors who talked more about social aspects of general practice seldom used the term 'trivia'.

it can mean simply taking into account the effect of the illness on a family, or doctors may refer to it when discussing doctor-patient interaction. Stimson's summary of the social aspects of the general practitioner's role isolates the various meanings inherent in the writings of general practitioners, and identifies six different interpretations; social relationships, social factors in disease and illness behaviour, social causes of disease, social consequences, social welfare problems, and a socio-psychotherapeutic meaning (Stimson, 1977). It seems likely, however, that many doctors in practice would have difficulty in articulating which meaning or meanings they attach to the term. Certainly, when discussing general practice work, 'social aspects of work' can refer both to the kinds of problems the doctor may deal with, and also the perspective he may take when dealing with an apparently physical complaint. In the same way that doctors adopting a clinical approach felt that their ability to practise good clinical medicine was curtailed, so too did some 'socially' oriented doctors raise the frustrations of attempting to work within this latter perspective. The belief in personal care became difficult in a system which was not organised around the assumptions embedded in 'availability', and 'knowing one's patients'. While doctors are still paid <u>per capita</u>, some doctors are now organising their practice so that they no longer care for a defined list of patients (Aylett, 1976). And while the choice may not be so deliberate, nevertheless the organisation of group practice tends to reduce the everyday availability of the doctor, by the widespread use of the rota system, and deputising services. The resultant decrease in contact with one's list patients is regarded by

some doctors as a mixed blessing.[1]

Availability, can thus bring its problems. 'I think being accessible to people [is important] so they know where to turn to if they have problems; we're too accessible at times' (G.P. 60). While doctors still remember what as one doctor described it, a 'come whenever you like' idea, patients cannot now see their doctor when they want, sometimes not the day they want, but must be fitted into carefully balanced workloads of the practitioner. Some doctors felt that they had made themselves too available to patients, and saw appointment systems as somehow redressing the balance, serving to make their services more exclusive. 'Availability' was now offered on a limited scale. Others felt, given the importance of 'availability', the patient should be able to see the doctor on that day, and hence ran their surgery on a semi-appointment system. Thus the last surgery of the day may be open, so that everyone who wishes may consult a doctor, although, again, there is no guarantee that they will see their own doctor.

The appointment system, too, militates against chatting to one's patient. Chatting time, once fitted into the short consultation, probably lasts only four to five minutes at the most.[2] One study by Buchan and Richardson (1973) suggests that time for 'social chat' between

[1] Small list size has been identified by one general practitioner as the key to greater personal care by the general practitioner (Gray, 1979). He argues the case for personal lists, suggesting that it improves the doctor-patient relationship, patient compliance and gives the doctor additional 'background' information. Horobin and McIntosh appear to support this argument when they state that only doctors with small lists can practise personal care (Horobin and McIntosh, 1978).

[2] Patients can be asked to return after the surgery for an extended discussion of their problem.

doctor and patient varies by social class, but that average time during any consultation for discourse is limited to a few minutes.

The responses of the general practitioners have been grouped into two orientations, two distinct perspectives of general practice and general practice work. For the doctors, these views of general practice were merely the ways in which they made sense and understood their work. Most did not see their statements as implying that general practice was a specialty - indeed the opposite was true. Although the issue was not raised directly a number of doctors suggested that general practice could not become a specialty because of the perceived 'breadth' or range of conditions which the general practitioner might see. Despite this denial, the orientations outlined above may be understood as the articulation at grass roots level of two perspectives which could develop into competing specialty claims.

The literature on general practice supports both perspectives. Typically they are identified as alternatives for the general practitioner, two paths along which he is free to develop his role (for example, O.H.E., 1974; McCormick, 1979). This research and others (for instance the work of Horobin and McIntosh), however, suggests that within an individual doctor exists a certain conflict of interests, that one doctor may well recognise both 'clinical' and 'social' elements of his role. Further studies of the actual practice of doctors is needed to see how these perspectives are put into play.

The debate continues; Noack offers a recent summary of the field of general practice and medical education, including in his international reader a number of articles which discuss the 'special' features of British general practice (Noack, 1980). Although not necessarily couched in these terms, both perspectives are represented in the

British section, authors identifying and emphasising as special the personal care element of general practice (for example, Marinker, 1980), or the clinical aspects of general practice work (for example, Fry, 1980).

Two Specialty Claims

These kinds of public reviews of perspectives or world views are typical of the way in which specialty claims are formed, articulated at a number of levels (official, or formal, and unofficial, or informal), criticised, revised and strengthened. What is left for us to do at this stage in the chapter is to speculate upon the relative merits of each of the two claims outlined for general practice. Bearing in mind the kinds of perameters outlined in the earlier discussion of specialisation we will focus upon the concept of epistemological boundaries, and upon the possible professional and political support each claim might arouse.

In the first instance it is not difficult to appreciate why there has been continued official support for 'clinical' general practice (such as mentioned earlier in the chapter). It is easier to cost and monitor a health service based upon clinical intervention than one in which doctors are involved in less tangible tasks such as 'social counselling'. From the point of view of man-power planning, too, clinical general practice requires fewer doctors than would 'social' general practice (O.H.E., 1974).

The clinical approach is concerned with the practice of scientific medicine. Thus the general practitioner is dealing with accepted

categories of illness, with 'objective' evidence and routine treatments. The apparent clarity with which clinical signs are perceived measured and confirmed or otherwise may offer the doctor certain positive features. As Greaves has suggested it enabled 'the practitioner to pronounce with certainty whether the disease was present or not and so increased his authority'; it also 'introduced a reassuring exactitude into his work' (Greaves, 1979). Primary medical care thus offers a form of medicine which is (apparently) neatly bounded by science.

Professionally, then, this approach offers no challenge to the dominant paradigm within which doctors have been trained and work. The established tradition of medical practice is not questioned, and one could anticipate professional approval for doctors willing to extend this tradition. Nevertheless, this approach does present a number of problems to be confronted concerning the development of clinical general practice.

Academic general practitioners suggest that what is special about the illness conditions seen by general practitioners is the stage at which they are first encountered. They are arguing, therefore, that illness conditions have characteristics peculiar to their early and late stages. The form of the argument is not unlike that used so successfully by paediatricians, that illness in children was qualitatively different to that of adults, and therefore required particular knowledge, understanding and management (Armstrong, 1979b). A specialty argument has more chance of succeeding if the members can reasonably delineate particular skills and expertise, and create a 'territory' around which to draw a boundary. One major difficulty with the general practitioners' argument is that of delineation; it is easier to draw

the boundaries around a particular age group than it is to define 'early' or 'late'; and the aetiology of chronic disease is not so well understood that such matters could be cleared up through the use of appropriate tests. Certainly it is not being argued here that specialties only develop in areas where categories of condition are pre-existing and recognised. Rather that at present this particular claim of the general practitioners requires considerably more refining and clarification in order of the knowledge boundaries to be recognised and understood.

The second approach has been termed the social approach, and identified with the notions of family doctoring, and whole person medicine. It has been said that medicine in general is moving away from a unifactorial to a multifactorial model and thus social factors will become incorporated into such a model as a matter of course. Nevertheless, others have argued that the 'socially oriented' physician forms a discrete category of doctor (Fuller and Fuller, 1978) and this is certainly how it has been understood in this chapter. The social approach has flowered as a distinct perspective in general practice over the last two decades,[1] although it is not alone in nurturing this approach, and members of other branches of medicine (for instance, geriatrics, community medicine and psychiatry) have likewise identified themselves with such an approach, some claiming it as distinctively

[1] Balint's ideas on whole person medicine in particular have not only deeply influenced the Royal College of General Practitioners (Stimson, 1977; Armstrong, 1979a), but have become amplified throughout general practice. Through their presence in vocational training (R.C.G.P., 1972c, Horder and Swift, 1979), Balint's ideas are assured a potent future.

theirs.[1] Although these specialties are all low status in medicine, the combined effect from the various groups gives the social approach professionally more force than it would have stemming from only one or two specialties.[2]

The social approach has also attracted comment from outsiders with an interest in general practice. Jefferys, for example, presents an articulate case for the need for increasing attention upon social and psychological factors associated with illness conditions, arguing that general practitioners would gain status enhancement through such a definition of their expertise (Jefferys, 1970). Another commentator on general practice (Armstrong, 1979a) takes the social approach further by hailing it as the new paradigm of medical nosology. Armstrong anticipated that in the future all conditions would be considered from a clinical and a social, or to use his term, biographical, perspective, but that the social perspective would become increasingly dominant over the clinical (Armstrong, 1979a, p. 5). General practitioners, the acknowledged experts in the biographical, would rise to new positions of professional dominance, rather as did the surgeons once the relationship was acknowledged between internal and external signs of the body.

There are, however, a number of difficulties attached to the social

[1] Szasz, for example, characterises the division within the medical profession as follows: 'Thus, the object of interest in medicine is the body [as a physical object] while in psychiatry it is the person as a "social being" or "person"' (Szasz, 1958, p. 230). More recently clinical psychologists have made comparable statements.

[2] Interestingly, Strong, in his account of medical imperialism, dismisses the social approach as a source of medical expertise (Strong, 1979).

approach. Apart from the difficulties of practising 'whole person' medicine raised by the general practitioners themselves, terminological and conceptual difficulties also exist. While Balint's concern for 'whole person' medicine cannot be doubted, it would be unfair to attribute the wider 'social' approach to Balint, or indeed, to suggest the false equation as does Armstrong, that Balint = biographical = social. Balint's background was psychiatry, and his interest lay in understanding an individual's problems in terms of personal and family relationships. Yet doctors, particularly those working in decaying urban areas, may not interpret all 'social' problems as attributable to personality, but may have to invoke other aetiology of 'social' problems (for example, bad housing, or faulty drains).

This leads onto the crucial weakness of this approach, which again involves the notion of boundaries. Although doctors talk frequently about 'social factors' and 'social problems' associated with illness, at present there is no formally agreed upon classificatory system for factors which might generally be termed 'social'. This means that each doctor creates his or her own category system, and each operates with a range of factors which fall within their conception of 'social'. There are certain, loose groupings, as Stimson found (Stimson, 1977), but this lack of definition results in imprecise terminology and blurred boundaries. Certainly, it is the case that doctors operating within the clinical tradition likewise show some individual variation in their interpretation of illness categories, but nevertheless there is considerably more institutional agreement over the shape and form of these categories than there is for 'social factors'.

Despite this present boundary weakness, if we take seriously Eaton

and Webb's proposals for the criteria of success of specialisation claims, then it is this latter perspective which should ultimately result in more professional support. It is this latter perspective which is at present under threat from outside groups (most notably from social workers). If potential encroachment from other occupational groups causes members of the medical profession to redefine their professional boundaries to include expertise in social areas then general practitioners have much to gain from the current conflict. This, however, does assume that it will be the general practitioner's claim to social expertise which is accepted by the profession, and not that of another branch of medicine.

This chapter has served a number of purposes. It has laid the foundation to future discussion by outlining to the reader the broader field of general practice. This is important because, in the first place, some understanding of the broader canopy of general practice is essential to place in context the academic movement within general practice. Secondly, the relationship between the service and the academic branches forms a significant 'subtheme' of the thesis - an issue which recurs in a number of chapters (for example, when studying the identity dilemma of the academics, and again when considering service and academic views about teaching the subject).

At a different level, the chapter introduced a number of ideas and issues which will be returned to, and which will recur throughout the thesis. Important to the future discussion of academic general practice are the notions of boundaries, both professional and epistemological, and various aspects of general practitioners' ideology, most notably, the concept of individuality. Of particular significance has been the delineation of the two perspectives of the

general practitioners. In a later part of the thesis these two perspectives will be returned to, for it will be argued that the courses in undergraduate general practice in the Scottish departments present a view of general practice which resembles either one or the other of these two orientations.

Overall, the discussion of specialisation lays out a frame of reference for the remainder of the thesis, which is to study in greater detail one aspect of this process, the institutionalisation of a university discipline. It was suggested in Chapter Two that one way in which the medical specialties became institutionalised was by gaining a place on the medical curriculum; the increasing specialisation of medicine and surgery was mirrored in the curriculum which grew with every new discipline. The focus of the remainder of the thesis, then essentially charts the same process for general practice. Implicit rather than explicit throughout is the assumption that by becoming part of the medical establishment general practitioners are ensuring the future of their 'specialty'. The next chapter describes the initial establishment of general practice departments, while those which follow explore the staff and the courses.

Section III

ACADEMIC GENERAL PRACTICE

Section Three is devoted to academic general practice, the departments, the staff and the courses. Chapter Four outlines the establishment of the departments in the university while the next chapter, Chapter Five, presents the staff of these departments and their identity dilemma as academics. Finally, Chapter Six is concerned with an official view of the courses as they appear on the course programmes.

Chapter Four

THE FOUR SCOTTISH DEPARTMENTS OF GENERAL PRACTICE

THEIR CREATION AND FUNCTIONS

Introduction

The previous chapter introduced both general practice and general practitioners. This chapter marks our first contact with academic general practice, and the source of establishment within the medical school, the departments of general practice. In the first of two parts, a wide perspective is taken. Academic departments of general practice are placed into context by outlining their development within the United Kingdom. This is followed by a more detailed description of the emergence of the four departments of general practice within the Scottish medical schools. The second part of the chapter examines the various types of department which exist, and their funding, and concludes by reviewing the aims of the four departments.

Material for this chapter was gathered initially from interviews with the full-time medically qualified staff members of the four academic departments. Other evidence comes from written accounts of the departments, largely by the membership itself.

I

Trends in the Development of Academic General Practice

As a branch of medicine, general practice has been in existence for over a century. Until very recently, however, it has had no validity as an academic subject, nor did practitioners have any representation within a British university. Its introduction and establishment is both recent and impressive.

City dispensaries were the first forums for any kind of teaching of general practice; undergraduate medical students could attend the dispensary, learn about the dispensing of medicines and observe the variety of conditions which remained non-hospitalised.[1] Although there is a record of a taught course in general practice appearing on the curriculum of an English medical school as early as 1935 (Barber, 1952), the teaching was carried out by another (unnamed) department. By the nineteen fifties, however, two general practice teaching units were in existence, one in Manchester, and the second in Edinburgh, the latter being created in 1952. When Pearson, Eimerl and Byrne surveyed the British scene in the following decade further progress had been made (Pearson, Eimerl and Byrne, 1968). There was one department (as opposed to a unit) of general practice, although no chair in the subject

[1] In his Memoirs of a Shetland Doctor, Taylor (1948) recounts how he started his working life in a hospital dispensary where amongst other tasks, he ran what he called an 'extra mural' practical class for medical students, teaching them about the dispensing of medicines. He later trained and qualified as a doctor.

Table 4.i

Changes in Teaching of General Practice in Universities in the United Kingdom 1965-1973

	Number of Medical Schools (29)			
	Pearson, Eimerl and Byrne 1965-66	Harris 1968	Byrne 1972	R.C.G.P. 1973
Departments of general practice	1	5	11	12
Chairs of general practice	0	1	6	8
All students taught general practice	8	12	22	23
Reports from students	3	9	12	14

Source: R.C.G.P., 1974

was reported (presumably the actual survey was carried out before the Edinburgh professor was appointed in 1963).

The (Royal) College of General Practitioners had always argued strongly for such departments (1952, 1955, 1966, 1972). They sponsored two studies to chart the progress of academic departments (Harris, 1969, Byrne, 1973) and continued the series with a further study in 1973. The series revealed a steady increase in both departments and chairs within the twenty-nine medical schools of the United Kingdom. By 1973 eight chairs and twelve departments were in existence, and the majority of medical students in the United Kingdom were receiving teaching in general practice (See Table 4.i).

Academic general practice, then, had flourished within that period, and not least in Scotland. At the time of the 1973 RCGP study three out of four Scottish medical schools had general practice departments, compared to London where only one out of twelve medical schools had a department. One year after that study, in 1974, Glasgow gained a department and a chair, thereby exaggerating the already existing difference between Scotland and London.

The Future

Since 1974, the increase in the number of new departments and chairs has declined relatively. Murray and Barber recorded more

recently that in the United Kingdom eleven out of the twenty-nine medical schools still had no department of general practice, and in one medical school (the London Hospital) general practice was not taught at all to undergraduate medical students, although an elective period was available (Murray and Barber, 1978). The authors reported that in that school 'general practice teaching is likely to expand' (Murray and Barber, 1978, p. 46).

The future may well be that a minority of medical schools remains without a department of general practice, or that teaching of the subject continues to come from a unit within a larger department. Scepticism about the value of such departments has always existed amongst some of the profession (for example, Wofinden, 1968), and whilst the General Medical Council reported optimistically that they anticipated departments in every medical school (G.M.C., 1977), there are indications of continued questioning of such departments. One example drawn from a symposium on the teaching of general practice is indicative of such thinking. In a reported speech of a Dean of Medicine

> He [the Dean] referred to the slow development of academic departments of general practice, particularly in the London medical schools, and stressed that until it could be shown that departments of general practice had done something for medical education, they could not be justified.
> (Medical Education, 1977, p. 148)

The Development of the Four Departments

The following accounts are of the circumstances and the reasoning surrounding the creation of the four general practice departments

within Scotland. They have been constructed from interviews with the heads of departments, and from whatever written evidence had been found. They are partial histories, in every sense of the word; they are incomplete, and relate largely the viewpoint of the teller (although other evidence has been used to support or question the account). Nevertheless it was thought useful to include these histories since they serve to underline some of the influential links made and retained by general practice departments.

The first account is of the creation of the Edinburgh department. It is fuller and more detailed than the others, largely because of an additional interview with the head (and founder) of the department by a senior member of the Centre for Research in the Educational Sciences, University of Edinburgh.[1] The professor has also written a formal account of the earlier phase of the department's life (Scott, 1956) which differs significantly from the interview only in that it stresses the role of the unit in teaching undergraduates.[2]

The professor (and founder) of the Edinburgh department recounted how he initially was employed after the Second World War in the university Department of Social Medicine in Edinburgh. One of his functions as a member of the department was to engage on research on the social factors influencing medicine. To help with this task, it was suggested that he recruit a social worker, a sanitory inspector and a health visitor. Accordingly, in 1947, he was joined by a social

[1] The interviewer, my supervisor, visited the professor on 8/11/71 prior to my commencing research in the department in 1972. Notes were taken during the interview and typed up immediately afterwards.

[2] One may guess that this emphasis upon the teaching function was important in arguing for the extension of the unit into a full department.

worker, although the other two members of the team never materialised. Over the next years he carried out several pieces of research, together with the social worker. All involved visiting families and quite often families who were in need of 'care' in the widest sense. The researcher found that he himself was pulled in to help with the care the families needed. He recounted that he was 'horrified at the way in which his research project had turned out to be a project concerned with the care of patients, and so he then tried to design a research project which would not involve him in looking after patients but would merely give him information' (Fieldnotes, 8/11/71).

In a further project the two researchers achieved this information gathering exercise by enlisting the help of local general practitioners (who presumably provided any medical services the researcher was reluctant to give).

With the introduction of the National Health Service, and the registration of general practitioners, the doctor realised that opportunities for pursuing his research interests were increasing. With a five year grant from the Rockefeller Foundation, he set up a Unit in 1952, combining with a voluntary organisation for the care of the poor to do so. The aims of the General Practice Teaching Unit were to do general practice work and at the same time to collect longitudinal information from patients. The same group also provided on a voluntary basis teaching for any students interested in the care of patients in general practice. At the end of the five year period a university committee was set up to consider the Unit's future.

At this time, the Unit functioned as a general practice, (started in 1948) and now staffed by four full-time members of the Social Medicine Department. The focus of the Unit (and the reported interest

of those involved) was, however, not general practice but research; the commitment to general practice was thus a necessary 'by-product'. With the recommendation by the Faculty that the Unit should develop into an autonomous department the emphasis shifted. A substantial teaching component was added to the already existing commitments of research and service. The professor recalled, 'The university committee recommended that a full department of general practice be set up, and that the quid pro quo for establishing this department - rather than returning the four staff members to social medicine - was that the department should provide a part of the social medicine course in the fifth year, and that electives in general practice would be made available' (Fieldnotes, 8/11/71).[1] Thus the first general practice department in Britain was established in 1957. It recruited two more full-time members to make up a staff of six, and fourteen part-time members of staff to help with the teaching. In 1963, the Unit director was given the department chair, and became the first Professor of General Practice in Europe.

Information about the other departments is less detailed. What is no doubt the case, however, is that after the founding of the first department the arguments for further departments were less difficult to mount. The precedent of a department assumes that in one medical school, at least, justifications for such a department have been heard and accepted. Other medical schools may not always require the same length of persuasion over the decision.

[1] See Brotherston, Martin and Scott (1959) for a fuller account of this part of the department's development.

The Aberdeen Department

The history of the Aberdeen department reflects certain similarities with Edinburgh, although with one significant difference; there was no existing general practice to provide a service element, and none created with the department. Briefly, in 1967, a unit was set up, entitled 'General Practice Teaching and Research Unit', and funded from outwith the University by a three year grant from the Nuffield Trust. A senior lecturer from the Social Medicine Department was appointed director.

How was such a unit founded? The professor of general practice recalled that he had been asked by a senior member of the Medical Faculty how he thought general practice should be taught, at a time when the undergraduate curriculum was being overhauled. Although there was opposition from his professor, he wrote a report suggesting that the subject could be taught through the involvement of local general practitioners, 'with someone to hold the reins at the university', as he put it. This report was submitted to the appropriate university committee. His ideas were obviously acceptable to the Faculty and led to the founding of the unit with himself as director. In 1969 the unit became a university department and in 1970 the director accepted the departmental chair.

The department remained smaller than Edinburgh (in 1973 the professor was aided by three full-time teaching staff, one senior lecturer and two lecturers). Unlike Edinburgh it had no teaching practice although there were plans at the time to build a university health centre (he mentioned a possibility of a teaching practice being founded). Instead, the department relied for help with its teaching

upon a large complement of part-time staff (forty-five in 1973) who were paid an honorarium, then £20 per annum per student, but who received no official university status.

Teaching of general practice in the undergraduate curriculum had been carried out for many years on a voluntary basis. In 1964 it became compulsory and the four-week attachment in the final (sixth) year of the undergraduate course did not alter when the department came into being. Interestingly, Aberdeen was the only Scottish department to be created within the main medical school campus, albeit in a hut.

The Dundee Department

The Dundee department stands out in many ways as unusual among the four Scottish departments. It does not, as the others did, have links with a social medicine department, and the professor had no previous university experience. The researcher has found little written about the reasons for such decisions. For those interested in academic general practice this story would be worth recounting, preferably by an insider who was involved in setting up the department.

The outline of events is that in 1969 (the same year as the Aberdeen department was created) a department and chair in general practice in Dundee were made possible with the help of a drug company, Pfizer Limited, who endowed £50,000 by covenant to the university for this purpose. In 1970 Dundee appointed their first professor, not a man who had previously held an academic post, but a general practitioner from Edinburgh. He had been involved for some years in post-graduate

teaching of general practice through participation in the Royal College of General Practitioners.

When asked for his account of the founding of his department, the professor first told of a letter recording an attempt by general practitioners in 1952 to found a department. These doctors had written to the medical school urging the creation of a department of general practice. The medical school was reported to be prepared to discuss the matter, but nothing happened. The professor's views were that 'the finances weren't there and the G.M.C. was not on the same wavelength'. He suggested that several factors were important in changing the climate of opinion. The precedent of the Edinburgh department had been influential, as had the Royal College of General Practitioners. Furthermore, there was a general move away from hospital care to general practice, and the Scottish Home and Health Department's Health Centre programme had planned for Dundee to have a large health centre. The professor reported that by this time 'finance and the G.M.C. seemed more favourable to ideas about general practice, the Professor of Community Medicine and a paediatrician went to a drug firm, said that a chair would be doing the university good, and so the department came into being, with a chair' (at a time again, when the curriculum was being radically overhauled). The advertisement for the chair, which appeared in the leading medical journals, emphasized the role of the Faculty in the creation of the department: 'for a number of years [the Faculty had] recognised the need to improve the teaching of general practice to undergraduates and post-graduates' (Medical News, 1969). Over his own appointment, the professor said that there had been considerable debate at the time, but eventually it had been decided not to follow the Edinburgh situation, and instead, they

appointed a service practitioner. When interviewed early in 1974 the professor remained the only full-time teaching member of his department (although a statistician was also listed in the University Calendar as a department member). The professor reported that he had been given the opportunity to take on a senior lecturer but had made the decision to use that salary to pay a group of part-time lecturers, of which he initially appointed eight although the number trebled within a few years. These practitioners were part-time staff, and certainly received rather more than the usual honorarium for carrying out their teaching duties (in 1978 they received £60 per teaching session).[1]

Initially the department's teaching duties involved an attachment scheme programmed in the final year (sixth year); later the department came to have considerable teaching involvement in other years, particularly the third year pre-clinical behavioural science course.

The Glasgow Department[2]

Glasgow was the last of the four Scottish medical schools to gain a general practice department. Its development has received fuller documentation than some by Murray (1977).[3] Although the department was

[1] Comparison of part-time staff is difficult since 'sessions' may vary in length and preparation time required. Over the year, part-time staff may do varying number of sessions; nevertheless, in 1978 £60 per session was above average payment.

[2] Throughout the writing, Glasgow is referred to as a department, although strictly speaking, some of the fieldwork was carried out before it became a full department.

[3] Murray, then a research fellow of the department, wrote his Ph.D. thesis on evaluation methods in general practice teaching; the thesis included his account of the development of the department drawn from a number of sources.

only founded in October 1974, an attachment scheme had been ongoing since 1954, together with two short series of lectures, at first voluntary, later made compulsory. The attachment scheme was notably successful, and the number of students and doctors involved increased throughout the 'sixties. On the strength of this, a suggestion was put in 1962 by some members of the Royal College of General Practitioners that a combined teaching practice and college headquarters be set up near the university. The idea did not gain overall support from members, and came to nothing. Again in 1963 it was raised, but the consensus of opinion was still against it. In 1964 the idea of a department of general practice to study 'illness in the community' was put to the university, but according to Murray, the then Dean felt that the time was not appropriate and the idea was given low priority.

When Woodside Health Centre was built, space had been allowed for university participation in general practice teaching, research and clinical services. In the year of opening of Woodside (1971), a senior lectureship in primary medical care was created jointly between the Departments of Medicine (at the Royal Infirmary) and Social Medicine (in Glasgow called Epidemiology and Preventive Medicine). The senior lecturer appointed had previously been in the services, and had worked in general practice for a number of years.

Once based in Woodside, the senior lecturer introduced more structured teaching in general practice into the curriculum, the first course of any length appearing in 1972, although general practice did not appear officially on the curriculum until 1975. On the strength of the considerable general practice input into the curriculum via other clinical subjects (see next chapter for details), a delegation from the

university sought funding for a chair.[1] An insurance company, General Accident, agreed to found the 'Norrie Miller' Chair, (and also to finance a researcher for three years). The department and chair came into being in October 1974.

Reasons Behind the Creation of General Practice Departments

The first part of this chapter was concerned with outlining the creation of the four Scottish departments of general practice. Such an account has hitherto ignored the question as to why such departments were established at all. The answer was not felt to lie in the personal accounts of the founding of the departments, nor in any single factor. Rather, by linking evidence gained from a number of sources the explanation sought should take into account professional, political and epistemological factors. The implication of this is that the establishment of academic general practice is a process of essentially the same nature as specialisation; it is, in fact, one aspect of this latter, larger process.

The historical account emphasised the importance of representation within the profession. It was shown to be unlikely that without the presence of general practitioners in the professional arena, the discipline would flourish. The Royal College of General Practitioners

[1] A member of another department told of the role of the Royal College of General Practitioners in the creation of this department. The College had 'manoeuvred' it so that a visiting professor in general practice could be in Glasgow at a time when the new department was under discussion. The visiting professor, it was said, was instrumental in its eventual creation.

played a significant role in acting as an important pressure group for those wishing to pursue academic general practice. Although the College had no direct representation within the medical schools, educational aims had always been given priority by them, and the College consistently argued for the creation of academic departments (for example, in evidence to the Royal Commission). Once the first department was created, of course, pressure from within the faculty could be applied to other medical schools.

This does not explain the overall professional support which was required to establish the first departments. Backing for such a venture must have been given by members of other branches of medicine, yet this is the most elusive data to seek out. Chapter Five documents the alliances the senior academic general practitioners made within the medical school; but the researcher has found little evidence outside the general practice literature documenting support for the academic development of that subject.

To consider reasons for the political support for academic general practice may provide a further clue to this question of why other members of the profession would encourage the establishment of academic departments of general practice. It will be remembered that in the 'sixties general practitioners experienced considerable discontent with their working situation, which led to an increase in the emigration of doctors, and an overall decrease in the number of graduates entering general practice. Yet the Government had committed itself to health care delivery, primarily through general practice rather than through hospital care, both with the introduction of the N.H.S. and also with the further commitment to health centres. It may have been the case that Government, and subsequently the G.M.C., support

for academic general practice was triggered off by the uneasy combination of the commitment to general practice on the one hand being countered by the decreasing number of general practitioners on the other. Since it was vital to the Health Service to keep the number of general practitioners from dropping lower, the creation of departments with teaching functions may have been part of the solution, since one accepted way to recruit students into a career has always been through student contact with that discipline. Professional support can now be seen to be a result of a desire amongst hospital specialists to likewise help in maintaining the front line of general practitioner care by approving of increased student contact with general practice.

But, as initially suggested, a number of factors should be taken into account in this explanation. Timing, for example, is important, although as a factor should be viewed cautiously so as to avoid an explanation which slips into historical determinism. The funding of medical chairs reflects the academic climate, and it is no accident that general practice became institutionalised at a time when there was more general expansion in tertiary education. It was in the late 'sixties and early nineteen seventies that the majority of general practice departments became established, along with a wide range of other disciplines (for example, sociology, drama, education, and a number of others within medicine - oncology and cardiac surgery being two). From the little evidence available on such matters, it seems likely that practitioners associated with the College of General Practitioners repeatedly put in requests for academic departments to be created. One could imagine such a request being placed whenever there seemed an opportunity for change - during curricula reorganisation, for example, or new leadership to the medical faculty. Only when such

a request coincided with those of a number of other interested parties was it likely to be viewed favourably.

One final consideration which feeds into this general discussion is the resurgence from the 'forties onwards in the related notions of social factors and social pathology. The increasing tendency when considering certain forms of illness and deviant behaviour to draw upon explanations which involved social factors has been documented both in Britain and the United States (for example, Jefferys, 1970; Armstrong, 1979a; Merton, 1957; Zola and Miller, 1973). General practice, with its distinctive 'community', as opposed to hospital, orientation, may well have been seen as an appropriate discipline to encourage, since general practitioners were understood to have some expertise in this area.

Why Scotland?

Allied to the more general question of why such departments were created at all is the subsidiary issue of why the Scottish medical schools were so successful in gaining departments while other medical schools in the United Kingdom, most notably in London, still remain without a department. Scotland, of course, has a long history of medical teaching. The first chair established in 1505 was the Aberdeen chair in the practice of medicine. One may well ask, is there something peculiarly Scottish which encourages innovation in their medical schools? If this were so, then Scottish medical schools would be uniformly modern, whereas in a number of aspects (for example, in the continued use of certain teaching methods) they retain

distinctively traditional features.

Another possibility is that a competitive market for medical students existed within Scotland. An innovation in one medical school would be quickly repeated in another university so that no one medical school could boast a better array of courses than another. In fact, for general practice this holds true; all four departments were established within a short time period (see Table 4:ii). Unfortunately, it is not always the case for specialties. A quick examination of the foundation of medical chairs in Scottish universities reveals little consistency.

It may have been that general practice in Scotland has never been awarded such low status as in England. Earlier, it was argued that the eighteenth-century Scottish trained physicians received a broader, more general training in medicine, and practised 'general practice' more openly and more respectably than in England. Even today, in Scottish universities, the general Arts degree, the Master of Arts, remains more popular and more acceptable than in England. In Scotland, then the ethos of generalism may still have more currency than in other parts of the United Kingdom.

One final factor relates indirectly to the age of the Scottish universities. The Scottish universities may have had more funds than many of the newer English universities from which to support departments. Halsey and Trow offer support for this hypothesis with their breakdown of the income of English and Scottish universities for the year 1967-68 (Halsey and Trow, 1971, pp. 90-91). Excluding Oxford and Cambridge, and the University of London (treated as one university), Glasgow comes out as the next most wealthy university in terms of total annual income, while Edinburgh follows three behind. Dundee and

Table 4.ii

Dates of the Establishment of Endowed Chairs in the Four Scottish Medical Schools

Subject	Medical School			
	Glasgow	Edinburgh	Dundee	Aberdeen
Medicine	1874/1713	1685/1913	1889	1505
Botany	1718	—	—	1860
Anatomy	1818	1705	1889	1839
Surgery	1815/1911	1777/1803	1889	1839
Midwifery	1815/1911	1726	1889	1860
Materia Medica/Therapeutics	1831	1768/1911	1889	1860
Physiology	1839/1965	1685	1889	1860/1968
Forensic Medicine	1839	1807	—	—
Pathology	1893/1911	1831	1889	1882
Opthalmology	1935	1947	—	1977
Bacteriology	1919	1913	1921	1925
Public Health/Social Medicine	1923	1898	1950	1951
Child Health	1924	1931	1950	1951
Genetics	1945/1973	—	—	1965
Psychological Medicine	1948	—	—	—
Psychiatry/Mental Health	—	1919	1956	1945
Orthopaedics	1959	1947	1965	—
Pharmacology	1964	1768	1980	1968
Neurology	1964	1947	—	—
Geriatric Medicine	1964	—	—	—
Pathological Biochemistry	1964	—	—	—
Biochemistry	—	1919	1975	—
Dermatology	1965	1946	—	—
Postgraduate Medical Ed.	1971	—	—	1971
Medical Education	—	—	1972	—
Administrative Medicine	—	1960	—	—
Clinical Physics	1973	1966	—	1965
Child Psychiatry	1973	—	—	—
General Practice	1974	1963	1969	1970
Cardiac Surgery	1974	—	—	—
Oncology	1974	—	—	—

Source: University Calendars. Dental and personal chairs excluded. Lectureships existed in some medical schools before an endowed chair was established in that subject.

Aberdeen have smaller annual incomes, but are within the top third of all forty-four universities listed regarding endowments and donations (Halsey and Trow, 1971, p. 90). Thus the happy association of sufficient funds with the enthusiasm for general practice departments, together with the knowledge that the first department of its kind was already established in Scotland may have facilitated the creation of the latter three Scottish general practice departments.

II

Types of General Practice Department

Having looked at individual departments, the second part of the chapter explores some of the significant aspects of their functioning; first, their structure and funding, and secondly, their aims. A number of types of general practice departments exist within the medical schools of the United Kingdom. These can be formulated, following Hodgkin's analysis (1974), into three types. It is purely fortuitous that within Scotland all three types have existed, although the first, typical of Glasgow pre-1974, no longer exists. The first type of department, then, is one created as part of a larger

department (usually community medicine).[1] Such a department is small, has limited resources, but is easy to start and run, requiring little finance.[2] This kind of department is still common in a number of English medical schools (for example, Bristol and Newcastle) where the commitment to teach general practice is not great.

The second type of department is autonomous, with a small whole-time departmental structure centred around a chair of general practice. Sufficient funds enable a ring of service general practitioners to help with the teaching on a sessional basis. This kind of department is exemplified by Aberdeen or Dundee (or in England, Birmingham and Leeds), and is the kind of department into which Glasgow developed. As a full-time department, it has been described as 'quick and cheap' to create (Byrne, 1973). Whilst this may be so, Hodgkin suggests that it is in fact the most difficult type of department to run, requiring a general practitioner of unusual calibre to successfully co-ordinate the service general practitioners with the requirements of a university course.

The third type of department, illustrated by Edinburgh (or, south of the border, Manchester or Liverpool) is an autonomous department with a full complement of staff and a university teaching practice. This latter feature has a number of immediate benefits; the practice can be used for teaching and research and also facilitates a service commitment for the full-time staff. The number of part-time teaching staff required to help is usually less than in type two.

[1] Technically this type of unit is not a 'department' but a sub-section of a department. Hodgkin, however, treats it as a form of department and I have followed his format.

[2] Hodgkin offers a fuller account of the advantages and disadvantages of each type of department.

As a form of department, it is the most complex administratively. The university is involved in administering the practice, for the department's staff who work at the practice are paid on the lecturers' salary scale and not as general practitioners[1] (thereby freeing them from one of the major constraints of general practice - the necessity to maintain a list size of 'average' proportion to assure themselves of a certain income). Income from the practice is returned to the university. Departments with university practices typically have greater resources and more full-time staff. The Royal College of General Practitioners has always indicated that they see this as the most desirable type of department (C.G.P., 1955, 1964; R.C.G.P., 1972b). It remains in a minority, although there are indications that other types of departments may adapt to this type (after the field-work for the research had been completed, the Dundee department changed to this model, acquiring a university practice in the locality, while the possibility was also raised of the Aberdeen department gaining an attached practice).

Funding

The different types of departments obviously require varying resources, and universities, or more specifically medical schools, must decide upon the financial commitment they wish to make to the teaching of general practice and tailor the department accordingly.

[1] Although they do receive seniority payment and payment for vocational training from the Executive Council, over and above their university salary.

A number of 'local factors' have to be taken into account when setting up a department, for instance, the number of service practitioners in the region potentially available for teaching purposes, or the possibility of the university creating or taking over a teaching practice for the department. Such decisions are solely the responsibility of the university, for, unlike other departments in the medical school who are funded from the National Health Service budget, university departments of general practice are funded directly from the University Grants Committee.

Just as funds available affect the kind of department created, so may they also affect the potential of the teaching. Virtually all departments require the services of part-time staff to help with teaching, for the modes of teaching adopted by general practice departments require a high student/teacher ratio. For their heavy investment in hours and organisation of 'teaching material' (patients) part-time staff have been traditionally paid an honorarium rather than a real wage. In Edinburgh, for example, part-time staff were paid £150 per annum which in 1972 rose to £200. For this small sum they were required, for twenty weeks of the year, to attend the department for seminars once a week (lasting a full afternoon), and on two afternoons a week to have students sitting in on their surgery.

The influence of the part-time staff on the department is to be discussed more fully in Chapter Eight. But it is worth commenting on the role of funding in establishing a particular relationship between the part-time and full-time academic staff. The small financial sums typically available for payment was not felt by either group to be adequate recompense for the tutor's commitment of time and energy in teaching; instead, it was seen to lead to an uneven relationship

between the two groups, described by an academic as one of dependency upon part-time staff for patients and facilities. In an attempt to justify the relationship as it stood, one full-time academic brought up two motives to explain why part-time staff continued their involvement with the department. The first was altruism: he felt doctors in his city were prepared to 'rally round to help the students' regardless of pay. A second motive of prestige was put forward. Prestige came with the university connection. It was also suggested that the part-time staff in one department enjoyed using the university staff club (one of the few 'perks') while another academic presented a more controversial view:

> There is also a status element as the patients like having students present. This means that either the general practitioner has been chosen by the student, or he is seen as a representative from the university and so either way gains some prestige from the situation.
>
> (G.P. 25)

Nevertheless, one of the senior lecturers reported that he felt the department could not ask too much of these doctors. Although he and some of the other members of staff were not wholly happy with the teaching by part-time staff they hesitated to do anything about it. Thus in one department at least staff felt that the teaching was compromised ostensibly because of the little financial reward they could offer.

The decision of the professor at Dundee to forego a senior lectureship in the department and use the salary ('plus a little help from the university') to pay part-time tutors resulted in the Dundee part-time teachers being paid more than six times the amount per teaching session that Glasgow paid their part-time staff. Not surprisingly, the Dundee professor reported that his relations with

the part-time teachers was good. Such a decision, however, was unpopular with other departments (and continued to be a bone of contention, Murray 1978, personal communication). It challenged the system of goodwill used by the departments of general practice, and changed the relationship between the full-time and part-time staff in a way which other full-time staff may have envied but could not follow.

Aim of Departments

Bucher and Strauss suggest that one of the ways in which to differentiate members within a segment is to seek out the core task of their work - '<u>the most characteristic professional act</u> of their professional lives' (Bucher and Strauss, 1961, p. 328, emphasis in original). A brief perusal of the aims of the four departments suggests that there are three core tasks associated with academic general practice which distinguish it to a lesser or greater extent, from service general practice. These three tasks, drawn from written documents about the departments are: the service commitment, research, and teaching.[1] In turn, each department reveals a differing commitment to each of these three tasks.[2]

[1] The aims, and the departments' commitment to each aim, was taken initially from the inaugural lecture of each head of department (one of the functions of which is to define publicly the scope and direction of the department). There is no tradition of inaugural lectures in Glasgow. However the professor has discussed the aims of the department in his interviews.

[2] The commitment of each department was taken from the inaugural lectures or interview material, plus a subjective assessment by the researcher based upon expressed interest of the department members, extent of publications, and content of publications (for example, whether reporting a new course, or a piece of research).

Freidson has emphasised the role of the medical profession as one of action, with the recipient being the patient (Freidson, 1970). Doctors divorced from direct patient care (as are, for example, community medicine specialists) often find this a problematic feature of their work. Both service practitioners and academic general practitioners engage in patient care. However, a brief consideration of the context of the latter's opportunities for patient care will indicate that there are critical differences in the type of care which an academic can offer, and that of routine practice. Patient care can no longer be the central task it is for service general practitioners, and instead becomes something which must be fitted alongside other duties.

Because such importance is placed upon practice by medical practitioners and yet opportunity for practice is necessarily limited, practice has become a critical issue for academic staff. All departments noted having a service function and most academic staff maintained at least a small commitment to practice.[1] This may take the form of four or five mornings a week, plus some afternoons of practice at a university practice (as in Edinburgh), or locum work for a few hours a week, which was the extent of practice for members of other departments.[2]

It was noticeable that in the written discussion of departmental aims, the department with its own practice accorded priority to its service role, while teaching and research came second and third

[1] A bone of contention in one department was that a senior member of staff never practised.

[2] Only one doctor mentioned that he <u>preferred</u> this limited commitment to patient care.

respectively (Scott, 1967). And, significantly, where the department's involvement in service work was less, teaching and research were given precedence (Knox, 1971; Richardson, 1972). While not too much importance should be attached to the order (priorities in departments can change, after all), the maintenance of a university practice requires a considerable investment by the department in terms of staff's time and energy. It is no doubt difficult, if not ethically dubious practice, to maintain a priority of research over and above patient care. A commitment to maintain a university practice demands a priority placement.

It can also be argued that maintenance of practice is easiest for members of a department with an attached practice. Here practice work is institutionalised into the weekly routine of the department. Furthermore each staff member has his list and his patients, and if the Edinburgh practice was typical, he finds his work accomplished more easily through the well-staffed and well-equipped practice. Although working time may be restricted, the list size may be half that of a service practitioner (the minimum list in Edinburgh was 1,000 patients per doctor, compared to the Scottish average list size which remains just under 2,000). The pace of work and the relative freedom from financial constraints are what many service practitioners may dream of. But just because the style of practice is removed from the usual, university general practices suffer from the stigma of atypicality.

The decision to have a university practice remains a controversial one. In the interviews with academic staff such a decision was presented as one requiring long deliberation (a view reflected in the literature, for example, The Practitioner, 1974). The grounds for rejecting a university practice (and although reasons may have been

largely political or financial such a decision was always presented with a different vocabulary of motives) was that such a practice was atypical, by serving atypical population, having smaller lists, and so on. It was also seen to isolate the department from the 'real' world of practice. One senior academic simply said that by not having a practice 'it made things easier with the local general practitioners'. This meant that he was able to involve them more in the functioning of the department, at the same time avoiding the 'ivory towered' image to which the academic general practitioners felt they were vulnerable.

Despite arguments against attached practices, senior academics suggested that their objections could be overcome under certain circumstances. One argued that a teaching unit in a health centre (particularly with its intended siting) would be isolated, a 'kind of ivory tower'. For him, a smaller university health centre as the practice base would be acceptable. Similarly, another spoke out against a self-run university practice, but was in favour of a university department in a health centre. He confirmed this view when he stated that he had previously felt that a university practice was a very artificial thing, with too many staff, and tiny lists. However, if the department became incorporated into a health centre (one was intended in the university) then 'this would be a natural evolution and nothing forced about it'.

Without a university practice, however, maintenance of any form of service work becomes more difficult. For academic staff, it is difficult to create a smaller version of 'normal' general practice. If doctors were engaged in practice only for a few hours a week, it could create a situation where what little general practice done could only be described, as it was by two members of staff, as 'minimumly

satisfying'. Earlier, in Chapter Three, it was suggested that important features of practitioner's ideology were 'continuity of care' and 'knowing one's patients'. It can readily be appreciated that if the member of staff practises only one or two mornings a week both features are difficult to sustain.

Despite the criticisms of university practices, the Royal College of General Practitioners has stated on a number of occasions that they regard this as an essential part of their ideal department (C.G.P., 1955; R.C.G.P., 1972b). Furthermore, the trend to this kind of department suggests that the advantages of having a university practice are seen to outweigh the dangers of isolation and artificiality which are identified as its main disadvantages.

We can look further into the issue of a university practice. While the presence of such a practice affords members of staff professional satisfaction through working with their own patients it also has, to use Merton's phrase, a latent function. Traditionally clinical departments in the medical faculty maintain a close relationship between clinical work and clinical teaching. Teaching is carried out on the wards, with patients who are under the care of the consultant, who can thus visibly combine roles of both teacher and practitioner. Academic general practitioners, if they wish to accept the dominant model of the medical school, therefore seek a situation where practice and teaching can be combined. A teaching practice is the nearest equivalent to a hospital ward, and for that reason carried greater value.

Research in universities assumes a major role. As one of the two major functions of academic life, research credentials form at least part of the basis upon which professorial (and other) staff are selected.

Thus research has become an important road to academic betterment.

But there are other reasons why research is so significant an aspect to university life. Far more than teaching, which is an essentially private activity within the university, research is the public arena of the department. It is through research and its associated activities (for example, attracting funding, new staff, and publications) that departments are seen to be academically active. Recognition for these activities is granted within the respective medical school, but more importantly research forms the link with the wider community of scholars. Research, then, can yield national and international recognition for a department and its staff.

Within medical faculties there has been a strong research tradition. Halsey and Trow found that staff in the medical faculty not only reported the strongest preference for research as opposed to teaching amongst the five faculties sampled, but also the greatest actual research activity (Halsey and Trow, 1971, part IV). Set into this context, it is not surprising to find that research was noted as a core task for every academic general practice department. However, for these departments the research task could be problematic. It is worth remembering that a general practice setting for research is comparatively new, and relatively few general practitioners engage in that activity. It was only in the nineteen thirties that research in medicine was emancipated from the laboratory setting and became hospital based.[1] Before this time research was not carried out unless the

[1] In 1929-1930 the Annual Report of the Medical Research Council included a suggestion that clinical research could be carried out in a hospital setting. Flexner deprecated the climate in British provincial hospitals where, he argued, unlike America, research opportunities were allowed to slip away. (Flexner, 1930, p. 260)

research variables were seen to be carefully controlled. This ruled out general practice where, because of the apparently rather unorganised nature of the environment (as compared to a hospital, for example), it was felt that strictly scientific research could not be carried out.[1] Even now, many general practitioners are unsure of how to transpose the rigorous methodology required by medical researchers into the setting of general practice, and instead may abstain altogether.

It is in this respect that one of the research functions of the department became relevant. Along with the Royal College of General Practitioners, which has encouraged general practitioners to do research (see, for example, issue no. 131 of the Royal College Journal), the academic departments of general practice were asked to provide both a source of research expertise upon which the service practitioner might draw, and also carry out research themselves (Editorial 1975; Birmingham Research Unit 1975). Only one example was quoted to the researcher of a service doctor seeking help from a general practice department; here the doctor had started a small piece of research and subsequently contacted the department because he 'did not know how to make it a proper trial'.[2]

One of the reported reasons why doctors were attracted by academic

[1] An interesting rhetorical device was employed by one academic which indicated an attempt to maintain 'rigour' in a general practice setting. Referring to his university teaching practice he used the term 'laboratory'. Thus his practice became a 'general practice laboratory' or a 'clinical laboratory' (Scott, 1967, p. 1316).

[2] Medical research is wedded to the randomised controlled trial (R.C.T.) which both methodologically and practically is difficult to accomplish.

departments was because they thought they would have more time to do research:

> After a year [of doing part-time teaching] I felt I was still poor at teaching as a general practitioner and also I wanted to have some research experience - or the opportunity to do some research - and so I applied for several jobs and took the . . . one.
>
> (G.P. 26)

Nevertheless, some departments appeared to be more productive than others in this respect. For example, the department with the least overall patient contact showed the greatest current research commitment. The department with a practice placed research third on its list of department functions, and individual members spoke less about ongoing research, although they had been active at some time in their career. This is not surprising: research is a time-consuming activity, and it seems likely that in practice patient care and teaching took priority over it when there was a clash of demands for an individual. It is revealing that in a more recent study of these same departments research was one of the activities Hannay found that Scottish academic general practitioners wished to have more time for (Hannay, 1980).

Teaching forms the core task which distinguishes academic general practice from service work. One of the major functions of any academic department as opposed to a research institute, for example, is that the department is expected to organise and co-ordinate the teaching of general practice to undergraduate students. Some of the staff indicated that teaching was the reason they entered the department - 'I was always interested in teaching as a post-graduate; I taught some undergraduates and nurses, and enjoyed it' (G.P. 27) (cf. Collyer, 1974).

Obviously teaching warrants a far lengthier examination than do the other core tasks of the departments, and essentially the remainder of the thesis will be devoted to various aspects of this major function of the department. One point is worth making at this stage. Unlike some other countries (for example, Canada), British departments are concerned with undergraduate teaching alone and not with post-graduate training. While the Canadian departments of family medicine (which are much larger) fulfil this latter function, in the United Kingdom vocational training in general practice is still co-ordinated by the Faculties of the Royal College of General Practitioners. Teaching in this country, then, is not exclusively an activity of academic staff; only the undergraduate teaching is. Selected general practitioner trainers carry out the post-graduate teaching with trainees, although there is some indication that staff in Scottish departments would like to have more involvement in teaching at this level (Hannay, 1980).

The teaching commitment of a department was more difficult to assess. Some departments obviously had less teaching time in the curriculum than others, although to what extent this reflected the lack of commitment of the staff in this area is difficult to tell - it could be that some medical schools were less willing to give that department more teaching time rather than a deliberate decision by the staff to become more involved with research or patient care.

This, of course, underlines the difficulty of doing more than merely describing the aims of the departments. Commitments to different goals are never permanent, but depend upon the stage of development of the individual department, and the interests of the personnel. Just as the academic staff's views on the service function

of a department doubtless change if the department establishes a teaching practice, then the relative weighting attached to research or teaching may also change. Those departments with such a practice have less time for research (while no doubt still recognising the importance of the latter activity). Equally, those departments with only one or two members of staff can afford to involve themselves only in a limited number of activities. The Glasgow professor recognised this: his 'choice' was to concern himself with the teaching, and when he felt himself to be in a position to argue for more staff to help with the teaching, then to allow the department to become more involved with research.

With the continued development of each department within the university, however, the emphasis placed upon each task in the departments may well change. More staff, the creation or attachment of a teaching practice, all represent areas of change for these departments. Such a longitudinal study of their development is, unfortunately, outside the scope of this research. One study which has thrown more recent light upon departmental duties is a postal questionnaire study (already referred to) by Hannay (1980). Hannay asked academic practitioners in Scotland and Canada about their department duties.[1] The findings concerning the Scottish academics are presented in Table 4.iii. Hannay asked each staff member to estimate how much time he spent on teaching research and clinical work, and secondly, how he would prefer his time to be divided up. Overall, Scottish staff reported that they would like to spend less

[1] Hannay brings out some interesting differences between departments in the U.K. and Canada, for example, staff in Scotland were less mobile, and much less likely to have patients in their own name.

time on clinical work and undergraduate teaching, and more time on post-graduate teaching and research. This bears up the previous comments of the chapter, that research as an activity takes a secondary place to other aims, while patient care and teaching, because of their nature, cannot be neglected, but may well 'swamp' time for research.

Table 4.iii

Percentage of Actual and Ideal Working Time for Staff in Scottish General Practice Departments

	Average Percentage of Working Time		
	Actual	Ideal	Change
Internal administration (including meetings)	13%	13%	0
External administration	6%	7%	1%
Service clinical work without teaching	34%	31%	-3%
Undergraduate teaching	21%	16%	-5%
Post-graduate teaching	6%	9%	3%
Research	13%	18%	5%
Personal study	6%	6%	0

Source: Hannay (1980)[1]

[1] Hannay received a response rate of 73%, that is, five of sixteen full-time medically qualified members of Scottish department did not respond (study carried out in 1978). Given the small numbers, responses from these four could quickly make the figures more or less convincing than they are. The important part of the table is the amount of 'actual' time staff estimate they spend on each activity.

This chapter has concentrated upon outlining and discussing the founding of the general practice departments in Scotland. While attention was paid to the details of each department's creation, the first part of the chapter also located the development of general practice in Scotland within the broader movement of the establishment of the subject within the university. The second part of the chapter concentrated upon the core tasks of the departments. Although the teaching function was dealt with only briefly, subsequent chapters will deal with this in more detail. But first, the chapter which follows will be concerned with the academic general practitioners. That is, having introduced the departments of general practice, we now introduce their staff.

Chapter Five

CAREERS AND IDENTITIES OF ACADEMIC GENERAL PRACTITIONERS

Introduction

Typically, sociological studies of higher education have focused upon the recipient of education, the student, rather than the immediate provider, the teacher. The university expansion of the early nineteen sixties generated a considerable literature in the field, but with questions concerned with the student predominating.[1] This focus of attention was equally true in America, where funding and research units in higher education were far more developed. Even work from the Chicago School of Interaction, whose researchers professed to understand the social world as interaction, took on this bias, the teacher remaining a shadowy figure throughout the studies.[2]

This chapter reverses the normal by bringing into the analysis the

[1] Universities Quarterly (March 1963) reports a spirited seminar on university expansion, with leading British educationalists taking part (for instance, Floud, Abrams, Hoggart). Apart from noting how difficult it was to find financial support for research, the issues raised all concerned students - their background, why they failed, in which faculties the increase in students would come, and so on.

[2] Two important studies of higher education from this school reflect the researchers' commitment to the 'underdog', the student; the teacher and the knowledge imparted in the institutions remain of secondary importance (Becker et al, 1961; Becker, Geer and Hughes, 1968).

teachers, that is, academic general practitioners who had a full-time commitment to the departments (a later chapter will introduce the part-time teachers).[1] The first part of the chapter concerns itself with the recruitment of staff into the departments. However, the discussion goes beyond merely outlining the career pattern of these doctors to analyse in some detail their (then) current standing within the medical school. In so doing it uses the conceptual framework typically reserved for the student, for the major part of the chapter addresses itself to the identity problems of the academic. More usually, the studies of academics which do exist have largely concerned themselves with the external factors associated with the role of the academic (for example, academic careers or tenure), or with the market economy of the university (for example, see the classic American studies in this field by Wilson, 1942 and 1979, or Caplow and McGee, 1958).

The British literature on academics remains scant by comparison. A leading educationalist, A.H. Halsey, noted in 1963 that 'Unhappily no serious study of academic men in England or by an Englishman has appeared since the Second World War' (Halsey, 1963). Together with Martin Trow, Halsey went on to complete what still remains as one of the few British studies, the eponymous classic, The British Academics (Halsey and Trow, 1971).

This thorough and lengthy piece of research, designed in the best empiricist tradition, initially concerns itself with the university structure, and within that, the kind of career possible for an academic.

[1] Some departments employed non-medical staff (for example, a social worker, or a sociologist) and/or research staff, who may have been medically qualified. Their role in the department is not examined.

Part IV deals directly with the views and attitudes of academics, but the reference here is not to the academic's identity, but rather the differing orientations to their work of those primarily concerned with a teaching or a research career. Other more recent British studies have tackled similar issues (for example, Startup, 1979) but do not have the breadth or empirical support offered by Halsey and Trow's work.

What is disappointing about Halsey and Trow's study (and other studies in the field are equally remiss), is that while the functions of teaching and research are given lengthy treatment, the researchers have not incorporated into the study another function of some faculties - a service function. Service work is a significant part of the work of a number of university disciplines - the health sciences are an obvious example, but so too, do law, business studies and economics have such an involvement. One part of this chapter will explore, through self-image or identity, the relationship between academic and service work.

This chapter, then, is concerned with the parameters of the identity of academic general practitioners. Not surprisingly, it draws little from the literature of higher education but relies largely upon the symbolic interactionist literature on identity. After locating these doctors within the social structure of the medical school it outlines the dilemma as they experienced it, neither secure in their identity as academics, nor as service general practitioners; the concept of 'marginal man' is utilised to explain their uneasy position.

The value of this analysis is twofold. First it will be argued that one can relate an understanding of identity and the forces which help to shape and change it to the pedagogy of the teachers. That is to say, the tensions in the self image of the course designers, the academics, are

reflected in the courses presented by the departments. That discussion will be presented in a later chapter. Secondly, the analysis of self-image raises more general issues surrounding the neglected relationship between academic and service work. While this has attracted little interest from researchers, for some professionals (doctors, lawyers) it is an important and problematic feature of their academic role. The relationship will be returned to later in this chapter. Initially, however, the chapter will introduce the academic general practitioners by a brief look at their careers.

Careers of Academic General Practitioners

Before the more detailed analysis of the self-image of the academic staff is developed, it will be useful to begin the discussion by answering the question 'who are these doctors?', 'why did they enter academic general practice?' The material collected is not detailed (each doctor interviewed was asked to give an account of his career leading up to his current position in the department, but the doctors were not pressed if their accounts were brief): nevertheless their statements allow us to make some initial remarks about careers.[1] Virtually all doctors interviewed were first incumbents of their posts;

[1] The term 'career' in this chapter is specifically concerned with work rather than taking on a broader meaning. For this reason I prefer Hughes' description of career to Goffman's; Hughes writes that 'career is, in fact, a sort of running adjustment between a man and the various facts of life and of his professional world' (Hughes, 1971, p. 406), while Goffman refers more generally to a career as 'any social strand of any person's course through life' (Goffman, 1961, p. 127).

all had pursued a professional career in some branch of medicine before they entered the departments.[1]

Within the profession, careers in hospital medicine and general practice are organised very differently. The medical career structure in hospitals is organised hierarchically, and is very competitive, particularly in certain specialties. Typically someone wishing to gain a consultant post will choose his (or less likely, her) specialty soon after registration, and will remain within it. As the individual moves up the career ladder, a series of promotion hurdles present themselves, often in the form of specialty examinations and membership to one of the Royal Colleges. These serve to mark progress, but also to limit movement between specialties.[2]

General practice has always been projected as the antithesis to this hierarchical competitive system. It lacks a proper career structure at present, prestige and income being less closely linked to an objective system of assessment. Any doctor can at present enter general practice immediately after registration and be assured of work. Further training, degree or diplomas are not necessary, although the situation is changing, and will change considerably with the introduction of compulsory vocational training (see note on page 229). Competition exists for the favoured areas of practice (for example, residential

[1] A total sample of academic general practitioners of the Scottish departments was taken; at the time there were twelve in post. Ten were eventually interviewed. See Appendix A.

[2] A national study of medical career choice, commissioned by the Royal Commission on Medical Education, has revealed interesting patterns associated with specialty choice and career decisions (Todd Report 1968, Last and Stanley, 1968). The study revealed amongst other things that general practice remained the second career choice for many of their sample.

areas of towns) but there continues to be parts of the United Kingdom which remain 'underdoctored' (Butler, Bevan and Taylor, 1973). A 'classic' description of a medical career (cf. Last and Stanley, 1968) was offered by one of the sample who considered hospital work but who assessed his chances of achieving a consultant position as unlikely, and 'fell back into' general practice, even though he then went on to choose the atypical career of an academic general practitioner:[1]

> I had wanted to be a G.P. since I was quite young (although I don't come from a doctor's family). While I was at medical school I tended to want to do the specialty I was in at the time, but later on I realised I was not bright enough to become a consultant so I again took to the idea of being a G.P. I don't know how much of this is post-event rationalisation.
>
> (G.P. 25)

What kind of career pattern did the academic general practitioners present? Briefly, what emerged was not any clear cut route to academic general practice (although this may appear with future generations of academics). Instead, as one might anticipate, a variety of careers were unfolded which, in different ways, had resulted in each entering academic general practice. Some had made this choice early in their professional lives, most after pursuing another medical career. Some will no doubt remain in academic life, others have already left to go into full-time general practice or elsewhere.

[1] For a number of reasons (market forces, i.e. availability of work, lack of required qualifications), general practice has always been regarded as a branch of medicine upon which one could fall if the hospital career failed or looked like failing. Movement within the profession since the introduction of the N.H.S. has been, crudely, from hospital to general practice, movement back into the hospital system being more difficult (in one study of mobility of general practitioners within their first few years of practice, only 14% gave a hospital post as the reason for their move away from general practice. They were more likely to have emigrated (Webb and Williams, 1972).

Few doctors had taken up a post in an academic department having only worked in service general practice.[1] A number had worked in the university medical school (usually in a department of social medicine); others had worked abroad or in hospital before entering service general practice where an interest in teaching developed. Significantly, virtually everyone had some previous contact with the university or with teaching general practice before entering an academic department (see Table 5.i).

In their accounts, few gave the impression of actively seeking a career in academic general practice; some suggested rather that the move had a large element of chance in it. One of the exceptions to this was a doctor who started his career in medicine, then spent a year in laboratory research, which involved tracing conditions back into general practice studying the general practitioner's management of particular conditions. He later went into part-time, and then full-time general practice, but continued his interest in research. He described himself as 'an obvious person to go into academic general practice' and looked out for a post in a department to become vacant.

Other doctors gave accounts which suggested less purpose. One, when asked why he went into the academic side of general practice said 'It was rather by default than anything else. I got into the atmosphere of it and stayed there.' (G.P. 26) (This happened while he was doing vocational training in general practice.) Another doctor said that he knew the professor of an academic department since they were undergraduates together, and was asked if he would join the

[1] Excluding the compulsory 'pre-registration' year in hospital practice which all who graduated after 1951 would have had to complete.

Table 5.i

Careers of Academic General Practitioners

Institutions Where Worked

Member of Academic Staff	Services Abroad	General Practice	Hospital	Research	University	G.P. Dept
Dr A	x	x			x	x
Dr B		x				x
Dr C		x				x
Dr D	x	x	x ?		x	x
Dr E	x	x		x	x	x
Dr F	x				x	x
Dr G		x	x			x
Dr H		x	x			x
Dr I		x		x		x
Dr J		x				x

Source: Interviews of sample

* The question mark at Dr D's career suggests that even the reporting of careers can be problematic. Although Dr D mentioned a period of hospital work, this was not reported in his biography in a university publication on his succession to the chair.

department. 'I had had no teaching experience, and was worse off than if I had followed up an offer to join a G.P. in . . . which would have been a goldmine . . . I like teaching but I fell into it' (G.P. 24).

Some academics referred to 'chance' as the major force in drawing them to their posts; if this were so, however, they would present themselves as a random sample of medical professionals. But how many service general practitioners possess the degree of M.D., and how many wish to further their research experience? In a comparison of basic characteristics of the sample[1] it was found that in a number of ways the academics differed from service general practitioners (see Table 5.ii). For example, the academic general practitioners were all male, while about one fifth of general practitioners are women; the academics were significantly less likely to be practising where they graduated, and all were members of the Royal College of General Practitioners, as opposed to one third of service doctors (R.C.G.P., 1973), (at the time membership was not an overt requirement of appointment; a number gained their membership after taking up the post). Furthermore the academics held a greater number of further qualifications than did the service doctors. Six held an M.D. This latter qualification is particularly striking since none of the

[1] These characteristics were drawn from the Medical Directory for 1974. The Directory lists date of qualification and university, further degrees and diplomas, Memberships, dates and where relevant, cities (for example, one used to gain Membership to the Royal College of Surgeons of Edinburgh or Glasgow); publications, and previous appointment. The data are supplied by the doctors themselves, and are thought to be fairly accurate. Since it was known that this information was available, the doctors interviewed were not questioned on such details.

Table 5.ii

A Comparison of Characteristics of Two Categories of General Practitioners in the Sample

	Category of General Practitioner		
	Service	Academic	Total
Sex - male	29 (72.5)	10 (100)	39
female	11 (27.5)	0	11
Date of qualification			
1935-44	11 (27.5)	2 (20)	13
1945-54	19 (47.5)	3 (30)	22
1955-64	4 (10)	3 (30)	7
1965 or later	6 (15)	2 (20)	8
Number with M.R.C.G.P.	10 (25)	10 (100)	20
Number with M.D. degree	0 (0)	7 (70)	7
Number with three or more higher qualifications *	1 (2)	8 (80)	9
Number practising where qualified	37 (93)	2 (20)	39
Total	40	10	

* Including Membership Examinations

Column percentages in brackets

service sample possessed one and it remains an exceptional qualification for general practitioners (Williams reported that in the United Kingdom a total of eighteen practitioners possessed one [Williams, 1974]). Of the six, at leat three had obtained the degree before they entered the department. This suggests that in their various careers the academic general practitioners-to-be pursued a commitment to further self education which is unusual amongst general practitioners (see Last and Stanley, 1968, p. 149), (although of course, less striking if they were already in an academic department).

Professional Recruitment

One of the problematic issues for the staff of the departments, raised by over half the doctors, was the question of how future generations of academic general practitioners would be recruited into the departments. At the time recruitment had been through a number of portals, although it was generally felt that the pattern of recruitment through another university department (for example, social medicine department) would not repeat itself (i.e. that these candidates would in the future be viewed less favourably). All doctors who raised this general issue stressed the importance of service experience. The danger of being labelled 'ivory towered' by service doctors was only too much appreciated by those who had themselves little experience of active practice. One doctor outlined what would, to him, be the 'ideal career' of an applicant:

> I think general practitioners should come into the university for a few years at a low level, then go into general practice for five to six years, and then they could go back into academia.
>
> (G.P. 73)

This career pattern would allow the doctor to gain some experience of, and taste for, academic life, but this academic background would be supported by experience of service general practice. Although a number of academic general practitioners would no doubt agree to this type of career, in practice a number of difficulties are present. First, academic and service work have a different set of values; the doctors in both kinds of work take on rather different perspectives of general practice. Having first worked in a university, service work may then become less attractive to the academic, and vice versa. This distinction was recognised by some:

> Do you think there will be a paucity of applicants for general practice posts in universities?
>
> Yes, a paucity with suitable applications but this is not very important. I want enough people to do justice to the show, and to teach and run my service commitment. I reckon that general practitioners are a separate breed and they need to be involved with patients and there is a conflict between this, and the requirments of an academic post.
>
> (G.P. 104)

Recruitment back into the university from service work may be even more difficult; it will be argued later in this chapter that the status of academics in general practice is lower than that of service workers. Furthermore, the two salary scales are not at all comparable; the academic salary is somewhat lower than that of an 'average'

general practitioner.[1] In contrast to medical specialists and some other professionals, academic general practitioners are unlikely to increase their salary with much consultancy work or private practice.

A further problem to be faced was exactly how to utilise the experience of a doctor entering an academic department who had worked only in service. One doctor argued that service practitioners as a group were rather naive and unused to university bargaining - and thus unlikely to make a successful career or to help the department. Academic general practitioners are not alone in facing this problem; Glazer quotes a very similar argument put concerning recruitment to an American school of divinity:

> The real difficulty faced by the school in relation to church experience . . . is the question of how to use most effectively the experience of men who have spent most of their active lives in the pastorate. When these men become faculty members they enter a school situation which differs in many respects from the one in which they have had their major experience.
> (Neibuhr et al, quoted by Glazer, 1974, p. 353)

We shall return to the discussion of how practical experience may be fitted into a formalised teaching situation later in the thesis.

The implication of the anxiety over recruitment into academic general practice was that the rewards of academic general practice may be hard to understand especially for second generation doctors who would not have the satisfaction of being pioneers. During the interviews

[1] This problem is faced by a number of professions where service work and academic compete for applicants. It seems to be particularly acute in industry; for example, see the submission to the Robbins Report of the Institute of Production Engineers on this matter, and their suggested solutions (Robbins Report, Appendix B, 1963, p. 396). Cohen (1974) outlines a similar dilemma for academic lawyers.

there was little talk of the pleasures of the work, and rather more of the problems facing the doctors. It was noted, for example, of one professor, 'He seems very unsure of himself and of what he's trying to do in . . . ' (Interview, 14/10/74). The impressions received during the interviews were substantiated when the interviews were systematically analysed for comments on self-image, the topic which will now be addressed.

Interactionist Studies of Identity

Just as identity is shaped in situations of interaction with others, professional identity is formed largely through group interaction in professional organisations. The Chicago School of Symbolic Interaction produced a number of studies all of which emphasised the role of the institution in shaping (and changing) professional identities (for example, Lortie, 1959; Bucher, 1961 [especially Chapter IV]; Becker et al, 1961; Strauss et al, 1964; Oleson and Whittaker, 1968). The relationship of identity to group membership appears at first glance to be straight-forward. For symbolic interactionists, membership exists at a symbolic level; thus one does not necessarily have to apply in a formal sense to belong to the group, but instead one requires to know at a symbolic level the necessary credentials for membership. Each actor therefore needs an understanding of the purpose of the group, a mastery of its specialised terminology as well as a grasp of the particular conceptualisation of that group (Strauss, 1959).

In his important work in this field, Mirrors and Masks, Strauss

details the complexities of the relationship between identity and membership (Strauss, 1959). Some groups, he notes, are more amorphous than others; membership criteria may be difficult to distinguish or the boundaries of the group may be hard to define. The relation between identity and behaviour, too, is not always straight-forward. Actors do not belong only to one group but to many; here the concept of 'situation identity' becomes important to differentiate which reference group is influencing the actor at present. Changes of identity occur with movement to another social group, or to another status (from novice to professional, husband to father). A change of reference group brings with it the necessity to learn a new vocabulary of motives, to adjust and renew one's self-image.

Having identified such general problems, Strauss then raises a question which is of particular significance to the concerns of this chapter; who, to paraphrase him, is more a physician, a doctor based in the community, or one who works in a laboratory? To turn the question to fit our concerns, is a doctor who teaches more or less of a doctor than one who practises in the community? The latter question, and the analysis needed to answer it, feeds back into the main issues at stake in the chapter. First, it is suggested that a hierarchy of tasks exists.

Within professions, the range of core tasks may be considerable, reflecting the diversity of approaches employed in professional work. However, it is seldom the case that all tasks are allocated equal weight - this applies to any group. Certain tasks are awarded different prestige within a professional group. The dictum 'Those who can, do, those who cannot, teach' suggests that as an activity teaching is generally awarded lower status than professional practice. Likewise,

the desire of a number of professions to create research situations for their membership reflects the prestige allocated to research by professional workers. To identify within any one profession a hierarchy of tasks, however, requires a shift of attention from a general discussion of professions and the organisation of work, to an analysis of a particular profession or institution and the distribution within of professional power. Since the focus of the chapter is the medical school, it is to that locale to which the analysis now turns.

The medical faculty is notable in one respect. Most faculties do not, and cannot, undertake to combine a professional commitment with academic work. But as Bucher points out in her study of power within the medical faculty, the clinical departments are unusual in that they undertake to run extensive and complex physical plants as well as more traditional work (Bucher, 1970). Associated health faculties (dental or veterinary) may be similar in this respect, but most faculties, even those vocationally oriented, are not typically involved in organising professional services.

In such faculties, members have overlapping identities, since teaching, research, service and committee work require that the participants act in a number of different capacities throughout the day. Academic general practitioners are involved with all aspects of academic work and also have a service commitment, and yet in the study to be reported their identity as academics and service worker proved problematic. General practitioners in Britain are linked into, and affected by a number of institutions (for example, the National Health Service, the British Medical Association), yet in the interviews the academics themselves underlined the significance of <u>two</u> reference groups to their self-image; these were other members of the medical

faculty and service general practitioners. It was chiefly these two groups to which academic general practitioners looked for legitimation of their position, and it was from these two groups they received a reflection of themselves as marginal. To use the term as introduced by Park (1928), these doctors were marginal men.[1] The crux of their dilemma was simple. Although general practitioners gained positions within medical schools, they remained socially marginal, other members of staff regarding them as 'general practitioners' rather than 'academics'. At the same time, because of their de facto membership of the university, general practitioners in the community no longer regarded them as general practitioners but saw their 'master status' as academics rather than practising doctors.

[1] The term is much older, but was first introduced by Park to explain one of the important concerns of the day, the problem of acculturation of second generation American immigrants. Park identified the marginal man as 'striving to live in two diverse cultures'. The essence of the problem was that the marginal man had adopted the cultural values of a society to which he could not, for reasons of his already existing ethnic group membership, fully belong. The concept was extended by Stonequist (1935) who continued to use it with reference to an individual's 'master traits'; Hughes' discussion of marginal man focussed upon occupational marginality (Hughes, 1945), and subsequent use of the term has been split between these two senses of marginality, occupational marginality implying that problems of membership were only experienced in an individual's work situation (for example, Wray, 1948; Quinney, 1977; Jenkins, 1972). The concept is not new to medicine but has been applied to members of the medical profession on several occasions (for example, Menzel, 1960; Inkster, 1977).

Academic General Practitioners within the Medical School

> Participants in organisations tend to see themselves in relation to those upon whom their success in these institutions depends.
> (Becker and Carper, 1956, p. 345)

In Scotland, medical schools have been in existence since medieval times. Early in the twentieth century, the medical schools united with universities, medical faculties becoming one of their governing forces. Combining tradition with elitism the medical school created a strong sense of belonging, although it is equally true that a faculty holds the potential for considerable dissention in its ranks, since it contains both pre-clinical and clinical staff, and (another potential source of differentiation) full-time and part-time staff.

These groups blur the faculty boundaries, yet the medical faculties within British universities typically display to outsiders a strong sense of membership, plus equally clearly defined boundaries around their membership. Apart from the degree of medicine, which all doctors in clinical subjects would necessarily hold, the overarching, dominant concern is with scientific, hospital-based medical practice. This emphasis on science and scientific method is illustrated repeatedly at medical school, for example, through research topics and research design, teaching, and by the criteria used to select medical students, who in Great Britain, have a science training.

The previous chapter documented the introduction of the general practice departments into the medical schools. Yet while general practitioners <u>were</u> successful in establishing departments, their status within the medical school, and the status of general practice as an academic discipline, remains contentious (Irwin, 1974; Longson, 1978). General practitioners have repeatedly stated their wish that

academic departments of general practice should have equal standing in medical schools (C.G.P., 1955; B.M.A. Working Party, 1965; Hunt, 1972). But the very need for such repetition suggests that the second class status of general practice implied by the organisation of medical practice is carried through to the university. Some years ago, one English head of department wrote 'Because we in general practice have no long tradition we are at a disadvantage in that we have a sense of inferiority and awe in the presence of medical academics' (Byrne, 1969, p. 69). The field work carried out in the Scottish departments supported this feeling and elaborated on the nature of the problem.

The status of the practitioners within the academic community was manifest in a number of ways; these included difficulties of funding (for staff and research), small amounts of, and unfavourable hours of teaching time, and poor premises, often removed from the main university medical school, the geographical distance serving to underline the symbolic marginality.[1]

The marginal status brought with it problems of morale for the academics. Factors such as lack of staff and facilities were symbols which reflected the faculty's view of their worth. But to use a medical metaphor, these were deemed the symptoms and not the aetiology of their marginality. The latter was seen to derive from the continued association of these academics with a branch of medicine which was perceived of as a wholly unacademic, service branch of medical practice. Thus one of the academic general practitioners' main concerns was with

[1] For a fuller discussion of these doctors' identity problems see 'Marginal Men; The Identity Dilemma of the Academic General Practitioner', unpublished paper by the researcher.

the nature of medical knowledge. They were aware that the whole set of connotations surrounding hospital practice was seen to be lacking in their subject which, almost alone in British medicine, was based in the community. For instance, they felt that other faculty members saw their subject as a generalised rather than a specialist subject, and understood it to be atheoretical, pragmatic as opposed to scientific, and mundane (cf. Longson, 1978). This combined with an associated perception of the general practitioner as academically gauche, unskilled at the complexities of university survival. This latter image was accepted and reinforced by the staff of general practice departments, although some distanced themselves from this stereotype, as the following quotation indicates:

> Universities say, well we've got a department, there it is (even if it is stuck away in a hut like ours is). But the Professor has great difficulties with other specialties in the university - I've found G.P.s rather naive and unused to university bargaining, and Dr X is a typical example of having had great difficulties, getting poor hours and so on. Dr Y had less since he was known and was more experienced.
>
> (G.P. 73)

To sum up, academic general practitioners arrived at the university with their identity prejudged, their history already written. They reported a perception of low social worth as academics; and felt that they were seen as inarticulate and lacking the vocabulary of motives appropriate to university life.

Survival Tactics

Having identified their marginal position within the medical school, one may then ask how these academics manage the situation? What strategies did they adopt to make the situation more bearable, to reduce their marginal status? There are a number of possible strategies to ease the adoption of institutional membership. Lofland, in Doing Social Life (1976), outlines eleven strategies, all of which involve the manipulation of geographical and symbolic features of an individual's environment by both the ingroup and 'significant others'. Success lies in the new identity of the individual and a strong sense of belonging. Lofland underlines the importance, however, of concerted group action; as he observes:

> Stable self conception and commitment are retarded to the degree that the 'others' of the socializee's environment disagree on his being a proper member or a member at all.
>
> (1976, p. 205)

One of the important features of the situation under discussion was that the faculty membership was ambivalent about this new group. Rather than providing reinforcement of their status of academic general practitioner, thereby making membership more 'real' to them, these doctors reported a feeling of scepticism amongst other faculty members over the validity of their membership. Therefore the strategies adopted by the general practitioners involved initially seeking out those members of the ingroup who would be prepared to offer institutional support. The first two strategies to be identified and described have been termed 'negotiated alliances', and 'curriculum infiltration'.

Members of departments recognised that one of the ways of

achieving advancement of their subject within the medical school and of raising their self-image was to gain access to power in the institution. This essentially means power through personal influences, institutional prestige and control of material resources. One way of achieving this in university (as in any organisation) is through successful alliances. Burns and Stalker describe the benefits of such alliances for the individual:

> He may be, and often is, able to increase his personal power by attaching himself to parties or sections of people who represent the same kind of resource and wish to enhance its exchange value, or to cabals who seek to control or influence the exercise of patronage in the organisation.
>
> (Burns and Stalker, 1961, p. xiii)

But power is an elusive concept, and difficult to locate within organisations, groups and committees (Bucher and Stelling, 1969). In an important paper on the topic of institutional power, Bucher expands upon the issue in relation to the medical faculty (Bucher, 1970). As a way of understanding why power was placed with particular individuals, she introduces the concept of 'assessed stature'. This, she admits, is an ambiguous notion (and it is revealing that she is forced back to naming indeterminate factors as the sources of power). Assessed stature, Bucher suggests, refers to members of faculty's perception that the individual has good judgement, is bright, and 'pulls his load' (Bucher, 1970, p. 29), as well as possessing more easily identifiable characteristics of institutional power such as official status within the faculty. Assessed stature is obviously a positive quality, and affects the ability of an individual to achieve the academic bargains he sought. Members of general practice departments sought alliances with faculty members, and yet some were less immediately successful

than others; a critical factor was whether they successfully negotiated an alliance with those faculty members with assessed stature.

Negotiating alliances represents an overarching strategy; all alliances are created for some purpose. The goal most often reported by the academics was that of curriculum infiltration, the process whereby departments attempt to gain further curriculum time in order to increase the exposure of their subject. Curriculum infiltration is attempted by most departments - any review of university timetables over a period will report the successes. Two main methods of infiltration are available: a direct takeover of time from another department, or the co-operative venture. General practice staff generally attempted the second (weaker) strategy, negotiating joint teaching with another discipline, using the teaching time of that department. Some kind of joint relevance must be created for justifying the combination; general practice theoretically has wider scope than some subjects, since most conditions begin (and may end) under the supervision of the general practitioner.

The power and the constraints of such alliances can be seen most clearly with two general practice departments. In the first department, a senior member of the department, new to academic life, made an alliance with members of other low status disciplines within the medical school (psychology and psychiatry), which resulted in general practice becoming part of a course on 'behavioural sciences'. The net result of this alliance was increased teaching time for general practice, but within the limitations placed upon the subject by the overall course intentions. General practice did not appear in the course heading but was subsumed under the general title (as were the

other disciplines). Moreover, the professor agreed to administer the course, a task which was as complex as it was time-consuming. (It is interesting and not irrelevant to note that this academic was appointed straight from a service post to a senior academic position, an example which was followed in a number of appointments to other general practice departments. After two years of being in post he reported that some faculty members still asked him to which department he was attached - 'Is it community medicine?'[1] This doctor reported greater uncertainty over his academic identity than did most others.)

The example of an initially more successful alliance comes from another university, where a senior member of the general practice department had previously held a joint post as senior lecturer in the departments of medicine and social medicine. He struck up an alliance not with the professor of social medicine (a low status subject), but with the professor of medicine, who was also Dean of the Faculty at the time and, who, to use Bucher's terminology, enjoyed considerable 'assessed stature'. This alliance gave the department when it came to be established, access to a powerful group which the previous alliance had lacked. Even before this department had gained official undergraduate teaching time the senior lecturer was experimenting with a number of pilot courses, combining teaching in general practice with that in medicine, and using the teaching time of the department of medicine. Later he expanded this approach to teach co-operatively with a number of other clinical specialties, namely, paediatrics, geriatrics and psychiatry. This senior staff member had less doubts

[1] One is reminded here of a telling footnote by Hughes: 'Those who are secure and successful have the power to exclude or check the careers of such [insecure] people by merely failing to notice them' (Hughes, 1945, p. 356).

about his identity as an academic, even though he was similarly identified as an academic general practitioner. Having been appointed from a university post, he had already learned the vocabulary of motives of academic life, (Mills 1940) and the apparent success of his alliances clearly reinforced his more positive self-image as an academic.

A few members of staff were quite open about their use of curriculum infiltration as a conscious strategy.

> When I arrived I was given a course of six weeks in sixth year, which at the time I accepted, although I didn't especially want to teach students at this stage like this. I must infiltrate, I thought. Again Professor Y was important, and Dr X (from other departments).
>
> (G.P. 104)

Other more junior staff merely reported that they 'would like' more co-operative teaching, although they were not in a position to argue at faculty level for such a change:

> I would like to see more colloquium teaching like we have in fourth year, where they get the different specialties together and discuss problems with paediatricians, neurologists, and so on, altogether. You get a better picture of life as it is that way.
>
> (G.P. 24)

Curriculum infiltration requires co-operation between members of different departments; the success of the academic general practitioners will depend again upon their ability to negotiate a worthwhile academic bargain. Such collaborative ventures may only result in general practice gaining a few hours a year (as in one department's participation with other clinical subjects), or it may lead to a significant increase in exposure of the subject, as is the example previously cited, where general practice took part in a

behavioural course, although at a price.[1]

Two points need to be stressed at this point. Firstly, coalitions, alliances and indeed curricula, are not fixed entities, but have a shifting nature. Some agreements may last for years, others are reviewed more frequently. Negotiation is therefore a constant feature of the medical school; only the institutional power of the actors may change.

Secondly, alliances and infiltrations have serious consequences for the development of the discipline. The two departments discussed above developed their courses in radically different ways, which resulted in quite distinct versions of the discipline 'general practice'. The first department, in order to align itself with other 'soft' disciplines, presented a social and psychological perception of general practice, a view which members of other general practice departments argued would 'alienate the faculty' but also academic general practitioners who were taking a hard 'clinical approach'. This alternative, of ignoring the dominant concern of the faculty with scientific medicine may in the long term gather its rewards if the 'social' perspective is accepted as legitimate within medicine, but in the short term it merely reinforced the overall perception of the subject as non-clinical and marginal to the main concern of scientific practice. The second alternative which emphasised the medical features of general practice, has been termed the more immediately successful, for it offered no challenge to the dominant paradigm within the medical

[1] A recent review of the curricula of the four Scottish medical schools reveals that none of the departments have had much success in this strategy.

school. Instead it sought to define general practice within the accepted scientific framework, and the academic staff of the departments as clinicians. Both developments may be seen as sharpening the weak, non-academic identity with which general practice entered the medical school.

A final strategy involved a more serious reconstruction than a mere sharpening of the boundaries around general practice. Members of one department proposed an idea so radical that it had not been (and was unlikely to be) accepted in their faculty. The course of action suggested involved a grand redefinition of the medical faculty so that individual departments (and hence identities) would be done away with. The product of the exercise would be a Department of Medicine. The advantages to general practitioners are, of course, immediately apparent. One member of staff explained:

> I think we would fit in better because students come to the department with the idea that it is a lower class of medicine and it affects them in the fifth year and may affect their perception of general practice for the rest of their lives.
>
> (G.P. 25)

The researcher did not ask these academics from where the idea derived but they are not alone in making this kind of suggestion. A modified version of a 'third faculty' created out of the departments of social medicine, occupational health, biostatistics, paediatrics, psychiatry and others is outlined by Stewart but is quoted and supported by an academic general practitioner, Byrne (1969).

In a number of ways, academic general practitioners were made to feel that they did not fulfil the membership criteria of the academic group. Despite their attempts to redefine the past, to create a new

and more acceptable academic discipline, the 'master status' of general practitioner, and all that the label implied meant that they remained socially marginal within the medical faculty.

But academic general practitioners experienced another form of marginality which brought with it as crucial identity problems for these doctors. The final part of the chapter will outline this second dilemma which concerned their relationship with service doctors, and briefly describe the reported strategies adopted by the academics to maintain their identity as 'service doctor'.

Town and Gown

While academic and service family doctors form different segments of the profession, have different missions, and share few core tasks, they nevertheless maintain important links with each other. Academic practitioners still count for less than 1% of all general practitioners in the United Kingdom: yet while they continue to represent general practice in the university, a critical question for them remains 'Am I still a G.P.?'

The tension which exists between the theoretical and the practical elements of a discipline have been noted by a number of observers (for example, Becker, 1972; Glazer, 1974), and the dissonance between the two is likewise reflected in the relationships between the theoretician and the practitioner (Hughes, 1973). Kendall, in an American study of 'town and gown' identifies some of the problematic areas within medicine (Kendall, 1965). These include economic competition for patients, and a difference in perspective and orientation, so that the

academics emphasised research and specialisation while the service doctors (in Kendall's study part-time teachers) emphasised practice. Furthermore, the overall cosmopolitan approach of the academics was contrasted with the local perspective of the service doctors.

Because of the nationalisation of the health service in Britain which reduced private general practice to a minimum, academic and service general practitioners are not economically competitive. However, the other two sources of strain identified by Kendall hold for this study. Practice and a local perspective are two important membership criteria to service general practice which academic practitioners have difficulty in fulfilling.

The Importance of a Practice

Continued involvement in practice is the core task which distinguishes service general practitioners from the academics, yet to maintain credibility with the service group, to retain their identity as general practitioners, the academics felt that they required both a practice and patients. The previous chapter has already outlined the debates surrounding an attached university practice. Sufficient to record here that despite the atypicality often levelled at such practices, the availability of patients (indeed, the doctor's <u>own</u> list), allowed these general practitioners a sense of 'belonging' as a service doctor:

> An ordinary G.P. would spend 6-7 elevenths of his time in his surgery, and have four half days in a hospital. We seem to spend just as much time with the patients; now whether we are pandering to ourselves by saying that it's better to spend half an hour with a patient when we could just give her some pills and say come back again, I don't know. It's what we do with the rest of our time that's different.
>
> (G.P. 26)

Other doctors were less fortunate. Maintaining practice presented considerable problems for them, and as the following quotation illustrates, offered them a less than satisfactory form of work.

> The idea that we could use out patients for teaching is problematic, because we have little time to practise and to get to know individual patients. At present we each do two half days a week and Professor X does one half day in a country practice. But we can't follow up patients or say come back again next week unless it was on a day when we were practising. This means that our patient contact time is small and that we are practising a very artificial form of general practice.
>
> (G.P. 74)

Thus the majority of academic general practitioners saw their marginality as being defined, initially, by their lack of sustained involvement in practice. But removal from full-time practice did not only mean fewer patients and more time for each consultation. A general practice newspaper ran an article headed 'How many professors of general practice are on call tonight?' thereby accurately hitting the raw nerve of the academic. For there were a range of fringe tasks, for example, night duty, baby clinics, out of which these academics opted. Thus while confirming their identity as a practising general practitioner (in the interviews they would often refer to 'my patients', or a case they had recently seen) they still felt that their lives were filled with other concerns associated with maintaining their university commitment. The need to justify their reduced service commitment

remained. As one senior academic noted: 'Many G.P.s do not realise that there is a great deal more to a university post than straight teaching and research. . . . The Department of General Practice has the same right and the same duty to contribute to the "community of scholars" as each and every other department' (Richardson, 1971, p. 626). The danger of this argument is that it emphasised the difference between the work remit of the two groups which the majority of academic general practitioners would not wish to underline.

Being an academic, however, meant more than just non-involvement in full-time practice work. The division between those who teach and those who practise is deeper than just a difference in hours. One academic, perhaps more reflective of his position than some, said that he did not think he <u>was</u> a G.P. but saw himself <u>as part of</u> general practice. This rhetorical shift is revealing. Academic general practitioners, as we have seen, have to justify and argue for their subject within medical school. Through such discussion these doctors develop a certain distance from their subject. They develop the ability to talk about the role of the general practitioner, to make generalised statements about practice, and about the work. They become adept at boundary maintenance; making statements like 'general practice is about . . . '.

By contrast, a practising doctor is seldom presented with the need to step back from his involvement with practice. The ground rules with which he operates may remain implicit, inarticulated. When interviewed, for example, some service doctors could not talk about general practice except in terms of their specific patients, in idiographic terms (that is non-generalising) as opposed to nomothetic (generalising) terms.

Some of the academics were conscious of this changed perspective.

One already quoted on this issue, expanded:

> I think, about myself, that I'm not a G.P. but someone who is part of general practice; I don't have the stresses of general practice upon me, but I do have the stresses of the particular job I'm in.
>
> (G.P. 73)

while another brought up the same issue with refence to his own career:

> I did not go back [he had been abroad] however, but I realised the need for G.P.s to teach; I saw myself cut loose from general practice, which was not easy as I had practised in . . . for thirteen years, so I thought I was suitable and available to teach.
>
> (G.P. 74)

Thus an academic shifts his perspective. He is no longer involved in general practice but with general practice: he is distanced geographically, but more importantly, symbolically from his service colleagues by his objective perspective of their taken-for-granted world. Adapting Gouldner's analysis of latent social roles - 'local and cosmopolitan' to this situation, one can argue that (as Kendall found) the academic general practitioners reflected a cosmopolitan orientation to their work, while service doctors maintained a local orientation (Gouldner, 1957). The academics, by the nature of their institutional membership (marginal though they felt it) oriented themselves towards the wider profession, as encountered through the faculty, but also through national and international contact. The academics, then, were concerned with seeking professional recognition from their peers outside the community. The service general practitioners, on the other hand, used what Gouldner has described as an 'inner reference group orientation', in this case other service general

practitioners. Recognition was sought from patients as well as other general practitioners, but contact with other medical professionals, for example hospital staff, was limited and often strained.[1]

Keeping in Touch

What strategies have the academic general practitioners adopted to cope with the situation? The issues at stake are rather different from those with the medical faculty. Service general practitioners were seen to be less interested in the academic qualities of the doctors and rather more interested in how 'in touch' the academic general practitioners were with the world of service work. The related two strategies adopted by the academics aimed to convince service general practitioners that they were, indeed, 'in touch' with the world to which the service doctors related.

One important criterion for membership to the group of service general practitioners is, as we have already seen, service work: hence the issue of service work has become an important one for the academics. One strategy for maintaining their self-image as practising general practitioner was to emphasise their service role by becoming as much involved in a practice as they could. This strategy, maintenance of service role, was actively carried out by most doctors, a number of whom were attempting to strengthen their service position. For example, members of two departments were attached to practices outside the

[1] As reported in the interviews with forty service general practitioners.

university, but only with locum status within the practice. This meant that unlike full-time doctors in the practice, the academics could not take part in the major decision making of the practice. At the time of the interviews the staff were at various stages of negotiating the position of 'full principal' within the respective practices. One doctor who had been successful outlined the strategy:

> I put myself on the deputising list at . . . Health Centre so that I can become involved in this too, because some time ago when they were discussing things at . . . [health centre] they were advocating the use of the telephone deputising service and I was most against it. Then someone asked when I last went out on a night call, which shut me up! . . . I've recently been made an honorary principal in a practice at . . . so that now I'm responsible for my own actions and am a proper partner and have a say in the running of the practice. Until now I had no right to have a say in the matters of the practice and was in fact very marginal indeed.
>
> (G.P. 71)

Increased involvement in practice was seen to be facilitated by the creation of a university based practice; but while more departments in the United Kingdom developed such practices, their drawbacks, too, were beginning to be appreciated. Apart from accusations of the atypicality of these practices (small number of patients, and loosening of financial constraints), voiced among service doctors, such a practice was also very time consuming. Given the finite number of working hours, the heavier service commitment cut into time otherwise spent on teaching or research work. A university practice allowed links with the service world to be strengthened but at the expense of academic work.

Apart from maintaining service work, 'keeping in touch' with service general practitioners involved a more subtle strategy of

deliberate confrontation with service doctors. This strategy of deliberately creating situations where they 'tested' themselves with service doctors, was mentioned by a number of doctors; the acid test was whether they revealed themselves to be, or were thought of as being, 'ivory towered', shown through holding unrealistic notions about service work, for example. This would have confirmed the suspicion held by service doctors that academics were out of touch with the service perspective, and thus were not 'real' general practitioners.

> I like to show G.P.s when I'm talking at a meeting, for example, to show them that I understand general practice, not to start with an idealised version of it but to accept that everyone makes different diagnoses at different times of the day - when they're tired, for example. To take this as given and start research here. I don't want to turn up and show I'm out of touch, and as long as I convince myself and others that I'm doing this then it's OK. Otherwise I would think of doing another stint in general practice.
>
> (G.P. 73)

The ongoing relationship with service doctors was something to which all academics paid considerable attention, dropping in the thermometer every so often as if to gauge the temperature of the relationship. Thus a current reading could be given. One doctor illustrates, referring to the proposed campus health centre:

> Two of the single handed G.P.s said that they would hand over their practices to me when they gave up, and the full-time doctors and myself would be able to practise there and use their patients. Earlier the city G.P.s would have regarded us as rivals, but now I feel that we would be accepted.
>
> (G.P. 72)

After reflection he added:

> I think the department now has considerable rapport with the doctors [in the area] who were originally quite suspicious but now seem to have accepted us. (G.P. 72)

Although the strategies outlined above have been presented as if initiated by doctors in one place and institution, at least some may be presented as a group response. General practice literature from Canada and the United States (in as much as they are comparable) report similar problems concerning status and departmental priorities (see Thorne, 1973a; Collyer, 1974; Hannay, 1980). The Royal College of General Practitioners, the body which has offered this group its greatest support, has remained sympathetic to the identity dilemma of the academics. Writing on the difficulties experienced, they outlined the problem:

> General practice is still a young academic discipline, and even where its emergence is welcomed there may well be those in high places in the university who view its claims with doubt, if not disdain. University general practitioners still face a 'credibility gap' and find themselves having to defend the dignity of their discipline. (Editorial, 1972, p. 277)

They continued by raising the second 'credibility gap' with service general practitioners; 'If he [the academic] does not appear convincing as a true general practitioner to his colleagues in the surrounding area then difficulties must occur. It is certainly necessary to convince local colleagues that university practitioners are themselves experienced in the field, are facing the real problems of the job, and are capable of remaining in touch' (Editorial, 1972, p. 278). Their solutions, in the Editorial and elsewhere, have been to argue for the creation of university practices to help maintain the

academic's service role (C.G.P., 1955, 1964, 1966; Editorial, 1972): to encourage these doctors to pursue academic research (Editorial, 1975; Birmingham Research Unit, 1975), and have set them up as research consultants to service general practitioners (R.C.G.P., 1972b). They have also proposed the College as common ground for service and academic general practitioners and suggested that close co-operation through College work would help bring the two groups closer (Editorial, 1972).

The theme of the 'credibility gap' was taken up by an English professor of general practice who proposed a strategy reminiscent of tactics used by the academics in the context of the medical faculty - that of redefinition. 'Perhaps one of our greatest problems is posed by our colleagues in practice in maintaining our credibility with them . . . in this context I am always reminded of Professor Scott's question "What is a typical general practitioner?"' (Morrell, 1974). By asking this question (or an alternative, what is a typical general practice?) academic general practitioners attempt to redefine the boundaries of typicality, to imply that their form of being a general practitioner (or their form of general practice) is valid as a service general practitioners.

What Price Conformity?

The identity problems of the academics have been raised for two reasons. First, it is argued that the pressures which affected their identity construction also played some part in the manner in which the general practice courses were created and produced. Secondly, the

dilemma outlined above is thought to be typical of that experienced by members of a number of applied professions.

Most importantly, however, such an account outlines the social forces within the medical school. The manner in which those with institutional power could shape and control the definition of knowledge was clearly shown. In the first place, the direct influence of the alliances negotiated within the faculty was seen to affect the overall orientation of the general practice courses. The influence of the faculty was implied at another level, however, through the conformity demanded to the overarching concerns of scientific medicine. This affected not only the orientation of the teaching but also other departmental tasks, for example, the methodology it was seen appropriate to adopt in research, and so on.

Did the academic general practitioners wish to conform? The evidence noted in the fieldwork was not clear-cut. Recruiting patterns, for example, suggested that unlike the trend noted in other professions (for example, Glazer, 1974), posts in general practice departments continued to be filled by doctors from service work. This implies that the academics were continuing to place greater emphasis upon the skills relating to practice rather than academic and research credentials which were seen to be more relevant by the academic membership. But as Mayhew stresses:

> It is a paradox that the more professional education buries itself in science, principle, theory and research, and the greater the prestige of the particular school, the more difficult it is to maintain the role and usefulness of the practitioner in teaching students.
> (Mayhew, 1971, p. 27)

Does this mean that academic general practitioners will remain socially

marginal to the faculty? Comparative material on other professions would be invaluable. Some evidence from studies of other medical disciplines suggests that such 'disorientation' (Lofland) is likely to be a temporary phenomenon. Basic science, obstetrics, paediatrics and anaesthesia have all at one time been viewed as the 'Cinderella' of academic medicine, only later to become established (see Young, 1883; Stevens, 1966; Armstrong, 1979b; and Thomas, 1979 respectively). Furthermore, communication with academic general practitioners suggests that the problems within the medical school ease with time.

Yet throughout the chapter other perameters were hinted at as significant to the final equation - two being whether the staff were new to academic life, or with whom the alliances were struck. It is felt that the degree of the marginality experienced will depend not only upon the standing of general practice within the profession at any point in time, but at a more local level, upon how well the academic general practitioners negotiate their position in the individual medical schools.

Finally, the chapter raised issues concerning the neglected relationship between the service and the academic branches of an occupation. The marginality outlined here was simply stated, and relates to the question posed earlier in the chapter: 'Who is more a G.P., one who teaches or one who practises?' From the fieldwork, it was seen that academic general practitioners attempted to construct membership credentials which incorporated teaching as well as service work. Yet the rhetoric adopted by <u>both</u> groups reinforced the notion that service work represents the 'real' work, and was therefore granted higher status. In this view, the general practitioners who did not become involved in service work remained on the boundaries of

the membership, marginal men.

One finds brief but revealing evidence to suggest that the academic branches of certain other disciplines are likewise allocated a lower status than their service component (see, for instance, Taylor on the teaching profession [Taylor, 1969], and Startup discussing civil engineering [Startup, 1979]). But overall the issue must remain unresolved. Whether or not teaching is perceived as a prestigious task within an occupation varies considerably between occupations, and no single factor can be selected as the determinant. While the case is still debated (for example Hughes along with Glazer proposes a different case to Thorne [Hughes, 1971; Glazer, 1974; Thorne, 1973a, 1973b]) one can make two points concerning the marginality of academics. First, it is <u>contextual</u>: that is to say one could imagine circumstances in which academic and service groups united against another occupation or another sub-group within the same occupation. Secondly, the marginality is created by the differing institutional base of each group, and therefore unlikely to be reduced by merely the passing of time.

Having presented the reader with the creation of the departments and introduced the academic staff, the final chapter of the section addresses itself to the courses produced for the undergraduate curriculum. The academics reappear in a subsequent chapter when their views of the teaching of general practice are compared with the views of service doctors.

Chapter Six

THE FOUR COURSES OF THE SCOTTISH DEPARTMENTS

Introduction

Having introduced and reviewed in a more general way the departments of general practice, their functions, and their staff, this chapter considers the courses provided by them. As such, it serves to link this section to the next, which moves on to consider the views of general practitioners and students on the teaching of the subject.

Curricula are socially organised phenomena. Referring to professional curricula, Atkinson uses the term 'arbitrary' to describe their final form: 'We must recognise that all educational knowledge . . . is in a sense arbitrary' (Atkinson, 1980). Atkinson is underlining the point (as Young likewise does [Young, 1971b]) that the knowledge which appears on the curricula has no absolute quality, that there is no 'natural' order or choice as to what should appear in the curricula. The term 'arbitrary' however, seems to underplay the basic process of selection which it will be argued, takes place in the creation of a curriculum. To study a curriculum in detail reveals what has been selected and defined as worthwhile or 'valued' knowledge by that group. This in turn suggests where the power lies within the group in charge of the curriculum, and what is the relationship in terms of knowledge and control between the staff and students. By way of introducing the subject, this chapter first outlines the basic structure of the medical

curriculum into which general practice fits. It then describes each of the four courses in general practice as they appeared in the departmental course programmes. The researcher was interested in studying what was selected for the course, and what was excluded, where the subject was placed in the curriculum and what teaching methods were used. The significance of these various features will be raised in this chapter but also pursued throughout the next section.

The data for this chapter derives from the course programmes distributed to staff and/or students at the time of the fieldwork (1973-75). These typically introduced the course, outlined its aims, described the teaching methods used, and noted any particular details relating to the teaching. Some of the programmes were more elaborate than others. A study of course programmes can reveal only the formal aims of the courses and how they were to be implemented. They cannot be taken as any indication of what was actually taught - a wide gulf may exist between them and the reality of the actual teaching. Nevertheless, as the discussion will illustrate, the course programmes did differ from one department to another, and in as much as they are seen to offer an 'official' departmental statement about the teaching, course programmes should be treated as significant data.

The Undergraduate Curriculum

Two often cited characteristics of a profession are firstly, its abstract knowledge, and secondly, its long period of training. Medicine, as an archetypal profession, has both a long period of socialisation into the profession, and a considerable body of abstract knowledge. Medical students in Britain are required to spend a minimum of nine years training for their career as a medical specialist, slightly less if they choose general practice. Of this period, at least the first third is concerned almost wholly with abstract knowledge.

The training is split into two major stages. The first part, the undergraduate stage, is carried out within a university medical school. In Scottish universities, the undergraduate training took six years at the time of the research, although the length has now been reduced to five years in all medical schools (however, Dundee has an optional first year of basic science subjects, thereby maintaining a six year curriculum for some students). During these years the undergraduate course introduces students to the foundations of medical knowledge, and later to clinical practice, including medical techniques and history taking.

The overall purpose of the undergraduate training should be, to quote from the body governing the curriculum, the General Medical Council:

> To provide doctors with all that is appropriate to the understanding of medicine as an evolving science and art and to provide a basis for future vocational training.
>
> (General Medical Council, 1967, para 8)

Its orientation, then, is non-vocational, while the post-graduate years are defined as vocational. Todd reinforces this distinction: 'We believe the proper time for vocational apprenticeship is in the intern year and afterwards, and not in the undergraduate course' (Todd Report,

1968, para. 372). This division, which might strike the layman as oversubtle in a training which is more widely regarded as continuously vocational, is recognised throughout the profession, although in practice it may cause problems.

The post-graduate years, those defined as vocational, are concerned with teaching students specific knowledge and skills related to the practice of a particular branch of medicine. This second stage of training commences with a statutory year of hospital work for all students. After this 'pre-registration' year doctors may choose either to enter general practice, for which further training may be undertaken but is not at present compulsory,[1] or to enter training for another branch of medicine which may take at least another three years. In all cases this latter training takes the form of apprenticeship, with specialty examinations.

In keeping with the focus of this research, however, our interest lies in the undergraduate curriculum. This itself is divided into two parts, the pre-clinical phase and the clinical phase (although in one or two English medical schools, for example, Nottingham, this division has been broken down). However, since the analysis is confined to Scotland, this division holds true. At the time of the research, the

[1] The N.H.S. Vocational Training Act, passed in 1976, will be implemented in 1981. It will require all students wishing to enter general practice to undergo vocational training of three years, a requirement which has considerable implications for the status of general practice (cf. the Apothecaries Act of 1815). Post-graduate training is given scant mention in this thesis as it is controlled and organised not by the academic general practice departments, but by general practitioners in the community. There are links: the post-graduate adviser for general practice in Glasgow is attached to the medical faculty but is not a member of the general practice department, for example (Hannay, 1980b).

pre-clinical period lasted for three years (now with the shorter curriculum, six terms). During this phase students are introduced to the disciplines which form the foundations of medicine, the basic science subjects (for example, physiology, biochemistry), and anatomy. The teaching furnishes students with an understanding of the sciences, and at a more general level, underlines the importance of the scientific method (Todd Report, 1968). Disciplines such as physiology have been codified and systematically laid out in text books, and texts such as Harper's Review of Physiological Chemistry, first published in 1939, now in its fifteenth edition, expound the accepted theory, presenting normal science as established and non-controversial (Kuhn, 1974).

Students, at this level may carry out some practical laboratory work, but although a variety of approaches may be used, teaching relies upon didactic methods (Lowe, 1971), the transference of fact from teacher to student. Typically assessment at this stage is dominated by multiple choice question examinations (G.M.C., 1977) where the conviction exists that there are correct answers to each question.

In the second part of the undergraduate curriculum, the clinical years, students continue basic science subjects but also come into contact with clinical specialties such as obstetrics, psychiatry and medicine.[1] These build upon the framework of the pre-clinical teaching, while the picture of the normal construction and working of the human body is now modified to include the malfunctions of body and mind. Some of the material continues to be dealt with through the use of

[1] Clinical subjects may have a small amount of curriculum time during the pre-clinical phase; this may take the form of joint teaching with a pre-clinical subject.

lectures, for clinical subjects, too, have a codified grounding. But students now find that for hospital-based teaching, they are grouped into small groups ('firms', or in Edinburgh, 'cliniques') under a consultant (this may be typical of Scottish rather than English medical schools [Crooks, 1975]). In this way they are introduced to the particular skills of history taking and examination of the patient, and have the opportunity to observe clinicians at work.

In addition to the formal teaching of the clinical years, students can also undertake electives in a specialty. These take the form of an attachment, are unstructured, and do not commit the students to any particular career. In Edinburgh, for example, such an opportunity arose in the fourth year where there was a six weeks vacation attachment, and a final phase (sixth year) elective of eight weeks.

A series of examinations, the 'professional' examinations, divide the undergraduate course. At the time of the research, professional examinations were taken after first year, fourth and final years. Most subjects are covered in these examinations, although a few disciplines require students only to sit class examinations. This indicates lower status, failure to pass being less serious than in the 'professionals'. Subjects can be up-graded to become part of the professional examinations. Few subjects remain non-examinable.

This, then, forms the basic structure of medical education in Scotland into which general practice must be fitted. The structure is not unlike that proposed by Haldane in 1915. Although there are continual, minor adjustments to the curriculum within each medical school, major changes such as the softening of the division between the pre-clinical and the clinical subjects, have not yet made inroads into Scottish medical education.

The Structure of General Practice Teaching in the United Kingdom

Previous chapters have reported both the expansion of the undergraduate curriculum, and within that, the increasing contact of the students with general practice taught at an undergraduate level. The early courses in general practice were rather different to those taught to undergraduates today, and will be discussed later in this chapter under the sub-headings of 'teaching methods' and 'vocational/non-vocational teaching'. What follows is a brief resumé of the recent courses.

Two reports were published in the 'seventies which offer details about the courses running at the time. The first was published in 1973, the second in 1978, the fieldwork for this thesis (and the basic information on the Scottish courses) taking place in the years in between the data collection for the first and the second reports. So neither study exactly parallels the Scottish based research.

In the early 'seventies general practice appeared as a subject in the medical curriculum of the majority of medical schools in the United Kingdom. Byrne's study of general practice teaching carried out in 1972, offers some evidence about the courses of the time (Byrne, 1973). The survey was fairly limited, however; it concentrated upon the timing of the teaching in the curriculum, and also summarised the general problems facing the academic general practitioners (cf. Chapter Five of this thesis). The study did not report on the other aspects of the teaching, the course orientation to general practice, or the teaching methods used.

In Byrne's study, general practice appeared in the majority of the medical schools as a clinical subject (see Table 6.i). Byrne found that the subject appeared in twenty-nine instances in the clinical years, and only four times in the years one and two, i.e. the pre-clinical years. In twenty-one schools, the course was compulsory.

The majority of the teaching took the form of an attachment to a general practitioner for a period of about two to four weeks. Byrne reported that the teaching time ranged from eight mornings in the fifth year to the longest reported time, four weeks full-time in the final year.

Table 6.i

Timing of Placement of General Practice Teaching by Year of Curriculum

Year	Number of Medical Schools (total 29)
Year One	2 *
Year Two	2
Year Three	3
Year Four	8
Year Five	10
Year Six	8
Any clinical year	2

* In several medical schools teaching takes place in more than one year

From Byrne, 1973

Murray and Barber's study, published in 1978, offers a more up-to-date record of the progress of undergraduate general practice teaching (Murray and Barber, 1978). But the paper also brings to light a situation already hinted at in Byrne's study, the growing complexity of the general practice teaching commitment in the curriculum.

Before that is discussed, the findings of the Murray and Barber study will be recounted.

The authors found that the clinical attachment was still the most common form of teaching. However, they noted that an increasing number of schools were offering the subject in more than one year of the undergraduate curriculum, and that small group teaching was now included, in most instances in addition to some contact with service practitioners. This seemed to be the case particularly where a department of general practice or a teaching unit existed. Finally, they commented upon the use of the 'long term family case study', where typically a student would follow a pregnant woman through her antenatal period and beyond, as either an optional or compulsory part of the curriculum.

But their study also uncovers a number of other features about general practice teaching, about which the authors made little comment. The most important is the increasing infiltration into the curriculum by the general practice departments (or units or divisions), although this appeared to happen in an arbitrary manner. Unlike Byrne, Murray and Barber documented the individual teaching commitment of all twenty-nine medical schools to undergraduate general practice. It is significant, however, that they did not attempt to represent the data in tabular form. From the description of the teaching of each school, one feels that this decision was forced upon them by the apparent idiosyncrasy of each school's teaching programme. For example, although clinical attachments were the most common form of teaching, some medical schools had no attachment (for example, Edinburgh, Cambridge, or St Bartholemews) while others had two, one in the fifth year and one in the final year (as in Belfast). Some were optional, others compulsory.

Small group teaching meant to some departments a few hours, possibly at the beginning or end of the attachment, while for others, it clearly constituted a major part of the course (as, for example, in Belfast where the department of general practice had a purported 81 hours of small group teaching). General practice often appeared in a number of years throughout the curriculum, departments either teaching jointly with another department (as did Birmingham, Dundee, or Edinburgh, for instance), or sometimes just sharing overall course time (like Bristol, Dundee or the Middlesex Hospital). In six medical schools only, did the students have contact with general practice in one year alone. Teaching time was sometimes specified, although with the joint teaching the actual time allocated to general practice was not clear, and one could not necessarily judge the weight of the department's contribution.

One example of a school's tangled web of teaching commitments will suffice. Leeds has been chosen, but the choice could have been from many of the medical schools. The Leeds entry runs as follows:

> The medical course at the University of Leeds is of five years duration; two years of which are pre-clinical and three years clinical. In the first clinical year the students have an introductory course in clinical methods and the Division of General Practice provides eight one-hour sessions with an emphasis on describing the processes on which clinical methods are based.
>
> During the psychiatric clerkship in the second clinical year each group of students has one seminar on psychiatry in general practice and spends two afternoons in the community. During the course in paediatric medicine the students are given one seminar on the care of children in the community. A three day course in clinical epidemiology in which the Department of General Practice (sic) plays a part is included this year. . . . A two month elective period is included during this year and about 30 students (20 per cent of the year) spend half or all of this time in general practice. Some minor projects are completed during this time. During the course on community medicine the division provides one session on the care of the dying.
>
> All students have a four week block in general practice

> during the final year. Two weeks are spent with a tutor in Leeds city, and for the second two weeks each student is attached on a full-time basis to a practitioner in the region. During the first fortnight the students have four seminars; and the last day of the four-week attachment is spent in the division with reports, assessment and discussion . . .
>
> (Murray and Barber, 1978, p. 44)

The Leeds pattern of teaching commitments is replicated in other medical schools, with general practice departments sharing teaching time with other departments. The notion of alliances negotiated with other members of faculty was introduced in the last chapter, and the above description of the teaching commitments of the department illustrates one of the outcomes - greater exposure of the subject without necessarily gaining more departmental teaching time. The apparent arbitrary nature of the alliances, which varied with each medical school, no doubt in part reflected local support for general practice teaching. However, from Murray and Barber's national data it was noticeable that alliances with some departments repeatedly figured more prominently, for example, subjects such as paediatrics, geriatrics, community medicine (often linked to general practice on the timetable) and psychiatry. This supports the suggestion that alliances were made with other low status disciplines; and certainly, there was little contact with the departments of surgery, or obstetrics and gynaecology, subjects generally considered prestigious.

The reliance upon teaching with a number of departments is indicative of a weak internal identity, or, to rephrase it, a fluid self-identity of a subject. In this case the discipline of general practice could be moulded in a number of ways to fit the teaching of other departments.

Finally, despite the variety of teaching arrangements, most departments of general practice had one main course which had been allocated more teaching time than the other curriculum inputs. Murray and Barber did not discuss this, but it may have been that these main courses were noted on the syllabus as 'the' general practice course (as happened in Scotland) whereas many of the other teaching commitments came under a general course title (for example, Clinical Studies, Man in Society) and so on. When discussing the Scottish teaching, the various teaching commitments of each department will be noted, but it will be the main general practice course which will be given more detailed consideration.

General Practice Courses in Scottish Departments

In Scotland, all four courses of general practice appeared in the clinical years, although in two instances courses were also being developed in the pre-clinical years. Attachment had originally been the main form of teaching, but in keeping with the more general trend throughout the United Kingdom three of the four departments have introduced group discussion. Two departments, however (Aberdeen and Dundee), have maintained the attachment as the main teaching method. The description of the courses as they were set out in the programmes will start with an outline of these two, followed by those of the Edinburgh and Glasgow departments.

Aberdeen

In 1973-74, the general practice course appeared in the final year of a six year curriculum (Aberdeen changed over from a six to a five year curriculum in 1974). The sixth year was divided into five eight week blocks; students rotated round each block, general practice sharing a block with mental health. Nine or ten students attended the course each time, and the teaching was repeated five times throughout the academic year.

The structure of the teaching can be best shown diagrammatically:

Week	Monday	Tuesday	Wednesday	Thursday	Friday
1	Briefing	Attachment to a teaching general practice			
2	Attachment to practice				
3	Attachment to practice				
4	Attachment		Case discussion	Visit to other practices	Seminar

September 1973

Each student attended a general practitioner in the region (which extended to the Highlands and Islands) for three weeks; four days of the four weeks were assigned to small group contact. The course had no final examination and the only evaluation was by way of students and two tutors' reports handed in at the end of the course. The handbook states that the course had one main aim, that the programme is 'to give the student an educational insight into general practice as it is now,

but also into the likely shape of general practice in the future' (handbook for general practitioner teachers of sixth year students).[1]

Three specific aims were described as follows:

1. Clinical

   (a) To widen the student's spectrum of illness by showing him the clinical conditions - minor and major, physical and emotional, acute and chronic - which make up general practice.

   (b) To demonstrate the common diagnostic and therapeutic problems involved in the early stages of illness, and how the doctor-patient relationship often differs in general practice from that in hospital.

2. Socio-medical

   (a) To show the student how the clinical, personal and social aspects of disease interact with each other. The student must see for himself how families and their doctor cope with illness and terminal care, and with the more intimate personal problems.

   (b) To give the student an understanding of the role of other community health services in the prevention and management of illness.

3. Vocational

   The student should know something about the opportunities, rewards, satisfactions and difficulties of general practice today, how its organisation is likely to change in the next ten years, and the probable future pattern of training for the specialty of general practice.

Evaluation was in the form of students' reports submitted to the department.

[1] The course programme referred to was only for the teachers; however, it is unlikely that the aims or teaching methods would be different in the programme the students received.

Dundee

In 1974-75[1] the Dundee department took part in teaching in three of the six years in the undergraduate curriculum (which it still retained at that time). In the third, pre-clinical year, the department shared a substantial number of hours with psychology and medical sociology, together forming a course in 'behavioural sciences'. The overall time allocated to this course was considerable (one hundred and fifty hours); general practice had a relatively small share in it, with visits to practices taking place on Friday mornings in the autumn term, for which three hours per morning were assigned. This course was examinable. The department was also involved in the fourth year 'Clinical Studies' course, which took place in the spring and summer terms of the academic year.

The course entitled 'general practice' occurred in the final year, when a six week block was given over to the subject. As in Aberdeen the students of the year were split into groups, here approximately sixteen, who rotated round each of the six blocks of six weeks. In the general practice course teaching was by attachment, students spending two weeks each with a rural practitioner, an urban practitioner and two weeks based in a hospital discipline where they studied the community component of illness (for example, through outpatients' clinics or hospital discharges). The course was not examinable, but students were set a series of exercises (for example, visiting the chronic sick, coping with a patient with a simple problem of a sore throat, spending a day with

[1] Fieldwork for this part of the research overlapped the academic years 1973-74 and 1974-75. Dundee was the last department to be visited and hence the course programme was for the latter academic year.

each member of the health care team); these exercises allowed some form of evaluation to take place.

The handout for students noted in the introductory remarks that the student had no learning in clinical medicine in the community in the early years of the curriculum, and thus needed an introduction before he became more actively involved in the setting. The aims of the course were set out as follows:

1. Clinical

   (a) To widen the student's understanding of patterns of disease.

   (b) To demonstrate problem definition and patient management in primary care.

   (c) To illustrate the special problems presented by the continuing care in the community of patients with chronic disease, and the relevance of the primary care team's contribution.

   (d) To emphasise the unity of preventive and curative medicine and to demonstrate the primary care team's contribution to individual patients and to groups.

2. Professional

   (a) To afford the student some insight into general practice as a clinical and professional discipline.

   (b) To allow the student the opportunity to express views on changes in general practice that his generation would wish to see introduced.

   (c) To assist the medical school to develop in students such understanding and attitudes as will promote an holistic approach to medicine.

Edinburgh

In 1973/74 the main thrust of the department's teaching occurred in the fifth year of a six year curriculum (Edinburgh changing to a five year curriculum in 1978). The department was also involved in teaching in an optional first year course entitled 'Psychology and Sociology in relation to medicine'[1] and there was a small teaching input into a fourth year integrated course entitled 'Nature of Disease'. In the final year students could choose an elective in general practice.

In the fifth year the class of one hundred and fifty students was divided into two, each half taking a block (a set of subjects) and then changing over. Thus the department had seventy-five students per term for its 'general practice' course and repeated its teaching programme twice a year. Thus the students had sixty hours of general practice for one term which worked out at two three-hour afternoon sessions per week. One of these afternoons was spent with a general practitioner member of staff (either full-time or part-time) observing in the surgery and accompanying him or her on home visits. A group seminar took up the other afternoon. The remainder of the time was to be spent following up patients at home, at a hospital clinic or in an institution. The student was encouraged to take an increasingly active part in the work of the practice, and also to 'benefit from the doctor/student relationship which might form during this time' (course programme).

To keep the numbers small, the seventy-five students were divided into six seminar groups of about ten to twelve students; three doctors

[1] A sociologist in the department carried out this teaching.

would also attend the seminars, these doctors being those to whom students of the group were attached. In addition to this, each student had a specific patient to 'work up' through the term, (visit and write an account of progress), and an interview with a senior lecturer of the department, a social worker by training. This latter feature of the course was seen as an important form of evaluation of the student's progress, although there was also a class examination, the examination taking the form of a modified essay question. The course aims of the Edinburgh department were set out as follows:[1]

1. To widen the student's understanding of patterns of disease.

2. Whilst emphasising the unity of preventive and curative medicine, to show when, where, and how the general practitioner can contribute to health promotion and to early diagnosis and control, by both individual and group care.

3. To demonstrate primary differentiation (or diagnosis) and primary treatment of patients' needs, at various stages of presentation, and taking into account personal, familial, psychological and wider social factors which may influence both the causes and effects of illness.

4. To illustrate the special problems presented by continuing care of chronic disease in the community and the services that exist, or should exist, to help the doctor meet the medical and social needs of his patient.

5. To let the student observe the doctor-patient relationship in general practice, to enable him to discuss how and why this relationship develops and to learn its significance.

[1] These are the eight aims of the Education Committee of the Council of the Royal College of General Practitioners (Education Committee, 1970).

6. To give the student some insight into the origins, present patterns, and likely future of general practice as a clinical and professional discipline.

7. To allow him opportunity to express views on the changes in general practice that his generation would wish to see introduced.

8. To assist the medical school to develop in students such understanding and attitudes as will promote an holistic approach to medicine.

The department, however, focussed its teaching on aims 3, 4 and 5, with the following justifications:

> Objectives 1 and 2 above can be achieved mainly from reading material and from teaching in other departments (including Social Medicine).
>
> Objectives 6, 7 and 8, are achieved by discussion of points raised by students themselves in tutorial sessions and particularly in discussion with their own doctor/tutor, supplemented by further reading.

Thus the course was built around a series of pre-defined topics; the core of the course consisted of two seminars and surgery sessions each on primary diagnosis, continuity of care and the doctor-patient relationship, surrounded by two orientation seminars, a revision week and the final week of the examination.

Glasgow

Glasgow was the most recent department to be created in Scotland, and when the senior member of staff was first interviewed there was no general practice course officially running in the undergraduate curriculum. The first teaching in general practice occurred in the fifth year of the old curriculum in 1972/73, the year Glasgow began the

changeover to a five year curriculum. In that year and the following, the senior lecturer in primary care was involved in a number of additional pilot studies with students in both the old and the new curriculum (see Table 6.ii). All teaching involved small groups of students, often based in a particular hospital or professorial unit, and all teaching was carried out with teaching time allocated to other departments (with whom the teaching was shared). During this period, the staff member built up a pool of service general practitioners to help with the teaching, and by 1974, twenty-eight practices were involved, often with more than one doctor per practice.

The main 'general practice' course in 1973/74 was based on a pilot venture run successfully the previous year. As with some other medical schools, the student group was divided into two sections, one which took the general practice course in the Autumn term, one in the Spring term of the academic year. The students were then subdivided into twenty-two groups of four, each of which had eight weekly teaching sessions during the term.

The method of teaching developed for this course was said by the senior staff member to be peculiar to Glasgow (he referred to it as the 'case method'). Students were taken out in pairs to see the patient in their home. Each student had to discuss a pre-defined problem of the patient with him or her, with the help of the problem oriented record sheet provided by the tutor. The students then returned to the general practitioner's surgery and discussed the patient's problem with the others in the group.[1]

[1] The precise detail of the method was not spelt out in the course programme but was clarified by the senior member of staff in an interview.

Table 6.ii

Outline of Teaching in General Practice

Glasgow Medical School 1972-1974

	1972-73	1973-74
1. 1st year (O.C.)	Visits Groups of fifty to Woodside	Not continued
2. 3rd year (O.C.)	Professorial Unit Students from Royal Infirmary, 4 hours	Now included all Royal Infirmary students 4 hours. Small group teaching, 8 students per group
4. 5th year (O.C.)	Class halved: 18 hours teaching and evaluation	To all students, time expanded to 8, 3 hour afternoons in groups of 4 students
6. 4th year (N.C.)	Collaborative teaching with Dept of Medicine (Royal Infirmary) 'weekly commitments'	As continued, expanded to 10 hours of teaching (5 days of 2 hours, pairs of students visit G.P. surgeries)
7. 5th year (N.C.)	Collaborative teaching with Psychiatry and Geriatrics, 4 hours and 2 hours respectively	Continued, now including collaborative teaching with paediatrics
8. Elective offered 5th year	One week attachment in the Easter vacation (approx. 60 students took it)	Continued
9. 5th year students (O.C.)	Collaborative teaching with health visitors and social work students - each visits patient	Continued with modification

O.C. - Old Curriculum

N.C. - New Curriculum

In the course programme the topics outlined to the students and tutors were organised chronologically. They included a range of conditions, from enuresis, asthma, headache, chronic bronchitis, to senile or presenile dementia. Evaluation took two forms: students were asked to complete two modified essay questions on conditions such as those specified in the previous sentence. Students and tutors were asked to complete a short questionnaire. In 1973/74 the course aims were as follows:

1. To enable the student to see 'diagnosis' and 'management' in physical, psychological, and social terms.
2. To show the student conditions not frequently seen in hospital which are responsible for a considerable degree of morbidity.
3. To demonstrate what is involved in the long term care of chronic ill-health.
4. To demonstrate the application of team care to ill health in the community.

Since the fieldwork took place, some of the teaching commitments of the departments have changed. It is worth briefly reviewing these changes, with the understanding that they, too, have a limited life expectancy, given the inevitable time lag between collecting the data and making it public. The evidence was derived from an unpublished paper by Hannay (1979), and from the university calendars, and refers to 1978/79.

Aberdeen has not changed its teaching significantly, although it has increased its input into the curriculum. Aberdeen now makes contributions to the second year introductory course, and to the systematic teaching in the third year. An eight week elective in the

final year can be taken in general practice.

The Dundee department however, now has a university practice and a medically qualified senior lecturer to help with the running of the department and the practice. Teaching has expanded to include student visits to practices in first year, in the second year collaborative lectures and demonstrations with the department of physiology. The access to patients gained in the third year has been extended to students in the fourth and fifth years with two to four mornings in the year allocated to general practice. There is now an optional eight week elective in practice.

In Glasgow some of the pilot schemes have been formalised to include all students of the year. All third year students, for example, now spend eight mornings in pairs learning about morbidity and history taking in a general practice setting. In the fourth year course (previously the fifth in the old curriculum) twelve afternoons are spent mainly in groups of four with a general practitioner, while collaborative teaching continues with the departments of paediatrics, psychiatry, geriatrics and infectious diseases. Glasgow also pioneered the use of computer-assisted learning in general practice as an additional, voluntary learning experience for students (the Departmental Report lists an impressive row of publications on the topic). Computer-assisted learning is made available to students in their clinical years.

The Edinburgh course underwent a number of changes before the fieldwork took place (for example, lectures were abandoned and the course aims revised). The course then stabilised until 1978 when the whole curriculum was reviewed, resulting in an increase in curriculum time for the general practice department. The increase in teaching time has been used to expand the time spent on attachments. The revised

course now offers students a four week attachment to a general practitioner, while the department seminars have been maintained.

General Practice and the Medical Curriculum

The detailed reviews of the courses offered by the Scottish departments did not lead one to think that they were qualitatively different to those offered elsewhere in the United Kingdom. The range of internal differences in course structure and teaching method related closely to the range suggested by the studies of Byrne, and Murray and Barber. It was felt therefore that further comparisons of Scottish general practice courses with the rest of the United Kingdom would not be very fruitful. What is worthwhile is a comparison of the Scottish general practice courses with the general structure of the undergraduate curriculum.

Earlier in the chapter an outline was presented of the common characteristics of the medical curriculum. Even a quick comparison reveals that the general practice courses did not fit readily into the dominant paradigm of medical teaching. The subject appeared in the clinical years in the curriculum, a placement which accorded it the status of a practical branch of medicine. But the Scottish courses were distinguished in three out of four instances by their non-examinable status, and in all instances by their avoidance of the lecture method.

In any curriculum an examination serves to reaffirm the rigid hierarchy of knowledge which Young argues is typical of the British educational system (Young, 1971b). By defining certain knowledge as highly valued (through its inclusion in the examination) the examination

thus delineates the boundaries of expert knowledge from that which is non-expert, excluded and socially devalued. From this springs the notion which exists today that 'If you cannot examine it, it's not worth knowing' (Young, 1971b, p. 37). This process of selecting out certain knowledge is particularly true in lecture-based courses culminating in examinations, for the lecture has already started this process which the examination merely confirms. Problematic courses for students are those which are examinable but have no lectures, for here the student has little understanding of the discipline's hierarchy of knowledge.

Remembering Young's dictum, the significance of the non-examinable state of general practice courses should now be clear, their social worth clearly painted. But one of the departments in Scotland did run a class examination. This will be discussed in Chapter Nine; it is worth noting in relation to the above, however, that one of the problems faced by the staff (as outlined by one department member) was that they had difficulty in articulating the criteria with which to judge a good paper from a bad one. This suggests that either the students were not alone in facing the dilemma of deciding what the valued knowledge of the discipline should be, or that the staff knew but were unable to shape the knowledge into any examinable form. This is one of the issues to be returned to when the Edinburgh data is discussed in Chapter Nine.

The second feature which distinguished the Scottish general practice courses from the majority of clinical subjects was their complete lack of lectures. The last paragraphs have begun to elaborate the relationship between the teaching method and the type of knowledge transmitted. This topic is important to any discussion of general practice courses, and the next part of the chapter forms an extended

discussion of teaching methods. Thereafter the chapter addresses two other issues defined as features of the courses which revealed significant differences. The first is their vocational dimension, the second their orientation to general practice work.

Teaching Methods

Three main teaching methods have appeared over the years in the Scottish courses - lectures (no longer used), the seminar or small group teaching, and attachment. Each will be discussed in turn.

Lectures

The lecture method dominates the undergraduate curriculum in Scotland. The majority of the pre-clinical and some of the clinical teaching is based upon the transmission of dogmatic material through lectures, and textbooks. The lectures consist of facts, 'scientific facts'; not 'everyday facts' (Sheldrake and Berry, 1976). These suggest a body of theory which has gone before the scientific establishment and achieved some degree of agreement. The lecture method, then, to borrow Atkinson's phrase, is par excellence, 'training

for dogmatism' (Atkinson, 1977).

The trend away from the use of lectures in general practice teaching is significant, especially as it represents such a contrast to the dominant method of teaching used in medical education. While other disciplines use small group teaching, ward rounds and attachments, these are in addition to a series of lectures. Initially, undergraduate teaching in general practice conformed. The first formal teaching on record in the subject has been noted as a series of lectures at St Mary's, London. The early College Reports suggested organising the teaching around a series of lectures, along with some visits to general practitioners (C.G.P., 1955; C.G.P., 1964). Four years after the College Report of 1964 a change came; Todd counselled against the use of this form of teaching because 'a series of lectures on the subject would seem particularly inappropriate' (Todd Report, 1968, para. 115). Instead, Todd recommended the use of group teaching or individual teaching with a general practitioner, thereby elaborating on the previous G.M.C. suggestion of a period of attachment (G.M.C., 1967). Interestingly, the Education Committee of the College Council, while setting out the aims of the teaching in detail, contains nothing on teaching methods (Education Committee, 1970). None of the Scottish departments used lectures; Edinburgh initially taught with lectures abandoning them 'about 1960'.

Lecture teaching implies the existence and transmission of the discipline's dogma. Lecture courses are typically supported by the use of textbooks, and so it is instructive to study what reading the general practice courses recommended.

The Aberdeen and Glasgow course handouts listed no reading, although this does not necessarily mean that none was expected; reading could

have been issued verbally. Dundee, on the other hand, cited six books in its handout, not textbooks in the accepted sense,[1] but rather books or reports about general practice - for example, Hodgkin's Towards Earlier Diagnosis essentially a working manual for the practising general practitioner (Hodgkin, 1973), a B.M.A. Report on Primary Medical Care (B.M.A., 1970), and in contrast, Lane's The Longest Art a Balint inspired account of general practice work written in a documentary manner (Lane, 1969). Edinburgh's reading list was smaller than Dundee's. Students were asked to read two of the reports which appeared on the Dundee list, the B.M.A. report, and a Royal College publication 'Present State and Future Needs of General Practice' (R.C.G.P., 1970).

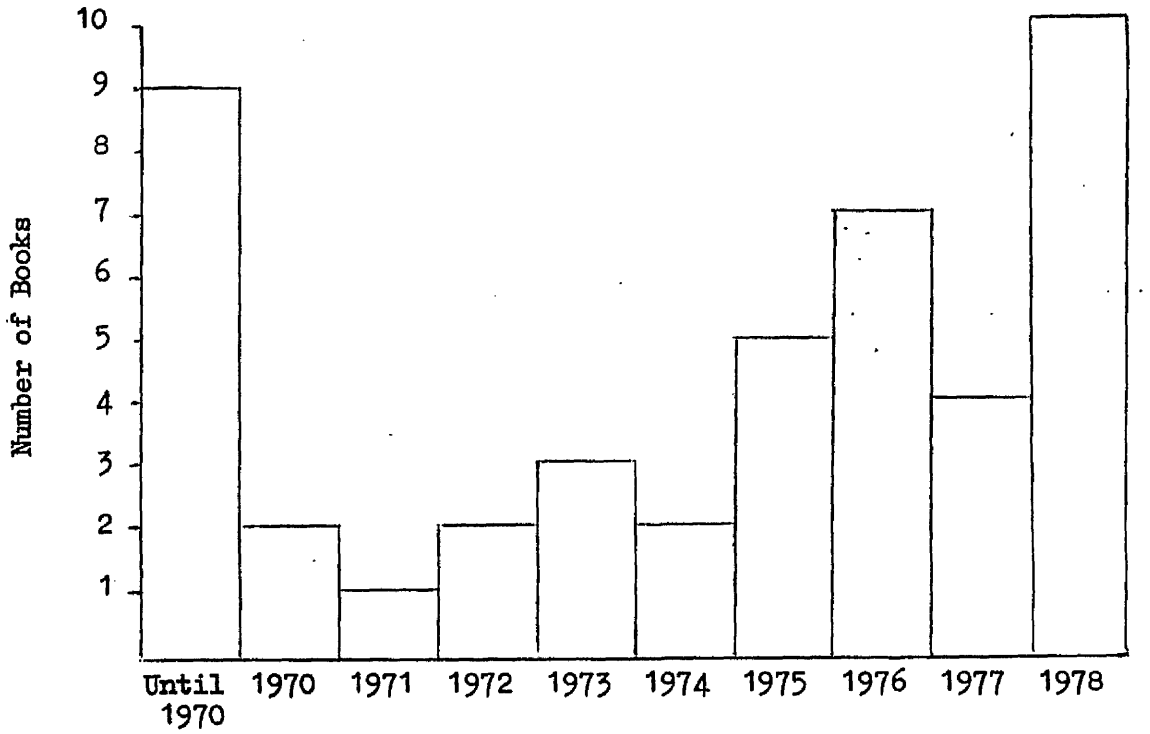
Since the fieldwork, the number of books relating to general practice has grown considerably (see Table 6.iii) although most of these are not textbooks. The first academic course book in general practice (its status as a textbook is debated) was published by the Royal College in 1972, The Future General Practitioner (R.C.G.P., 1972c). The book was geared to the increasing market of vocational trainees in general practice, and as such, was not really appropriate for undergraduates.

Only a handful of texts specifically designed for the undergraduate general practice courses have been written, for example, Harvard Davis, General Practice for Students of Medicine (Davis, 1975), or General Practice Medicine by Barber and Boddy (1975). The lack of both lectures

[1] The term 'textbook' refers here to a book written specifically for a student audience, which aims to present the reader with an introduction to, or an overview of, the particular field.

Table 6.iii

Books Relating to General Practice Listed by Daniels and White by Year of Publication



Source: Daniels and White (1979)

The authors, in their Medical Textbook Review, list (text) books on each of the medical specialties which they have selected as useful for undergraduate courses

and textbooks should be treated as important data since it suggests that there is little consensus over the body of knowledge known as academic general practice. One might have anticipated that this would have built up with the establishment of courses, since one of the underlying functions of teaching courses is that it generates a common framework of reference within which the teachers can work.

However, this is more likely to happen in courses taught through lectures. The lecture, more than any other teaching method, is one in which the lecturer is constrained to deal with unproblematic knowledge, for the structure of the lecture relies upon a passive audience. The strong boundaries of control which this implies between staff and students is mirrored in the substance of the lecture. Thus the lecture delineates in a manner unchallenged by students the worthwhile knowledge of the discipline (that which is imparted through the lecture) from the less valued knowledge (that which is not taught) - a demarcation which is reinforced through the examination. Valued knowledge, once defined, becomes institutionalised through the publication of textbooks. Subjects which base their teaching upon lecture courses quickly establish a body of agreed upon knowledge which becomes the received views of the discipline.

Having noted the avoidance of lectures by the general practice departments, the teaching methods which were used by the departments will now be discussed. But the question which remains to be answered is why the decision to avoid lectures was taken. It is a question which deserves serious consideration and it will be addressed later in the thesis.

Small Group Teaching

The second form of teaching used by the Scottish departments is small group (or seminar) teaching. Groups may be as small as three or four, as in Glasgow, or as large as twelve or sixteen, as in Edinburgh and Aberdeen respectively. The actual number of the group, however, is of less importance than its other parameters. In small group teaching the student is encouraged to play an active role in discussion, which usually focuses around a topic, often chosen as being controversial. Thus the tight control of knowledge by the teacher which was typical of lecture teaching, is broken down. Unlike both apprenticeship and lectures, the student may be exposed through the discussion to a variety of opinions and attitudes of his fellow students as well as the teacher's.

The extent to which the discussion is controlled by the teacher may vary considerably. Atkinson, in an example which will be quoted at greater length in Chapter Nine, discusses small group teaching during hospital ward rounds (Atkinson, forthcoming). During the teaching, Atkinson reported, the clinician steered the responses towards those he considered correct, and maintained considerable (although not complete) control over the information. In other small group teaching situations, such as those described by Beard, the teacher may be less directive and allow the class to come to their own decisions (Beard, 1970).

Small group teaching was used to a lesser or a greater extent by three of the four Scottish departments. A distinctive feature of the Aberdeen and Edinburgh small groups was that there was more than one teacher involved, a situation which in some faculties, certainly, would be regarded as most unusual. It seems that the departments were deliberately

creating a situation where the students were not presented with only one view of general practice, one teacher's perspective which might be taken for the received view. Instead, the situation encouraged the students to hear a variety of interpretations of general practice work. Dundee, although not incorporating small group teaching into the teaching, supported this general principle by requiring students to visit more than one general practice.

One feature of small group teaching which contrasts with apprenticeship is that discussion can only centre around codified knowledge. Thus small group teaching, by its nature, forces both staff and students to articulate their experience. But by doing so, they also become involved in selecting out certain experiences. While students absorb much in their attachments to general practitioners, through the discussions they begin to understand to what aspects of general practice the department attaches especial significance. The difference between small group teaching and the lecture is that in the former, the boundaries around these definitions of worthwhile knowledge and less valued knowledge are less clear.

Attachment:

The attachment, the final teaching method to be discussed, was originally a general term which encompasses four, related approaches. These were as follows:

(a) Health Centre - the student attended a health centre regularly and learned about general practice in this particular setting.

(b) Residential - the student lived with a general practitioner for a week or two, being constantly in his company and thus becoming aware of every little detail in connection with a general practitioner's daily life.

(c) Attachments - the student attended the general practitioner's morning surgery and accompanied him on his morning rounds every day for one or two weeks.

(d) Day-visits - the student spent one day in the company of a general practitioner.

(taken from Maclean, n.d.)

The majority of schemes now fall somewhere between (b) and (c).

In pre-literate societies, the expanded form of attachment - apprenticeship - was (and remains) the dominant mode of vocational training. Over the centuries its role in British medical education has changed. In Chapter Two it was recounted how apprenticeship became devalued as a form of teaching when medical knowledge became more scientific and the curriculum became standardised. Apprenticeship became equated with skilled manual work, where the craftsmen could neither read nor write. However, the apprenticeship model has never been lost to medicine, although the emphasis placed upon it has changed. Now post-graduate training remains true to apprenticeship although specialty examinations do have a written element, while the undergraduate curriculum has incorporated attachments and electives - short term apprenticeships - within a more formal teaching programme. (The fact that there are vocational methods at all in the undergraduate years indicates the ambiguity over the recommendations that those years should be non-vocational.)

As a form of teaching, apprenticeship is individualistic,[1] that is to say, it typically involves the transference of personalised knowledge from master to apprentice. The apprentice learns, by observation and practice in the presence of his master, not a socially agreed upon way of practice, but the characteristic style of his master. In its purest form, apprenticeship moulds the student in the image of his master; the student then displays not only similar beliefs and attitudes, but also similarities in decision making, and technical competence. It is, then, a form of teaching in which the apprentice submits to the authority of his master, for he has no other immediate point of reference.[2]

This raises two issues. The first is that apprenticeship is a form of teaching which can not cope with specialisation, for the range of one man's knowledge is necessarily limited (Merton, 1957). Secondly, true apprenticeship is based upon tradition; since knowledge is passed from master to apprentice, diffusion of new ideas are limited to that of personal contacts.

A central feature of apprenticeship is that it implies the transference of uncodified knowledge, the rules of thumb of the practitioner. These are the forms of practice which the master uses in his work, but about which he may remain unaware, or unable to articulate. To use Polanyi's phrase, 'apprenticeship is concerned with

[1] Conversely, Goody and Watt argue that <u>formal</u> teaching is individualistic; by this they mean that reading and writing are an individualistic form of learning, rather than the knowledge itself being individualistic (Goody and Watt, 1962).

[2] A recent fiction classic dealing with apprenticeship has been the writings of Castenada (1974 and others).

the transmission of "tacit knowledge"' (Polanyi, 1974). An example of this inability to articulate such rules of thumb comes from Young's exploration of individuality among factory workers. The author begins by quoting from her field notes:

> Dolores continued having difficulty tweeking off the tail of her lead wires and Sigrid said 'Here now, watch this. Look how I do it. Look where I put my tweezers'. And Sigrid put her tweezers down with one edge turned at an angle and she quickly twisted off the lead tail. She did not, however, explain what it was she was doing. Dolores tried a few more and at last she got one where she could tweek off the end.
>
> Until Dolores perceived it was the angle, not <u>where</u> Sigrid held the tweezers, she could not do the task.
>
> (Young, 1972, p. 72)

Elliott notes that in modern professional education there has been a 'coming together' of vocational methods of training and formal methods (usually taught courses), (Elliott, 1972). Thus occupations whose sole methods of teaching used to be apprenticeship now incorporate some degree of formal teaching, while occupations with professional status have maintained a period of apprenticeship in the training, as for example, lawyers with their 'articled' period, or architects who have a one year 'associateship'. One explanation for apprenticeship being maintained is presented by Polanyi, who suggests that occupations have knowledge they cannot codify (Polanyi, 1974). A rather different (and in the researcher's opinion, more plausible) explanation comes from Jamous and Peloille (Jamous and Peloille, 1970). They suggest that the maintenance of uncodified knowledge may be seen as a form of occupational control. By retaining an element of indeterminacy, the group protects itself from becoming wholly reproduceable (for a lengthier discussion of these ideas, see Atkinson, Reid and Sheldrake, 1977).

The ideas embodied in the notion of an apprenticeship have been dwelt on in some detail as they are influential in medical education. Transference of knowledge through apprenticeship was seen by general practitioners as the most valid form of training for that branch of medicine, and if hospital specialists were asked, they too, may have similar beliefs.

In the Scottish general practice courses, apprenticeship played a slightly more muted role than in a number of the English courses which were based on 'pure' apprenticeship.[1] All four departments allowed the student some contact with service practitioners, but not all courses were true to the notions embodied in apprenticeship. Two departments, Glasgow and Edinburgh, attempted to structure the contact with service practitioners rather more than did Aberdeen and Dundee.

In the Aberdeen course, students spent just over three weeks with the general practitioner, accompanying him throughout his daily work. In this situation, the student was exposed mainly to the views of his teacher (and since a number of students were sent to rural areas there was more likelihood of the teacher being single-handed). During these three weeks, the doctor had little control over who attended the surgery, and it was difficult for him to structure the teaching.

In Dundee the attachment was modified by the students attending two kinds of general practice, and therefore being exposed to a greater

[1] Nowadays, apprenticeship may take a variety of shapes and forms. Many apprenticeships are partial, as in medicine; that is, they form only part of the training. On the other hand, apprenticeship may be limited in other ways; trainees may learn only a very limited set of tasks. For example, Marshall describes the training of American meat cutters who learn to cut only certain parts of meat, while in Turkey, meat cutters have a more traditional apprenticeship, learning the whole carcass (Marshall, 1972).

number of styles of practice. Nevertheless, it is revealing (although logical) that neither the Aberdeen nor the Dundee course was examinable, since neither was dealing with codified knowledge. As such, the courses were the exception in the clinical years where it is usual to provide some form of examination at the end of the teaching.

Although both Edinburgh and Glasgow described the student contact with the service practitioner as 'an attachment', there was a deliberate attempt by each department to limit and structure the interaction. Students taking the Glasgow course had no prescribed contact with doctor and patient. Although they met the doctor in his surgery, and were introduced by him to patients, they were always in groups of two or more, and the meeting focussed upon a prespecified condition.

In Edinburgh, similar notions prevailed. Although in this course the student had surgery contact, an attempt was made to shape the surgery interaction around a topic, which itself was not concerned either with 'coughs and colds' but with a more general perspective of the doctor's work (for instance, continuity of care). In both these latter instances, then, the attachment showed considerable modifications. Indeed in the case of Glasgow it would be fairer to review the teaching under the heading of small group methods, while in Edinburgh the (structured) contact with general practitioners formed only one part of the whole course.

The reliance upon service general practitioners to carry out the teaching is important in itself. The implications of this will be returned to in a later chapter which concerns the part-time teachers, but it does confirm the statement already made that the departments continued to place high value upon practical experience rather than upon theoretical knowledge of general practice.

Vocational/Non-Vocational Dimension

General practice has until recently, been the one medical career which could be taken up immediately after graduation,[1] and so undergraduate training has had to be both general but also specifically vocational. It is not surprising to find that early writings on the topic of the training of medical students for general practice argued firstly, that the newly graduated student was in fact little use to a busy general practitioner, and secondly, that undergraduate education should offer more opportunities for practical training specific to general practice: 'No amount of book knowledge of the principles of treatment, or of the means and methods available, is sufficient in itself to make a good general practitioner. He must be trained at the bedside, in the out-patient room, in the dispensary' (Elliot Dickson, 1918, p. 420; see also a companion article by Crerar, 1918).

Likewise, the first undergraduate course in general practice, started in 1935 at St Mary's Hospital Medical School in London, took the form of a series of lectures about general practice. This course would now be defined as vocational, since it was composed of information directly concerned with practice, viz. 'buying a practice', 'on common ailments', 'on equipment', 'on paper work' and so on (Barber, 1952). Nowadays, as already indicated, schools are advised to 'avoid those aspects of the subject which are more appropriate to later specialised vocational training' (G.M.C., 1979, p. 13).

While this may be so, nevertheless a vocational element is apparently permissible. The influential recommendations from the

[1] It is still theoretically possible until February 1981 when the Vocational Training Act comes into force.

Education Committee of the Council of the Royal College of General Practitioners included as one of their eight aims 'To give the student some insight into the origin, present patterns, and likely future of general practice as a clinical and professional discipline' (Education Committee, 1970, p. 111). This would seem to allow at least some discussion of general practice as a form of medical work and career.

The Scottish courses varied in the degree to which they incorporated vocational aims in their teaching, a situation which still existed several years later when Murray and Barber studied United Kingdom courses (Murray and Barber, 1978). Three of the four Scottish departments included a vocational aim, but even within the three, there was a considerable range over the emphasis placed upon this aim.

In Aberdeen, for instance, the department selected the aim of the Education Committee (quoted above) and gave it precedence as the 'general aim of this programme'. The assumption that this course was oriented towards the vocational end of the spectrum was supported by the teaching method used, the attachment, since it has been argued that this form of teaching is primarily used to convey knowledge of practice. During the attachment, the course programme noted that the student 'should be enabled to study the problem of general practice records, and might learn about the taking of calls, making appointments and general administration from the secretarial staff - or from the doctor's wife' (Course programme).

Dundee, too, included a category of professional aims, and as Aberdeen, taught through attachments. Dundee's vocational orientation was further emphasised by the statement at the beginning of the programme which suggested that the course was intended as some kind of career training, 'the 1974/75 sixth year student has had virtually no

learning in clinical medicine in the community in the earlier years of the curriculum and thus needs an introduction before he becomes actively involved in this setting' (Dundee course programme, emphasis added).

As with the first two departments, Edinburgh listed the Education Committee's vocational aim in the course programme, but signalled its lack of importance by suggesting that this aim could be achieved by 'points raised by the students themselves in discussion' and by 'further reading'. The Edinburgh students did sit in on surgeries but the course programme indicated that this and the small group teaching had a clear structure to them. Their attempt to avoid placing too much weight on vocational intentions was further underlined in the introduction of the programme which noted the department's avoidance of factual material about general practice which they 'consider as more appropriate to the graduate and post-graduate phases' (course programme). In contrast to the other courses, the Glasgow department omitted from its course aims any mention of portraying past or future general practice, and did not incorporate attendance during a general practitioner's surgery as part of the course.

As the courses appeared in the University Calendars, all bore the title 'general practice', as indeed did the course programmes. In the course programmes, however, the courses were described not as being concerned with general practice, but instead with 'illness in the community' or 'clinical studies in the setting of general practice'. The notion that these courses were concerned with 'medicine' or 'illness in the community' is complex, and one to be introduced in the pages which follow.

The Clinical/Social Dimension

One final dimension along which the Scottish courses in general practice were seen to differ was the clinical/social dimension. Here one may recall the categories 'primary medical care' and 'family medicine' which were used to distinguish the orientations of service general practitioners. The clinical/social distinction refers back to the same distinction.

Three of the four Scottish courses recognised both the clinical and social elements in diagnosis and treatment in their courses' aims, while one course (Dundee), omitted in its aims any mention of the social factors in diagnosis. Even within the three, however, there were distinct differences.

Of the four departments, Aberdeen and Edinburgh have been identified as taking a more 'social' interpretation of illness, while Dundee and Glasgow were placed further along the clinical spectrum. Aberdeen's course programme included 'sociomedical' aims, in which was specified personal and social aspects as well as clinical aspects of disease, early diagnosis, and the doctor-patient relationship in general practice. Edinburgh, in a more detailed programme, likewise placed emphasis upon the social aspects of illness, and began to spell out how the department attempted to implement the perspective.

Each student was given a patient for the term, and in the course programme a standard set of eight questions was outlined as a guide to the student's clinical and social review of the patient. Briefly, questions 1 - 3 were concerned with the provisional diagnosis, pathology and long term prognosis of the patient. Questions 4 - 8 concerned the social aspects; questions here related to the social functioning of

of the patient, the effects of illness on the family, the management of illness, and the patient's other relationships, and other factors, such as economic or religious factors which were seen to affect the condition and its management. In addition to the above, the department devoted two of the six focused seminars to the doctor-patient relationship, as well as underlining the student-doctor relationship.[1]

Similarities can be drawn between the orientation of these two courses and the family medicine perspective identified earlier in the thesis. Both the programmes acknowledged the importance of clinical conditions, both placing clinical aims first on their list. But both specified the influence of non-medical factors in affecting the illness and its management.

Just as it was suggested that Edinburgh and Aberdeen course aims could have identified within them the family medicine perspective, it will now be suggested that Glasgow and Dundee may be similarly aligned with the primary medical care perspective of the service general practitioners. Their course aims included only one mention of the social correlates of illness conditions. Instead, both emphasised the clinical side of general practice, the course aims being orientated around primary care. Dundee repeated the term in each of the clinical aims, which stressed the role of the primary care team, primary diagnosis and chronic illness. Glasgow, organising the teaching around the 'case' method, likewise organised the course aims around general

[1] In the early 'sixties, the Edinburgh general practice course synopsis in the University Calendar used the term family medicine - 'The General Practice Teaching Unit offers a course of lectures, tutorials and practical instruction in family medicine'. The wording changed after 1963/64 and became less specific.

practice morbidity, long term care with the chronically ill, and the primary care team. In a brief introduction to the programme, the course principles were outlined as care of people in the community, clinical medicine in its widest sense, and complementing the systematic teaching given by other university departments.

Having said that, it must be emphasised that this is not a rigid dichotomy being argued for the two types of course. The evidence suggests rather that the courses tended towards the social or the clinical in the way they were officially set out. But there is evidence to suggest that neither type of course took an extreme position. For instance, both Glasgow and Dundee based at least some of their teaching in the patient's home; although the course aims emphasised clinical work both did refer to social factors or 'holistic medicine', while Dundee included in its reading list one book of the 'family medicine' school, Lane's The Longest Art (Lane, 1969). All that one can say is that the two perspectives have been broadly identified in the course programmes.

It would have been of considerable interest to compare the Scottish course orientations with that of other United Kingdom courses, but the data was not available. Murray and Barber's paper was not sufficiently detailed in this particular respect, while the textbooks of general practice mentioned earlier are not necessarily widely used or representative (although it is worth noting that both Barber and Boddy, and Davis took a 'clinical' perspective).

This chapter has reviewed the four courses of general practice as they were outlined in the course programmes. The programmes have been interpreted here as not only revealing the basic structure of the courses, but also taken as public statements made by the departments about their subject. As such they were treated as significant documents.

The preparation of the programmes demands that members of each department make public to other departments, and other members of faculty, their vision of general practice. This has to be given shape and form through primarily, the aims and the teaching methods used. Here the exclusions are as important as the inclusions, and the selectivity of each department in choosing certain aims, certain ways of teaching, have been taken as revealing how each department wished general practice to be viewed and understood by others. The course programmes are, then, on a grander scale, one channel through which general practitioners delineate and refine boundaries of their subject.

But the course programmes are only a beginning. This chapter has identified certain features about the courses which warrant further examination. The following section concerns a presentation of views of general practice teaching held by those doctors significant to the research. Chapter Seven deals with two of these groups. The first part of Chapter Seven will review the service doctors' opinions about the teaching, while the second outlines the academics' views of their courses. In this second part, the issues of the course orientation, and whether or not it is vocational will be revisited.

Section IV

PERSPECTIVES ON TEACHING

This Section deals with the views of the general practitioners on teaching general practice at an undergraduate level. Taking each research category in turn - academic, service and part-time - it presents data on each of their perspectives. Chapter Seven outlines the views of academic and service staff, for purposes of a comparison, while Chapter Eight considers the intermediate group, the part-time teachers. Chapter Nine introduces the Edinburgh data. It extends the analysis to include the students' perspective, and the same chapter also includes a case study of a teaching situation.

Chapter Seven

ACADEMIC AND SERVICE GENERAL PRACTITIONERS' VIEWS OF TEACHING GENERAL PRACTICE

Introduction

This chapter represents a shift in perspective from an official to unofficial views of the courses. The reality of the general practice teaching lies not in the official programme of the courses nor in the teachers' perspectives alone. To understand academic general practice one must seek out the perspectives of all the participants of the shared experience. Thus having outlined the courses as they appeared in the programmes, the thesis moves on to present the general practitioners' views of the courses and of general practice teaching. By 'general practitioner' is meant both the academic and the service staff, and in introducing both categories into the same chapter, the chapter fulfills two purposes. First, by reviewing the academics' views of their courses, this chapter extends the analysis begun over the course programmes. Thus questions raised earlier from the programmes over orientation and aims will be taken up again and elaborated upon in the light of the responses from the academic staff. This discussion forms the first part of the chapter.

The chapter also includes a comparison between the academics' views of the courses, and the opinions of the service general

practitioners about how they felt general practice could and should be taught. The chapter ends by considering any differences which arise between the views of the two groups.

Institutions affect identity, but also play an important part in defining what counts as valid knowledge and as high status knowledge for members of that institution. The responses of the sample must, to some extent, reflect their institutional memberships. The service practitioners, a number of whom knew little or nothing about the organisation of undergraduate general practice teaching in their city, were comparing the best way professionally, to present what they saw as the important aspects of their work. The academics on the other hand, were operating with a different set of pressures, and with a different set of institutional rules (already outlined in Chapter Five). This chapter begins with their responses to questions concerning the courses.

Academics' Views of the Courses

The guide lines from the Royal College of General Practitioners concerning the teaching of general practice are fairly broad, and allow for variation. Analysing the interviews of this set of doctors, it became apparent that there was going to be no consensus emerging between the departments. Indeed, a recognisable feature of the interviews was the criticism of other departments' teaching, combined with a certain defensiveness by staff about their own courses.[1] Disagreements also existed within departments. Although departments had an official view, some doctors made it clear that they did not agree with this. Perhaps most obvious was the doctor who started the interview as follows:

> I think I should perhaps discuss what I am doing here and what I see as the role of the department, which are not necessarily the same things.
> (G.P. 74)

Methods

There was considerable agreement that the subject should not be taught through lectures. Members of all departments supported this, and when asked why, offered similar reasons. The departments, they

[1] There were a number of instances where the researcher recorded that further questions would have been worth asking, but that she felt that the member of staff did not wish to discuss the matter further. In one interview, for example, she recorded that 'Dr . . . does not talk any more about the course, and I feel he has steered deliberately off it. I would have liked to return to discuss the seeming contradictions in his argument, but don't' (Interview, 14/3/75).

said, did not wish to impart the kind of information usually found in lectures. The following answer also hints at other reasons:

> General practice cannot be taught like this, it cannot be categorised amongst factual recall . . . G.P.s don't like lecturing, they are happiest in a one-to-one situation. There's no factual information in general practice, or at least there is a considerable amount, but we assume that it's taught elsewhere.
>
> (G.P. 26)

The implication of this was that whatever factual information existed on general practice, it was of less importance than the material put across by other teaching methods.

One result of placing little emphasis on factual material in any course is that examinations may become more problematic - particularly in medicine where at least part of the examination typically depends upon the recall of factual information (as for example in the multiple choice question). A senior member of only one department made the comment that 'exams constrain the type of teaching'. He reported that he was given the opportunity to make the course examinable but had chosen not to do so.[1] The reasoning behind this was that

> If it had to be so then I would have failed, if I couldn't teach without forcing students to attend because of an exam.
>
> (G.P. 72)

It could be said that the courses, with their lack of received opinion,

[1] It was interesting that staff of other departments raised the 'missed' opportunity of this department to make their course examinable, a reaction which suggests that although examinations may be seen as problematic (see Chapter Nine) nevertheless they were seen as desirable.

were not amenable to standard examination procedures, and that the decision to forego an examination was in fact truer to the material and the teaching methods employed. Yet examinations carry with them status on the undergraduate curriculum; the examinable courses usually form part of the professional examinations, and the feeling in general was, and remains, that students take more seriously subjects which culminate in an examination.

Although agreement existed over how general practice should not be taught, there was less unanimity over how it should be taught. As one academic said, 'I think each department tries to justify its own methods because it has been given a certain time allocation and has to say this is the right way of doing it' (G.P. 73). Another member of the department added: 'No way is right or wrong, as no one really knows how to teach general practice' (G.P. 72). This comforting view allowed each department to feel that its methods were suitable, that no 'best way' existed.

The staff were not asked to comment specifically on each teaching method they employed in their courses, but most made reference to the methods at some time during the interviews, even though the comments were brief. On attachments, staff from the two departments which relied most heavily on this form of teaching, had this to say (and interestingly, both discussions related to the choosing of tutors):

> G.P.s . . . lend their practice for students to observe, take the students into their homes, and don't teach them, just let them see patients as people . . .
>
> (G.P. 104)

A doctor from another department made the point that he attempted to choose doctors who appeared to have a willingness to chat to students:

> The whole purpose is to show general practitioners in action, not to teach general practice, so the selection is fairly low key . . . The students live in the cottage hospitals, and what they get out of the course depends on the enthusiasm of the students and the doctors, how much they take the students on rounds with them, night calls and so on.
> (G.P. 74)

His colleague elaborated on what he saw as the purpose of the course:

> Students should also realise that by seeing general practitioners at work, that G.P.s can act, feel, think competently and imaginatively, that they have different resources from hospital people, and that the problems are different. Students get a chance to realise this.
> (G.P. 73)

The vocational implications of this form of teaching were recognised by the staff in the above statements, although fine distinctions were drawn between students seeing general practitioners in action, but not being taught general practice. The doctors argued that the students on attachments were there to observe the working doctor, and that one direct result of this was that students learned to understand the perspective of the general practitioner.

Although most departments included some form of group discussion, there were fewest comments on this form of teaching. The exchange of opinion was seen to be important, and students were encouraged at this point in the course to pool their opinions and individual experiences. Although this was the theory, some of the difficulties

were outlined in the interviews. One member of staff reported that he felt that they had not conveyed the objectives of the course to the students, who came to medical school only to take degrees. The greatest difficulty was in getting the aims across; the seminars were not necessarily of all that value, they had to struggle so much as a group, he said (G.P. 27). Another outlined a potential problem; the tutorial had two goals which were possibly conflicting:

> One is that there is a policy of non-direction for group discussion, and yet the staff have specific topics decided prior to the seminar which they want to get discussed. What tends to happen is that the staff do a bit, then let the students have a bit of discussion, then the staff start up again. It can result in one of the staff giving a mini-lecture.
> (G.P. 26)[1]

For some doctors the one-to-one arrangement where the student sat in on surgeries, was the most important aspect of the teaching. Others thought that this should be limited or not incorporated into the course at all. One senior academic had very definite views about the limitations of surgery attendance as a form of teaching relevant to the undergraduate course:

> I did not want to teach in the one-to-one situation of a student sitting in surgery because firstly, it's very time-consuming for the G.P.s, it takes longer with a student present; secondly, it's not general practice being taught on my course, I don't want the students to see coughs and colds, flu and so on - that's general practice, and thirdly, I don't want a pupil-teacher relationship, group discussion is better, and fourthly, doctors can't control what comes into the surgery.
> (G.P. 71)

[1] The degeneration of the small group teaching into a lecture situation was something abhorred by several of the staff in the department.

These were the staff's views on the main methods used by the departments. Departments also incorporated other teaching devices, such as giving students a patient to follow through for the term, or taking them to contrasting general practices. At the time of the research, one department was experimenting with the use of videotape recordings of consultations. One of the doctors explained that this was seen by members of the department as a way of coping with the anticipated increase in student numbers - an explanation interesting in that the notion of reverting to lectures (traditionally a method of managing the problem of large numbers) was not treated as a viable alternative.

The various methods used by the departments were recognised by the academics as unusual in the medical curriculum; staff used terms such as 'radical' or 'unique' to describe teaching by these methods, and usually this was seen to be a positive feature, although it was also used as a reason for student difficulties.

Discussing teaching methods in isolation is an almost impossible task, since the above quotations have already introduced other issues relating to staff's views of the intentions and the orientation of the courses. The first of these issues, introduced in the previous chapter, is the vocational orientation of the courses.

The Vocational Issue

Members of all departments were asked if they felt that their course was vocational. Particularly since three out of the four departments had 'professional aims' built into their courses, and two used a teaching method which encouraged the transmission of vocational knowledge (through attachments), it seemed important to seek the staff's opinion on this issue. Fieldnotes reveal that the question was unpopular; members of staff did not like having this question asked; the issue was clearly contentious.

This issue also revealed the conflicts between the staff of a department more than did other questions. The two departments with staff of more than one best illustrate the range of answers. In one of these departments, Aberdeen, two academics said that they were not teaching general practice but 'illness in the community'. At the same time, their teaching method relied heavily upon attachments, and they reported a certain amount of time spent on appointment systems, prescriptions and so on - material which the researcher defined as having direct vocational meaning. On the other hand, another member of the same staff emphasised the recruitment aspect, recounting how pleased he was that more students entered general practice in his area than elsewhere in Scotland.[1] Significantly, when asked whether he felt the course was vocationally orientated, he replied 'It is not explicitly vocational, although I don't feel that you can separate out vocational and non-vocational like that. The difference is spurious' (G.P. 72).

[1] Other members of the department gave a different interpretation of this, suggesting that it was due to job availability in the area.

Again, the other large department, Edinburgh, revealed similar differences in points of view. The department's course programme suggested that the vocational aspect of the course would be played down, yet one view here was that more of the department's teaching time should come in the morning rather than the afternoon, since at the latter time the practices were rather quiet, and students would not be exposed to the 'heart of general practice'. 'I would like to see them [the students] have a whole morning, then we could take them into the surgery, then on home visits, see the really acute stuff, the morning calls; the surgery sessions are O.K. but nothing much happens in the afternoon' (G.P. 27). Another member of staff, however, pointed out to the researcher that the content of the surgeries was unimportant, since they were not teaching general practice, a view in line with that of G.P. 71 (of another department) who argued against using surgery teaching at all, since he felt it was difficult to escape from teaching 'content' in that setting. Finally, one academic expressed the view held by others: '"Vocational" in the department is almost a dirty word, and I think we take it too far. I think every brand of medicine has a responsibility to represent their specialty at its best. Some doctors do introduce a vocational element . . . ' (G.P. 25).

Obviously, when formulating the teaching programme, the departments bore in mind the ruling made by the G.M.C. that undergraduate education should not be vocational, but should aim to give students a general grounding in medicine. Staff at times made a post-graduate/undergraduate distinction when talking about a topic 'that's a post-graduate topic'

would be a likely statement.[1] But to the researcher's knowledge other disciplines did not take such care to claim that their teaching was not vocational. Classes in the clinical years were (and are) often held in hospitals, with students observing the clinician at work, performing an operation, delivering a baby. Syllabi for other subjects quite often include the term 'practical instruction', as in 'a course in practical midwifery'.

The staff's concern not to teach the routine work of general practice was backed up by a further statement made by a number of the Scottish academic general practitioners. Members of the various departments did not present a consensus over the purpose of their teaching, but they did stress that they were <u>not</u> teaching general practice. The use of this term was common parlance in the departments but also in print; a senior academic elaborated in a paper written in 1967:

> One would not, therefore, find much support for the teaching of general practice <u>as such</u> to medical students. This is a matter for post-graduates. The emphasis would therefore, be not on teaching general practice but rather on the teaching of medical students <u>in the setting</u> of general practice.
>
> (Scott, 1967, p.1316, emphasis in original)

This rhetoric may appear on first reading to be near tautological, but in fact has its own logic, which is concerned with selectivity. Thus when a fellow academic general practitioner from Southampton wrote

[1] Fieldwork notes from Edinburgh: Dr . . . in a pre-seminar discussion raises a number of topics which it is generally agreed are 'post-graduate' topics and should not be raised in the seminars. Examples are to what extent should a doctor delve into family history and 'stir things up', another was how much a doctor depended (emotionally) on her patients. (2/2/72)

> As undergraduate teachers therefore we are not trying to teach students about general practice but to teach them about clinical medicine in the community. As it happens, quantitatively, much of clinical medicine in the community occurs in the setting of general practice.
>
> (Forbes, 1974, p. 374)

he was arguing, as was Scott, for the selection out of the sum experience of general practice certain features which have special importance as teaching material. In fact, Scott and Forbes were arguing for the selection of different features, as it will be shown that their courses had different orientations.

In the interviews, the academics mentioned a wide range of topics which appeared on the courses, from concepts such as team care, the doctor-patient relationship, to specific illness conditions such as angina or rheumatoid arthritis. The significant point which united these otherwise diverse topics was that they were not taught to the student in order that he or she would learn about general practice per se, but that they would learn about 'medicine in the setting of general practice' or 'medicine in the community'. The distinction may well be a fine one, but the use of some term other than simply 'general practice' seemed to imply that the purpose of the course was to transmit selected, non-vocational material. The title, then, served to distance the academics from being seen to teach a vocational course. By organising the course around concepts such as team care or primary diagnosis, the intention was not to tell students how to carry out general practice work, but rather to underline some common aspects concerned with working in a medical team, or to any first diagnosis. Likewise, in courses organised around specific illness conditions, the important features were those relating to chronic illness, for

instance, rather than specific management of that particular condition. In essence, the staff were more concerned to abstract certain features of more general relevance from the overall practice experience.

While it could be argued that the staff were committed to the creation of theory, there is another explanation worth proposing. General practice work has been characterised within the profession as largely concerned with the diagnosis and treatment of minor medical conditions (Wright, 1973; Irwin, 1974, both acknowledge this). The medical work which general practitioners routinely practise may involve minor illness conditions, but to teach a course around this feature of their work would merely confirm the stereotype to the undergraduate students. One way to avoid the low status connotations that 'general practice' brings with it, is to persuade others that one is not teaching general practice as such, and to choose an alternative title for the course. The terms 'medicine in the community' or 'clinical medicine in the community' imply a course concerned with 'medicine' rather than general practice, and both terms have a more appealing and acceptable ring to them.

By now it will be seen that to understand academic general practice one must become involved in a number of terminological battles. These are crucial, as Strauss reminds us in Mirrors and Masks:

> Contention for terminological prizes is not mere squabbling over words for words are mandates for action, and sometimes classificatory decisions involve a matter of life and death. At the very least, men's interests are deeply involved.
>
> (Strauss, 1959, p. 27)

Medicine in the Community or Community Medicine

The use of the various terms to describe the courses is worth investigating, but initially an additional complication must be dealt with. Through a change in title, in the early nineteen seventies a number of departments previously called 'social medicine' became departments of community medicine, thus neatly complementing the general practitioners' term 'medicine in the community'. The similarity in terminology did not go unnoticed:

> There has been some confusion surrounding the term 'community medicine' and the future role of the general practitioners, much of the argument being semantic rather than practical.

wrote Hannay and Curran from the vantage of community medicine (Hannay and Curran, 1973, p. 113).

Relations between the two disciplines have not always been the most cordial,[1] and the continued usage of the similar terms may be interpreted as rhetorical evidence of a battle over territory. Both subjects wish to claim that 'the community' as their specialty, and despite the fact that community medicine specialists argue that they are concerned with groups, while general practitioners claim the individual, clearly the matter is not resolved by this single distinction.

In 1976 the Faculty of Community Medicine Newsletter ran a short series of articles tracing back the use of the term 'community physician'

[1] Fieldnotes of observations in general practice departments first revealed the tension between the two disciplines, subsequently confirmed by personal experience from a post in a community medicine department.

(Francis, 1976a, 1976b). Francis concluded that the earliest British use was in 1955 where the term was applied to 'that branch of social medicine which deals with matters relating not to individuals but to groups' (Gordon, quoted by Francis, 1976b, p. 45), thereby claiming the term as belonging to social medicine. Historically, of course, the general practitioner has had strong links with public health, as he became more involved in matters of state welfare, which involved groups rather than individuals. This aspect of a general practitioner's work which led to a blurring of the role, and therefore the boundaries between general practice and social medicine, is underlined in a further quotation from Gordon's 1955 article: 'In very scarcely populated parts of this country there may be another community physician, that is, the general practitioner, when he is sole medical adviser to a village or a large tract of country' (Gordon, quoted by Francis, 1976b, p. 45).

The two subjects remain linked in the medical curriculum, for in more than one Scottish university they have been allotted a set period of teaching time to share (as in Edinburgh), while a number of academic general practitioners hold a post-graduate diploma in public health. Despite such evidence of a shared past, it seems likely that in the future, community medicine and general practice will develop quite distinct identities. It seems unlikely that future academic general practitioners will continue to hold post-graduate degrees in community medicine, and in a number of other ways the boundaries between the two disciplines may become sharper.

Having dealt with community medicine, the chapter returns to academic general practice. Taking each course in turn, the views of the staff of the four departments will be considered over the particular

orientation of their courses. The first to be discussed is one course which was defined in the previous chapter as taking a social orientation.

Medicine in the Setting of General Practice

Members of one department, Edinburgh, referred to teaching 'medicine in the community', or 'medicine in the setting of general practice'. Yet their course was seen as having a distinct orientation towards family medicine, towards a form of general practice which stressed the importance of social factors (identified in the course programme as meaning housing, religion, and so on), and family relationships when considering diagnosis and treatment. How do the terms fit together? The researcher received her first clue to an understanding of the particular perspective of the department in an early conversation with a member of the department. They were discussing the doctor-patient relationship. The researcher suggested that this relationship was possibly special to general practice, but instead of receiving confirmation of the idea

> Dr X said that many students thought that. In fact he wanted to show that the relationship was not qualitatively different to that in hospital.
> (Fieldnotes, 10/2/72)

This notion, that what they were teaching had general applicability, was confirmed in other interviews. The argument put forward was that the kind of teaching the department carried out could be done with clinical patients (that is, hospital patients) as well as with those

who came through general practice. From this followed the lack of interest in the content of the surgeries, and indeed the desire to have structured surgery teaching. What was stressed was that the staff were teaching a perspective, a framework with which to view conditions. It is worth recalling one quotation given earlier 'we don't teach the principles of diet, but the difficulties a patient might have in relation to dieting. We spend time doing this, putting the information into our perspective . . . ' (G.P. 26). Thus the staff argued that they were not teaching 'general practice' but a more general perspective which could be applied to the practice of any form of medicine.

Although the staff talked of teaching 'medicine in the community' or 'medicine in the setting of general practice' it became apparent that the word 'medicine' was being used in a particular way, and did not in fact contradict the previous suggestion that this department took a 'social' orientation to its teaching. Here it is useful to introduce some additional material collected from observation in the seminars.[1] The fieldnotes of the seminars reveal the implementation of the social perspective both through indirect and also direct ways. For example, when a student presented a problem in the seminars, a staff member would ask about the relationship within the family, about the housing and economic conditions of the family ('would she like more space but cannot afford it? / who is the bread-winner?') A telling

[1] The interviews are not strong on this topic, partly because they were the first the researcher carried out. She missed the importance of asking staff about the course intentions, partly because she was observing the teaching at the time, and tended to talk to staff about particular features of the sessions, the all-over purpose being taken for granted.

occasion was the first contact the students made with the staff of the department. The fieldnotes record that 'the term"social factors" is mentioned many times during the session; one doctor (a full-time staff member) says "the social background of the patient is the most important aspect which the course takes great pains to stress"'(13/1/72).

To link the notion of teaching a perspective to 'medicine' and 'social orientation', it is suggested here that the staff were attempting to expand the boundaries of medicine to incorporate a social element as well as a clinical one into the process of diagnosis and management. The staff's references to medicine in the community or in the setting of general practice, referred to this redefined version of medicine, with its social component. Schematically, one could say that they were adding a further layer onto the process of diagnosis, so that it was seen to comprise not only of clinical considerations but also of social ones.

There was considerable agreement among the staff over the 'line' taken; those few staff members who continued to emphasise the importance of the actual conditions, who felt that students should see morning surgeries with the acute cases could be understood as missing the intended purpose of the course.

This then was the approach of the Edinburgh staff members, an approach which formed a coherent departmental policy, and one in which aims and teaching methods fitted together. But what of other departments? How did staff understand their teaching policy? Glasgow, the next to be considered, consisted at the time of only one member of staff, so the question of internal consistency between members did not arise. The senior member of staff in Glasgow presented a view of his course and its intentions which contrasted with that of Edinburgh.

Medicine in the Community

The first significant statement to unlock the Glasgow rhetoric was the senior academic's insistence both in writing and in the interviews that general practice was akin to clinical medicine (see Barber, 1973). This was not the rhetoric of the Edinburgh department, and the researcher asked what was meant by the word 'clinical'. The senior member of the Glasgow department replied that it was a question which should also be asked of the part-time staff, 'because it's something that I've been on at them all year about'. He continued:

> Clinical medicine is something with an organic basis, something in the individual which is organic, psychological and social. The organic bit is the important part, however, for example, a headache which has as its basis stress or anxiety is counted as organic because it has an organic effect on the person. Someone who comes to him for example, wanting rehoused, that's not organic and he's not interested in teaching that to the students.
> (G.P. 71)

He went on to say that he wanted the teaching to complement the hospital side of teaching, that he wished to show, in one case, chronic illness in the stages before and after it went to the hospital. In the interview with him there was little talk of social factors and family background; instead, the focus for this academic was on team-care, selected conditions, and the intent to teach 'generalist-medicine'. (This latter term was also used by academics at Aberdeen; generalist here meant non-hospitalised, and the reference was to the understanding that general practitioners dealt with the majority of illness conditions without referring them to hospital.)

Although the Glasgow staff member, too, talked of teaching medicine in the field of general practice, or medicine in the community, the course as he outlined it had a different orientation to the Edinburgh

one. The reasoning behind this course was that general practitioners saw illness conditions at a stage which other doctors did not. The course, therefore, emphasised illness conditions special to general practice, (like chronic illness), and it was case centred. This set of ideas, although couched in terms of teaching generalist medicine, can be understood as a specialist argument. The general practitioner essentially becomes a specialist in dealing with illness in its early and late stages. It is not a new argument; MacKenzie suggested the same many years ago (MacKenzie, 1919). In this view, social factors affecting the illness are recognised but their importance reduced, while the links with hospital medicine are kept strong. The distinction between hospital medicine and general practice is made; they are dissimilar because each studies different types of conditions, but the distinction is not qualitative - they are both forms of clinical practice.

Illness in the Community

Staff in the above two departments presented two quite different sets of reasoning associated with their teaching, and there was considerable, although not total consensus between the staff and with the official policy and teaching methods. Staff of the other two departments did not present such overall agreement. Aberdeen had previously been identified as social in orientation, (although a strong case for this bias was not made). In interviews with two of the staff, it soon became apparent that their comments did not fit into the anticipated pattern. G.P. 74 suggested what the term 'illness in

the community' meant to him:

> We are showing illness in the community, trying to undo three years of hospital teaching, saying what about 90% of the illness, you've seen the 10%. We show students the broad spectrum of illness and also the concept of team-care.

Later he said:

> I'm beginning to think along the lines of Fry, that doctors can treat 4,000 patients; this is feasible if the team works. But I think that nurses and doctors are unwilling to change their traditional roles.
>
> (G.P. 74)

One other academic in the department also emphasised that they were teaching illness in the community, and the switch from 'medicine' to 'illness' implies that he too, took a more clinical view. This was confirmed both by the references to the importance of the 'clinical' side of general practice

> Medicine as a specialty is now lost, as each branch of medicine becomes a specialty. I see mature general practice as stepping into the void . . .
>
> (G.P. 73)

but also by the obvious concern over what he felt was a strong Balint orientation in some general practice departments.

> They're playing at being sociologists because it's soft and no numbers are involved, but this is leading them in the direction of a different cohort of university people, I think it's the wrong direction . . . Balint was a shot in the arm but is now an overdose; I think that they will alienate the faculty . . . their adoption of this theory challenges the credibility of general practice with the university and with the mass of service general practitioners who cannot think like this.
>
> (G.P. 73)

Both these doctors quoted above agreed that the teaching should not

be socially but clinically oriented, but in the interviews their position over what the department should teach appeared less sharp, less well defined. Furthermore, two staff distanced themselves in the interviews with the official departmental policy.

There are two ways in which the lack of definition of these staff members can be explained. Either one could argue that staff simply held discrepant views about the orientation that the course should take. Or, (and indeed, this is not mutually exclusive), one could argue that the particular method of teaching the department adopted did not encourage a tight definition of the teaching. The department based most of the teaching on attachments, and as one of the staff pointed out, the course orientation depended upon the individual general practitioner. The control of the teaching, more so than in Edinburgh or Glasgow, was handed over to the part-time staff. They saw the students for a concentrated period of three and a half out of the four weeks, and they defined the course content for students. The full-time staff saw little of many of the part-time staff (a number were not within easy travelling distance of the department) and had little contact with the students. This lack of control over the teaching by the full-time staff may have resulted in less opportunity for them to revise and refine their course intentions; it also may have meant that they felt less need to since they had less influence over the actual teaching.

The final department to be considered, Dundee, also organised its teaching around attachments. Although there was only one staff member,

there was internal inconsistency between the departmental programme and the interview material, if the rhetoric was being 'read' correctly. The senior academic described the sixth year course as 'a crash course for students who haven't had any behavioural science, in the social aspects of medicine'. Yet the course programme was previously described as of clinical orientation as it alone of the four departments contained no mention of social factors or the doctor-patient relationship in its aims. In one interview the senior academic outlined the special characteristics of general practice which he felt, because of its setting in the community, provided a rather different contribution to the undergraduate curriculum than did other subjects. The special characteristics included features which suggest a bias to the clinical; the doctor-patient relationship (although the staff member said that he was not sure whether this could be taught - a significant remark;) clinical strategies (diagnosis); psychiatric and social diagnoses, and the role of the health care team in primary medical care.

The suggestion that the diffusion of the department's message was in the hands of the part-time staff was raised by this academic, who noted that 'it is most important that part-time staff do not have too diverse a philosophy about general practice' (G.P.104). He reported making a conscious effort to keep contact with them, and initially took away the part-time staff for a few days for an intensive training session.

The rhetoric of academic general practice is complex, and needs reviewing here. It is important to underline the fact that the material refers to what the staff <u>say</u> about the teaching, and not the teaching itself. It is also important to remember that what is presented here is at the level of hypotheses; only relatively short

interviews were carried out with a small number of academic general practitioners. Unfortunately no review of all the United Kingdom courses has given sufficient detail to compare the rhetoric of the different departments, and test out the propositions.

The Scottish academics were eager to be seen not to teach general practice. This was certainly in line with official policy about the non-vocational direction of undergraduate teaching, yet it was noted that the departments pursued this policy with an ardour which was unusual. It was suggested that members of the departments did not wish to teach the routine of general practice, the 'coughs and colds' identified within the profession as the low status work of the general practitioner. Instead, the departments selected out features of more general relevance.

The overall orientation of the course was indicated by the use of certain key words, sometimes in the title. Thus, although both socially and clinically orientated courses might be described as those teaching medicine in the community, only the latter would include the word 'clinical' or 'illness'. Similarly, descriptions about courses which involved the terms primary medical care, illness conditions, team-care, (cf. Metcalfe, Nottingham, and Forbes, Southampton) would be clinically orientated - because in fact the staff were using the rhetoric of the service practitioners (see The Practitioner, 1974). By the same token, those departments using the rhetoric of holistic medicine (cf. Irwin, 1974) would present courses with a social orientation.

The proliferation of terms - medicine in the community, clinical medicine in the community, medicine in the setting of general practice - and the inconsistencies between and within departments may all be taken

as signs of the developing specialty. At the time of the research, departments could be seen consciously formulating their approaches, defining special features appropriate to the teaching of the subject in the undergraduate curriculum, outlining the boundaries in relation to hospital medicine. While this process is ongoing in any discipline, it is particularly critical to an emergent specialty, Two departments were identified as presenting quite distinct, although separate arguments for the contribution of general practice teaching, which showed some parallels to the previously identified perspectives of the service general practitioners. Two departments offered a less coherent position. It was suggested that the teaching methods affected the clarity with which the academics defined their position, but also affecting this was the state of the discipline. Academic general practice was then very new. Departments had not agreed upon the purpose and intentions of the courses. Other studies of subjects recently introduced into the curriculum have found similar internal disagreements between the staff (for example, Sheldrake and Reid's study of behavioural science teaching [Sheldrake and Reid, 1973]). This inconsistency may typify new subjects where the dogma has not yet been created, where the received view not clearly defined, (as evidenced by the lack of textbooks, for instance).

In contrast to the academics' views on the general practice were the ideas held by the service general practitioners about general practice teaching. The chapter continues by presenting these views, and concludes by comparing and contrasting the academic and the service views on the topic.

Service Doctors' Views

At some time during each interview, service doctors were asked how they would teach general practice to undergraduate students. Since the majority of the sample would have had little experience themselves of being taught the subject at this level (since it became popular after most graduated), it was emphasised throughout the interview that it was undergraduate education which was to be discussed, and not the more familiar post-graduate general practice training. The newness of the subject presented difficulties for a minority of doctors. Although there was near consensus about the method of teaching the subject a small number of doctors had little to say about the courses. Any detailed probes about how such a course could be organised were not viable. Furthermore, a larger number of Glasgow doctors than anticipated were unaware of the (then) newly formed university department of general practice in Glasgow, and also unaware of the different methods of teaching currently in use in the medical schools. Their responses, in general, may be seen as 'gut reactions' rather than an informed comment on current undergraduate teaching of general practice.[1]

The first issue to be discussed is how the subject could be taught to undergraduates, that is, what teaching method would be selected; later, the course content will be similarly analysed.

[1] Even where the doctors were aware of how general practice was taught in their city, this does not mean they would advocate a similarly structured course. One Edinburgh general practitioner, who knew about his department's course, did respond that he thought the teaching should carry on as it was. Others indicated that they understood the present situation but would not choose to follow.

Teaching Method

The service general practitioners were first asked how they thought general practice could be taught at an undergraduate level to medical students. There was near consensus on this issue. Thirty-six of the forty doctors proposed some modified variant of apprenticeship (see Table 7.i). The most common suggestion was that the students 'sat in' on surgeries (sixteen doctors suggested this); the next most popular method was attachment (fifteen) while five doctors said that the only way general practice could be taught was by 'doing it'. No doctor proposed more than one of these methods, although some doctors proposed one or another (in which case the method first proposed was tabulated). Of the sixteen doctors who suggested surgery attendance, eleven added home visits as an accompaniment, but no one suggested home visits alone.

Although these three methods have been grouped as variants of apprenticeship, there are minor differences between them. 'Sitting in' and 'attachment' involves the student in attending the surgery, observing the doctor at work, and possibly accompanying him on home visits. Attachment is typically a short, concentrated visit of weeks or months with a doctor, while 'sitting in' is vaguer, and does not carry temporal connotations. Neither sitting in or attachment, however, necessarily implies that the student carries out any work; they are both passive activities. Some doctors felt that it should be so.

The suggestion of a small group of doctors, that students should learn by doing, implies a far more active role than is usually accorded students in many professions. The researcher was left

Table 7.i

How Would You Organise a Course for Undergraduate Students in General Practice?

	Methods of Teaching	Number who Proposed it	Comments
36 doctors agree that the subject is suitable for undergraduates	Do it	5	All mutually exclusive suggestions
	Attachment	15	
	Sitting in surgery	16	
	Home visits	11	Proposed along with surgery attendance
	Seminars/discussion	3	Proposed as an extra to attachment/ surgery
	Lectures	8	
	Cannot teach it	4	

n = 40

uncertain as to how many doctors would allow undergraduates to take such an active part in their surgeries, although from data elsewhere in the research, it was clear that some doctors did allow students to take histories from patients and carry out very minor tasks.

A small group of doctors proposed seminars or lectures as a possible addition to some form of attachment - three and eight doctors mentioned these additions respectively. Seminars or group discussions were seen to have the value of exposing students to a number of opinions (another group of doctors suggested that students should attend a number of practices, an activity which essentially performed the same function). Doctors were very tentative about their suggestions of lectures; 'I suppose you could have a few lectures' was a typical response, and notably different to the adamant 'There's only one way to learn general practice - by doing it!' However nine doctors voiced contrary views about any kind of group of 'formal' sessions. Proposing attachment or surgery attendance as the method of teaching, they predicated their statements with a dismissal of anything more structured: 'I'm not sure that one can teach it by formal lectures . . . ' (G.P. 66), or 'What goes on in general practice doesn't lend itself to formal teaching' (G.P. 34).

Four doctors rejected the notion that such a course should appear on the undergraduate curriculum. Two argued that it was a post-graduate subject, and as one said, since undergraduate training was 'all facts and figures, general practice has no role here' (G.P. 32). The other two doctors said that they thought attachments would be impossible (although they raised it as a possibility and not the researcher). One had the view that students would find surgery attendance boring, while the second felt that logistically, it would

be difficult to send one hundred students out to practices. Neither of these latter two proposed any alternative method of teaching.

The majority of doctors, then, saw the way to teach general practice was by some form of attachment to a general practitioner. A notable feature of a number of the responses was the adamance with which the doctors held their views about teaching. Typical is G.P. 59 who answered the question with a thump on his chair:

> There's only one way to learn it, sitting in the doctor's chair, or next to it. You can't learn it by speaking about it, or films, you must experience it. [Why?] Because you have to see the conditions, you can't learn them in a classroom.

or G.P. 51 who responded

> I don't think you can teach general practice, you have to come out into the field. The student should be attached to a practice, or sitting in and going round with a doctor, so that they can see the conditions in which patients live and work.

These two quotations bring out a further point. The distinction which both doctors above made between teaching and learning is common in general practice.[1] One cannot teach students general practice but the students could learn it. This led to statements like that of G.P. 41, who said, 'The students should not be taught anything', but who continued by discussing what students on an attachment should learn about general practice. Although the student played a passive role in learning, his presence in the situation was vital. He was there to observe and experience. 'It brings it home to you if you

[1] It is interesting that not all languages have separate verbs for 'teaching' and 'learning' - for example in French 'apprendre' means to both teach and learn.

see it' (G.P. 70). 'The practical should be taught in the practice' [Researcher: Why?] 'Because [at university] you can't get the atmosphere of a morning surgery with the telephone ringing and people fainting' (G.P. 67).

Such a notion implies a lack of faith in the power of formal teaching methods, and considerably more faith in the significance of personal experience. It also relates to the notion that apprenticeship (or attachment) concerns the transference of knowledge that cannot be codified, that is, (to use Polanyi's phrase) 'tacit knowledge'. Such knowledge, though 'unteachable', was seen to be transferred to the student through a kind of 'osmotic' process. Thus, 'you cannot teach it to undergraduates, you expose it to them and let them draw their own conclusions' (G.P. 32).

Doctors saw the 'tacit' as not only experiencing the 'atmosphere' of the surgery. They recognised that a number of skills could only be acquired through practice, and saw these skills as wholly unteachable. They often concerned people; 'In general practice you just look at your patient and you already have half the diagnosis' (G.P. 60). They talked of 'sizing people up', 'learning to know who is sick and who isn't'.[1]

[1] Doctors are not the only occupational group who learn to 'size up' people. It is an everyday activity (Goffman, 1959) although our typologies vary depending on our perspective. The following example of sizing up is of a trainee door-to-door salesman accompaning his 'teacher', the sales manager, who views everyone as a prospective buyer.

> The night I [trainee] went out with him [sales manager] we drove into this driveway. There was this man standing there working in his garden. Howard lifted his hand, waved at the guy and said, 'good evening'. The guy got this big smile on his face, raised his hand and waved. Howard looked at me and says, 'This asshole is sold, get out the contract'. He sold him too . (Bogdan, 1972, p. 61)

An example from a profession is provided by Jackson and quoted by Leggatt (1970). Jackson found that teachers he interviewed expressed great hostility to outsiders' evaluation of their classroom performance, sharply mistrusted tests because they served to assess the child's natural ability rather than the teacher's effectiveness, yet were fully confident that they could directly and immediately assess their own performance; as one teacher replied on being asked how this was done, 'Oh look at their faces' (Jackson, quoted by Leggatt, 1970, p. 193).

One further comment related to this notion that general practice was largely unteachable. Three doctors mentioned that general practice was an 'applied' or 'practical' subject: this was seen to mean that the subject had no theoretical base of its own; the clinical medicine that a practitioner relies upon was clearly not seen as constituting a special type of medicine but was merely putting into practice knowledge gained from a number of other specialties - paediatrics, geriatrics and so on.

Course Content

Although doctors thought that much of general practice was unteachable, they still held definite views about what the student should be learning. Answers to the question 'What should students learn on such a course?' fell into two broad categories. The majority gave some kind of 'social factors' answer, which has been split into 'background' and 'approach to people'. The minority, but distinctly alternative response, was clinical - students should learn about early and late management of illness conditions. By specifying such topics, the general practitioners were implicitly defining the area of expertise which they thought special to the general practitioner, although we have seen that only a few reported that they understood general practice was a specialty, or that such knowledge constituted special knowledge.

Conditions in which patients lived (and worked) were seen to yield important 'social' information to the general practitioner. The doctor could, literally, put the patient into context. This is, of course,

the 'whole person' medical philosophy which was discussed in an earlier chapter. Some doctors were particularly anxious that the student appreciated this aspect of general practice. G.P. 49 was one such doctor:

> [A student should learn] how people really live; to know the homes, family, social problems, all the family tensions and see how these problems are part of the illness.

Given the importance attached to such information about the patient, the value of attachment, and particularly home visits, can be readily understood. 'The conditions of Gorgie are not in a text-book' (G.P. 41).

Doctors adopting this kind of emphasis talked as if general practice work was largely composed of dealing with non-medical problems, that complaints were either in the form of non-clinical conditions (anxiety or stress for example) or that physical conditions masked the 'real' complaint.[1]

> There's an emphasis on physical disease in medicine, how to recognise and treat it. But 70% (and the figure varies) of people in general practice are either not suffering from disease (for which you can give pills) or complain of illness which can be recognised but they don't actually have it. How can you learn this except by sitting there and recognising it. Seminars are not very effective, there is no substitute for being on the ground, doing it.
> (G.P. 53)

One doctor, although unusual in that she felt that lectures could play a part in the course (although not without some contact with the

[1] This argument has gained theoretical respectability in general practice through the writings of Michael Balint (see Chapter Three).

doctor), offered the following account of this perspective in answer to the question, what would she include in the course?

> You've got to be prepared to listen to people, they might come in with a sore back, but the real problem is the husband is drunk or something. They have no one to talk to, so they come to the doctor - it has therapeutic value, and they feel much better. So you try and find out about their home background, not necessarily what they present you with. It gives you good insight, knowing this. You learn as you go along not to accept the face value, and of course, vice versa, see that there's no organic problem first. You can't work to the clock. It doesn't always involve very medical work. You could have a basic lecture with discussion and send them round with the G.P.
>
> (G.P. 57)

The point about non-medical work, not always made directly, was that it contrasted strongly with the purely clinical approach taken in hospital medicine. Doctors wanted students to see that general practice was different, and more than that, to accept general practice on the practitioners' terms, to 'see' it as the doctors involved saw it:

> It's important for all students to know about the social background of the patient, much is missed out in hospital, and they don't see the patients in their own background. They don't understand the difficulties for patients to get to out-patients, also they don't think some hospital specialists understand that the patient needs the illness explained to them - this varies depending on the consultant.
>
> (G.P. 43)

Another feature of general practice work which the doctors thought important for students to observe, has been given the heading 'approach to people'. This general heading covered statements concerning doctor-patient interaction, and viewing patients as 'people' as opposed to 'cases' or 'illnesses'. Quotations given earlier regarding 'sizing

people up' could be reported here, for this skill fell into the category. One doctor suggested that 'the nearest thing [to a course in general practice] would be a course in public relations' (G.P. 53). Another said:

> General practice should only be taught by attachment to practices and it would have to be taught for a very long time, as it takes a long time to learn, some never learn to deal with patients, others do have a flair . . . If the doctor [or student] is ill at ease, then he'll never be able to deal with patients, and this you can't teach, being at ease with people and getting them to talk.
> (G.P. 70)

Finally, G.P. 34 summed up as follows:

> What goes on in general practice doesn't lead itself to formal teaching. It would be difficult to convey what goes on; Balint and his colleagues come nearest to discussing this. It is difficult to see how you could make this into a formal course.

This was certainly the majority view of the learning content of undergraduate general practice. However another, smaller group of service doctors did feel that a student should learn about the clinical conditions special to general practice. This contrasted strongly with the notion of 'whole person' medicine which was behind the majority view. But it is interesting to note that even this group of doctors did not necessarily think that the students should be taught the clinical content through a lecture course, but that it too, could be learnt through exposure to the conditions at the surgery. G.P. 47 illustrates this point:

> In surgery and home visits they can pick up chests, skins, hearts and antenatal, and the interplay of depressive illness, which they see much of today.

Others talked about the student learning about childhood illness, trivial or minor illness which could include 'the coughs and colds of general practice'.

It would be untrue to suggest that all doctors saw general practice as having no 'teachable' content. Attachment was seen as the most important teaching method for the teaching of general practice to undergraduates, and most suited to the transmission of the kinds of topics already mentioned. However, some doctors did feel that a part of the subject could be taught in a structured way. Information about practice most often mentioned as 'teachable' in a more formal sense, was that concerning the organisation and administration of a general practice. This could include record keeping, hiring practice staff, and financial administration, but also the paper work which the doctor is involved in (sick notes, referral notes, health certificates, etc.). G.P. 32 noted, for example, 'I suppose you can teach basic principles, for example, the organisation' but added - 'but you can only learn it by being a trainee'. Another, who had started in practice with a very disorganised lady doctor with no telephone or records, said that it would be a help to learn about practice organisation (it seemed that some doctors used the words 'organisation' and 'administration' if not interchangeably, at least with some overlap). Organisations could mean not just that involved with running the practice, but also the paper work which the general practitioner's involvement in the social services brings:

> You must try and impart the basic needs - social and financial problems, how to get on with patients, needs related to this, this is not taught; the manipulation of social security, changing houses, how housing is allocated. Some can be taught through the lecture situation.
>
> (G.P. 48)

Finally, relating to this topic, service doctors were asked what the students would get out of this exposure to general practice. Again, answers could be classified into two types. Some felt that students should have the opportunity of seeing a doctor at work, prior to taking up general practice themselves; this, then, was a vocational purpose to the course.

> Students should see a good general practice - I wouldn't have stayed on here or in general practice but here you can do things on your own, and don't always have to send the patient through to the specialist. We can do bloods, and x-rays. Students should become aware of this 'independent' aspect of general practice - I was pleasantly surprised when I came here and saw the facilities . . .
> (G.P. 62)

or

> It is important to expose all students to it so they can decide if they are attracted . . .
> (G.P. 32)

The alternative purpose was that the students would have greater understanding of the difficulties under which the practitioner worked. This was seen to be important particularly if the student was <u>not</u> planning on entering general practice, for a number of doctors felt that the new generation(s) of specialists who had entered the health service after it became nationalised (and who therefore had no general practice experience) were singularly intolerant of general practitioners. Doctors responding in the latter manner often cited several instances where they had felt put down by a specialist who had failed to understand why the general practitioner had acted in this manner. This was sometimes then followed by a further account of a specialist who had failed to understand the 'background' of a patient, and who had acted

in a manner which the general practitioner felt was misguided.[1]

General Practice - Common Sense or Philosophy?

Given the variation which existed amongst the service doctors regarding other aspects of their work, their relative agreement over issues relating to teaching is all the more noteworthy. In the first place, what is significant is that although the model for teaching undergraduate medicine is a lecture course with clinical work built around the lectures, not one general practitioner assumed that undergraduate general practice should follow this method. Instead, the model they adopted was a post-graduate one. This was certainly the one with which they were more familiar - apprenticeship is the time-honoured method of professional learning. Yet all had experienced undergraduate teaching of other clinical subjects. The service doctors' statements on how they would teach the subject suggests that they continued to make the distinction between general practice and other clinical subjects. It was not like the others; it was not so amenable to formal teaching. The argument articulated by a few, that it was an applied subject, suggests one reason why this should be so. Some felt that unlike other clinical subjects there was no theoretical base to general practice that could be taught to students; even the clinical conditions were not seen as necessarily forming the 'meat' of a lecture

[1] Atrocity stories, for such these are, have been considered at length by Stimson and Webb (1975), and Dingwall (1977b). The authors' argue that such stories are revealing in that they focus upon the point of conflict in the relationship, and attempt to redress inequalities between the two sides.

course.

Yet the doctors did think that general practice had special qualities as a branch of medicine. The second point of note to be taken from their interviews is that their statements can be seen as a plea for the continuation of the apprenticeship method even at an undergraduate level, because of what is implied by apprenticeship. These doctors clearly felt that the essential skills of the general practitioner were uncodifiable, that they remained at the level of indeterminacy. They were arguing that particular aspects of general practice were important (such as background, the family) but that these important features had to be experienced and could not be constituted into formal statements or rules. Thus it was never suggested that generalisations or theoretical statements could be made about general practice.

This view that the work experience of a practitioner resists theoretical interpretation is shared by other professionals.[1] Esland finds 'naive and limited' the similar perspective of teachers regarding their craft (Esland, 1971a, p. 83). He notes that this viewpoint is used by colleges of education to argue for further on-the-spot training, yet despite its apparent limitations, Esland does agree that it is held with some justification.

General practitioners are not unlike teachers in their work situation. Both work in the relative isolation of their surgery/classroom, away from the direct view of their colleagues. To watch a

[1] Alan Davis has suggested in a personal communication that a similar argument was used in the nineteenth century by architects for not teaching art formally.

colleague at work would be seen as somewhat unprofessional, unless in extenuating circumstances. Discussion amongst colleagues of patients/pupils may be limited, and the doctor/teacher may have little opportunity to isolate and abstract from his own work practices which might be common to others of his profession. The doctor/teacher may understand how he works, but not how his work is typical of a certain way of practising. He is, then, not in a position to create generalisations. That task is left to the observer, who may walk from surgery to surgery or classroom to classroom to gain some overall impressions in terms of style, and form, content or method. As a previous chapter argued, the academic general practitioner (or indeed the educational researcher) is granted this position from which to view the vivid present[1] of the practitioner. One may look to him for such generalisations or theoretical statements.

Even if the doctor is interested or in the position to visit a number of practices, medical ideology emphasises the particular at the expense of the general - it is particularistic, as Freidson would argue (Freidson, 1970), rather than as Parsons has suggested, universalistic (Parsons, 1952). Thus the medical perspective draws the doctor away from seeking general statements, to concentrating upon the individual cases, or patients (this was very evident in the interviews, when points were illustrated through particular patients).

A further point in relation to the general argument is that at present medical theory is directed towards explaining the aetiology of a condition in clinical rather than in social terms. By attaching importance to the home environment, and to 'social factors', general

[1] Schutz' term, used by Esland (1971a).

practitioners are seeking explanations for illness which lie outside the clinical. Psychiatry has certainly offered some theories (and Balint's name was mentioned by a few general practitioners). But given the lack of much coherent received opinion about non-medical aspects of conditions, it is not surprising that the doctors' notions of such factors remain at the individual level, which in turn, forces a teaching method which at best suits uncodified knowledge.

It is important to realise that the sample did not regard general practice philosophies as theories, but as common sense statements. 'Whole person' medicine is seen in terms of a common sense understanding that information about a person's life style makes diagnosis and management easier, rather than in terms of theories about aetiology which allow that non-biological events can influence physiological processes, or psychiatric theories about relationships between stress and physical illness. The theories have become incorporated into the everyday terminology, their status as 'theory' now largely unrecognised.

An interesting, although rather innocent experiment was carried out in the field of social work which underlines this very point. Carew tape-recorded social worker and client interaction, and also interviewed the same group of social workers (Carew, 1979). He analysed the theoretical positions each took in the interaction, and then asked each social worker to identify the theory behind his statements. Few could. Instead, the social workers referred to personal experience or advice from more experienced colleagues as the source of their statements, in a way which was reminiscent of the general practitioners. The author concludes:

> The findings in this paper clearly indicate that these practitioners were not using theoretical knowledge as a basis for their activities to any significant extent, and that the literature on this subject had had very little effect on the way in which they approached their work.
> (Carew, 1979, p. 362)

Yet this conclusion surely misses the point. First, although practitioners may not recognise their statements as stemming from a particular theoretical perspective, this does not mean that they are not using that theory. An alternative interpretation is that the theory is no longer recognised as such. Rudé, writing on ideologies within a culture, notes that 'among the "inherent" beliefs of one generation, and forming part of its basic culture, are many beliefs that were originally derived from outside by an earlier one' (Rudé, 1980, p. 28) - 'outside' meaning 'often taking the form of a more structured system of ideas political or religious . . . ' (Rudé, 1980, p. 28). One should not assume that if the theory remains unrecognised it does not exist.

Secondly, Carew makes the distinction between theory as second level abstraction, and the practical thinking which every practitioner carries out in his daily life.[1] Although this is a valid distinction, practitioners, too, are theorisers, as Mill well knew:

> There cannot be a worse authority in any branch of political science than of merely practical men. They are always the most obstinate and presumptuous of theorists.
> (J.S. Mill, quoted by Hamilton, 1980, p. 3)

[1] In the thesis, the term 'theory' has been applied to a set of ordered ideas of an abstract nature. This is the more common usage of the term; it is important, however, to recognise the other usage.

Interestingly, the notion of every individual as theorist has been elaborated by ethnomethodological writing, where the term 'practical theorising' refers to the seeking out of common sense theories behind everyday statements.

Service and Academic Views - Comparisons and Contrasts

To date the views have been presented of both academic and service doctors over teaching general practice at an undergraduate level. Before the chapter is concluded, it is instructive to compare the views of the two groups. In the event, there are more contrasts than comparisons, but the latter will be mentioned first.

Both groups shared the opinion that general practice should not be taught through lecture courses. This forms the centre-point of agreement. Reasons given were similar, that the significant features of general practice remained uncodified, and were therefore unsuited to the demands of the lecture.

The second point of agreement was that general practice had certain features which separated it out from other branches of medicine. Censensus here was less strong amongst the academics but the setting, the family and the individualistic nature of practice were mentioned by some members of both groups.

Here the similarities stop, for academic general practitioners held a number of opinions which contrasted strongly with those of the service general practitioners. In the first place, academics believed that the subject could be presented in some structured manner to students; that is, they felt that certain aspects of it could be

taught. 'Being there' at the surgery was important but not sufficient; members of all departments wished to draw out certain general features from the individual experience of the students. Thus academics believed that one could abstract from the particular to the general, even though agreement over the general was not very fully developed.

Secondly, although lectures were rejected, some departments placed considerable weight upon small group teaching. Unlike service practitioners, members of some departments saw these semi-structured forms of teaching as or more important than surgery attendance, not merely as a complement to 'sitting in'. One department in fact had no surgery attendance; teaching through small group interaction was the method used on the course.

Thirdly, the majority of service general practitioners emphasised that it was important for students to comprehend the background and the family; these factors, they stressed, were significant when making a diagnosis in this form of medicine. Members of some departments agreed, and incorporated such an understanding into their courses; others laid far less emphasis upon a 'social' interpretation of illness. Instead, they focussed the teaching around illness conditions, mentioning in particular chronic illness, or early diagnosis. Surprisingly, the service doctors mentioned this little, although chronic illness, for instance, forms about one fifth of their case load (R.C.G.P., 1973). They did not see the illness conditions of general practice as special, or as potential teaching material.

Perhaps the most significant difference was that the academic doctors did not see the courses as a forum for teaching 'general practice'. They did not wish to portray general practice as the life and work of the general practitioner (although we have seen that this

is a problematic issue for these doctors). Instead, the academics wished to abstract from general practice certain features of general significance, although they seemed to be divided over what those features should be.

Thus we can see that very different notions about teaching existed with service and academic general practitioners, held by groups who were both united and yet divided in their commitment to the future of general practice. The curriculum literature recognises these two antithetical notions about the teaching of a practical discipline (for example, Esland, 1971a; Reid, 1978). On the one hand, the practitioner is seen to concentrate upon his 'logic in use', believing that his practice is unique, particular, and his thinking not amenable to theoretical analysis. The theoretician, on the other hand, neglects the practitioner's logic in favour of his own 'reconstructed logic'; he seeks general statements, and believes in rationality, universalism and order. Action is on the one hand, and knowledge on the other.

Both positions are, as Reid points out, socially determined by the context in which such notions are formed (Reid, 1978). In medical practice doctors are encouraged to think in terms of the individual. Freidson, in his discussion of the 'clinical mentality' (Freidson, 1970, Chapter 8) stresses the particularism of the profession. He notes that doctors are socialised into emphasising 'the primacy of first hand clinical experience rather than scientific laws of general rules' (Freidson, 1970, p. 164). General practitioners may represent an extreme position here; their place of work has until recently, been more isolated than hospital doctors, and more than hospital medicine, the biographical approach emphasises the individual biographies of each patient.

Within universities a different kind of thinking exists. High status knowledge, known to the few, becomes enshrined in educational establishments which in their turn permit the few, not the many, to enter. One of the central notions in a paper by Glazer entitled 'The Schools of the Minor Professions', is that the 'route to higher professional standing lies in replacing the professionals and the practitioners with the scholars and the research workers' (Glazer, 1974, p. 350). Thus the institutionalisation of that discipline within the university, adds status, while the professionalising process, tied up with conformity to the established traditions of universities, serves to create a special brand of knowledge (what Glazer calls 'superior knowledge').

At present general practice teaching does not wholly conform to the traditional pattern of undergraduate medical teaching, and one cannot predict that it will. At the same time, the present courses do not fit the notions held about teaching by service practitioners. The compromised position of the academic general practitioner can be fully understood. Just as their identity 'crisis' reflects the influence of both service practitioners and other academics within the medical school, so too do the courses reflect the 'pull' of these two groups.

If one foresees courses becoming increasingly structured, less reliant upon attachment teaching, and less concerned with teaching 'vocational' general practice, then the influence of the service practitioners may be understood as weakening. The gradual structuring of courses suggests increasing conformity to accepted medical beliefs about the nature of teaching and the way subjects should be taught - although with no lecture courses academic general practice will always

appear deviant.

General practitioners are, as yet, only mid-process. They have not yet achieved what Glazer would advise, that is, the replacement of practitioners and professionals with the scholars. General practice courses in Scotland are essentially organised by the academics but taught by the part-time staff. It is to a consideration of this latter group's views on teaching to which the thesis will now turn.

Chapter Eight

PART-TIME STAFF - THEIR VIEWS

Introduction

By now it must be apparent that with small departments of general practice and an emphasis on small group or individualistic modes of teaching, the full-time academic staff cannot personally carry out the majority of each department's teaching duties. For this purpose each department recruits a number of part-time staff, or 'tutors'.[1] These tutors are the focus of interest in this chapter. Through an analysis of their views on undergraduate general practice teaching, the chapter adds to the perspectives which the previous chapters have presented. The data is drawn from interviews with a sample of twenty-two part-time tutors from two general practice departments in Scotland, Edinburgh and Glasgow.[2]

Reliance upon part-time staff to help with teaching is typical throughout medicine, and in this respect general practice departments are no different (Byrne, 1974). The incorporation of part-time staff into the medical school is however, not without difficulties, and the

[1] The dividing line between a full-time and a part-time member of staff in the medical faculty may be thin.

[2] Staff of the two departments with the more structured teaching methods were interviewed. The choice was dictated largely by convenience - all part-time tutors in Glasgow and Edinburgh were working within the cities. In Aberdeen and Dundee part-time tutors were located throughout the region. A larger study of part-time teachers would be most worthwhile, however, as they do form an important yet neglected group.

literature on part-time staff has concentrated upon spelling out the nature of the problems (for example, Kendall, 1965; Sheps, 1965). The source of the potentially strained relationship between full-time and part-time staff has been identified by Todd in terms of the differing commitment of each kind of clinical teacher, on the one hand the group who has made education and research its focus, and on the other the busy practitioners whose primary concern is with their professional practice (Todd Report, 1968, paras 508, 509).

But with the exception of the above reports, the perspective of the part-time teacher has been virtually ignored, an omission which typifies the casualness with which this group's contribution to medical education is treated. Rather than focussing specifically upon the relationship between the full-time and the part-time staff, this chapter explores the undergraduate teaching programme in general practice as perceived and understood by the part-time staff of two departments. The concern of these doctors, upon whom the major burden of the teaching fell, was with the practicalities of carrying out the teaching; and the interviews reflected this emphasis. The views of the part-time staff will be discussed under three headings: teaching method, course content and course orientation. But initially, as was done with the full-time academic staff, there follows a brief review of the part-time teachers themselves.

Recruitment

The characteristics of the teachers were studied through information provided by the Medical Directory (see note on page 194). The majority of the sample was male (only two were female, which accurately reflected the overall small proportion of women tutors - see Table 8.i). All part-time teachers had at least seven years medical experience at the time of the interview, and all were practising in the city in which they trained (not uncommon in Scotland). They were in many ways, 'typical general practitioners'. There were differences, however; at the time of the interviews nearly three quarters were members of the Royal College of General Practitioners, compared to the national figure of one third of all general practitioners. Furthermore three part-time staff held an 'M.D.' degree, an academic qualification which is rarely held by general practitioners, while five of them possessed three or more academic qualifications. There is the suggestion, therefore, that some of these doctors were above average in their interest in academically inclined activities, and their willingness to teach the less surprising.

In all instances except one, the part-time staff reported that they were approached by the head of the department, either individually or by practice, and asked if they would be interested in teaching undergraduates.[1] The one exception to this was a group practice the members of which decided that they would like to teach, and wrote to the university offering their services.

[1] The 'old boy' network was used by the professors in selection, although some departments attempted to draw up formal criteria which tutors had to fulfill.

Table 8.i

A Comparison of Characteristics of Part-time and Service General Practitioners in the Sample

	Category of General Practitioner		
	Service	Part-time	Total
Sex - male	29 (72)	21 (95)	50
female	11 (28)	1 (5)	12
Date of qualification			
1935-44	11 (28)	6 (27)	14
1945-54	19 (48)	8 (36)	27
1955-64	4 (10)	8 (36)	12
1965 or later	6 (15)	0 (0)	6
Number with M.R.C.G.P.	10 (25)	16 (73)	26
Number with M.D. Degree	0 (0)	3 (14)	3
Number with three or more higher qualifications (including membership examinations)	1 (2)	5 (23)	6
Number practising where qualified	37 (93)	22 (100)	50
Total	40	22	62

column percentages in brackets

Nine had not taught before; of this group, six said they had never thought of teaching before they were approached. Being selected, however, was seen to reflect well on their professional abilities. One spoke of being 'rather flattered', while another felt that part-time staff were

> chosen people. We didn't apply for the job and we don't always want to teach, but are flattered at being asked, it's a question of it's an honour to teach, so we accept.
>
> (G.P. 01)

Thirteen had taken part in teaching of some kind before, and saw their new involvement in the undergraduate course as an extension of their earlier interests in the broad field of 'education'.

The status of part-time staff within the university, however, is ambivalent. In some medical schools they are recognised, in others not. In most cases they are only paid an honorarium, i.e. a token sum of money for the teaching, and they may enjoy such privileges as membership of the university staff club. When the part-time staff were asked if they thought they were underpaid for the job most replied affirmatively, 'Grossly, I don't consider we are paid, that's how I think of it. Mind you, it's called an honorarium. The inconvenience four students make in your life is considerable' (G.P. 08). Although doctors felt that the pay was low, it did not deter them from continuing to work for the departments. One doctor, when asked about pay, merely replied: 'It never irked me; I'm extremely bad at estimating pay in a job' (G.P.09).[1]

[1] The researcher has records of service practitioners who were approached to teach in the department, but who refused because they felt that the financial rewards were too small. These tutors then, are obviously those who mind less about the salary. On the other hand, some belonged to practices where outside expenses were pooled; in other words, all the partners were bearing the brunt of the low income carried by the one partner.

Given that general practitioners can earn more for other kinds of 'outside work' than for teaching, the full-time staff may well have been correct when they spoke about the kudos attached to working in the university, and indeed, academic contact was one of the reasons part-time staff said they enjoyed the work. Other reasons given were 'meeting the students', and the 'educative value' of having a student, seen to be more up-to-date in medical thinking, around one's practice.

Teaching Methods

The part-time staff were asked about the teaching, both the method, and also about their views on what they found most 'teachable' in general practice. The discussion of teaching method and course content will be separated, again with the understanding that this is a purely heuristic device. Since Glasgow and Edinburgh adopted different methods of teaching, responses from the doctors attached to each department will likewise be dealt with independently.

To recap the Edinburgh course, two main methods were combined. The emphasis of the course lay on surgery and seminar teaching, although students also followed up a patient and had an assessment interview with a senior non-medical member of the general practice department.

The tutors reported no problems with the students being present at their surgeries, and indeed, most doctors said that they liked having someone else around the practice. Sometimes the reason given

was educational; the students were seen to be more up-to-date in their medical knowledge than were the doctors, but more often they seemed to use the students as a kind of external stimulus to prevent the doctor from 'slipping' in his daily routine (this suggests that the student acts as a means of disrupting the doctor's taken-for-granted, that the student can perhaps 'see' the patients with a fresh eye. It also suggests that the valued isolation of the practitioner is in fact double-edged.)

The seminars were potentially more problematic. Three doctors and usually eleven or twelve students attended them weekly. The seminars had apparently become more structured than they used to be,[1] and there was a general feeling that this was better. The part-time staff were divided, however, over the value of the seminars. While one doctor saw them as essential to the course, allowing students to consolidate impressions gained during the surgeries, another found them repetitious of the surgery discussions.

> At the seminar level it [teaching] is more difficult [than surgery] because I have already explained it all at the surgery and the student doesn't want to go through it all again.
>
> (G.P. 06)

The perceived benefit of the seminars may have been dependent upon the amount of teaching that the part-time staff felt they did at the surgery.

One of the important features of these seminars was that, unlike in general practice, the doctors had their routines exposed to an

[1] This was taken to mean that they were now organised around a series of three topics.

audience of other doctors and students. In general, the part-time staff had been socialised into seeing this professional confrontation of positive value, if a little unusual for general practitioners. It reinforced to students the perceived individualism of the general practitioner:

> Do you ever disagree with the other doctors in the seminars?
>
> Yes, and the students see it. It shows there are different ways of delivering care, attitudes vary and practices vary. I don't think our differences should be all sorted out before hand.
> (G.P. 10)

Most argued in principle that the differences of opinion between the doctors should be articulated in front of the students, while one doctor only thought that they should present a united front to the students.

> This is something I feel strongly about, we should agree on the content of the seminars and not just have the G.P.s sitting there sticking pins in each other. They're all different, all independent, but we should agree on the content and stick to it.
> (G.P. 07)

The seminars also served another function for the doctors, about which some doctors were quite conscious. When G.P. 03 was asked how he felt about having his routines exposed to other doctors he reported that it was initially very threatening, but continued to say that it was also very educational.

> You get used to it. I feel that the lecturers learn more than the students [laughs]. The seminars are the one forum where you can learn about other doctors, and how they act; you know about your partners from record cards but there

> is a real cross fertilisation of ideas in the seminars. Part of the reason I may be able to discuss things better now is that I am growing more experienced myself [and more confident].
> (G.P. 03)

Without attempting to draw out psychological implications of the above, one can simply point out that to interpret the seminars as a learning situation demands that the doctor takes a particular perspective of general practice work which assumes that 'experience' can be articulated, transmitted, and thereby learnt. It also suggests that this perspective itself is a learnt one.

The Glasgow course, it will be remembered, was organised quite differently. In Glasgow it was suggested that doctors took groups of students to selected patients' homes, left each student or two students for an hour to discuss the patient's problem, and then returned all the group to the surgery for small group discussion. The Glasgow teaching was carried out without a full-time member of the department being present. The department offered the method of teaching, guidelines to teach by, and examples of conditions; the tutors were left to pick the specific topics themselves within the general framework outlined. Thus there was scope in Glasgow for each tutor to tailor his course to suit him or herself.

Seven of the twelve tutors interviewed reported carrying out the case method as specified. The other five mentioned modifications to this basic pattern. One doctor allowed students to sit in on a surgery once a week 'which they loved'. Another thought the only way general practice could be taught was by taking students to patients' homes, where he carried out most of the teaching, omitting the general surgery discussion at the end of the afternoon. He added:

> I don't prepare anything although I know this might be wrong. I'm teaching about [patient] management which I should know about from experience, which is what I'm there for. If I had to look things up then I shouldn't be in practice.
>
> (G.P. 19)

Two doctors found the three hour session too long, and said that they only kept the student for about one and a half hours since they found the time hard to fill. One of the above used R.C.G.P. tapes, while another tutor relied heavily upon audio-visual aids, preferring sometimes to take students to the university to show films, rather than to patients' houses. He argued that the latter task was too time consuming, and he did not always have appropriate patients.

The practical difficulties with this case method of teaching were pointed out during the interviews. As the doctor above mentioned, a patient with the appropriate problem (presumably the condition the doctor had chosen for the week) might not turn up at the surgery. Young working men were seldom available, and the tutors were forced to ignore their particular problems. Other difficulties mentioned were that selected patients might return to work before the teaching day, that a particular practice might have a biased age population, mostly elderly or young married couples, for instance, which made it difficult to select patients with illness conditions outside the age group; acute illness was less predictable in advance, and finally, 'good' patients should not be used for teaching purposes too often. The implication here was that in fact the teaching tended to focus upon certain categories of illness - chronic rather than acute conditions, with very young and elderly patients rather than young and middle aged, and women's complaints rather than men. Now it could be argued that

these were the very conditions which tutors were meant to be focussing upon, so that the course aims were being fulfilled in this respect. What is of interest is that a number of the part-time staff felt that they were constrained to use these groups by force of circumstance rather than by choice.

The Glasgow method of teaching did not result in the doctors confronting each other in group discussion, but it did allow students to be exposed to a variety of opinions. While in Edinburgh this was built into the course structure, in Glasgow it was achieved in a number of instances by the fact that doctors in a group practice would often take turns teaching, so that the students would meet more than one general practitioner. In both departments, the overall feeling was that this was valuable, and that it was important for students to realise that different views existed, that there were different kinds of general practitioner.

Both courses also exposed the part-time tutors to student criticisms, and all doctors were asked how they felt about this. There was some agreement about the degree to which they accepted students' criticisms. Overall, eighteen doctors said that they received criticism from students, sometimes adding adjectives such as 'acid' or 'quite outspoken' to describe the criticism. Tutors generally did not appear to resent the remarks, although many contrasted their judgement on matters with students' inexperience. Views about criticism revealed the practitioner's view of general practice. The doctor who believed that 'Medicine, especially general practice, is an imperfect science, and you must use intuition so there is not necessarily uniformity of opinion' (G.P. 17), accepted as valid, criticism from students. Those

who believed that wisdom accumulated with age, saw criticism as less valid coming from those who were young and inexperienced.

Course Orientation

In previous chapters, it was argued that the two departments, Edinburgh and Glasgow, orientated their courses in different ways, the first emphasising the social perspective, the second taking a clinical perspective of general practice. During the interviews with part-time staff, doctors were asked about the course orientation, although it was assumed that between selection by the head of department, and self-selection, the tutors would agree with the particular emphasis of the course. It was further assumed that it would be the clinically orientated doctors who would agree with the clinical orientation and vice versa. In other words, there would be a correlation between the tutor's own practices and his sympathy with the course. The questions on this topic were insufficient to tackle this complex issue, and the relationship between a tutor's own perspective and the course emphasis is a topic which research has still to tackle.

On this issue tutors were first asked what aspects of the course they found difficult or easy to teach. This question was intended to tap 'perspectives', but in fact revealed more about the particular constraints of the teaching method their department adopted. As with

the previous discussion on teaching method, the responses from each department will be dealt with separately.

The Edinburgh department organised their course around themes. Responses to the question of what aspects of the course tutors found easy to teach and what topics difficult did not fall into easy categories. The staff had conflicting ideas about the course and its purpose, and this was reflected in what they thought they should be teaching. Two said that they found the clinical medicine easier:

> Do you find some aspects of general practice easier to teach?
>
> I find the philosophical bit from the department difficult to get across, in fact difficult to understand myself. I find the straight clinical medicine easier.
>
> (G.P. 04)

While this comment suggested that the above tutor did not necessarily see the course as having a 'social' orientation, other responses did confirm the emphasis of the course. Two doctors said very definitely that they were not teaching clinical medicine - 'that's someone else's job' (G.P. 04). Four said in response to the question that they found the main objectives of the course easy to teach, some specifying that they found the doctor-patient relationship easy to teach - an interesting comment when one remembers the service general practitioners comments about the quality of the relationship. However, when these doctors were asked why this was so, it quickly became apparent that their responses firstly related to surgery teaching, and secondly that 'easy to teach' had a specific meaning.

> I then asked G.P. 02 if he felt that some aspects of general practice were more teachable than others.
>
> Yes, anything more factual is more easily teachable, and some aspects are more concrete than others. Continuity of care and the doctor-patient relationship I find very teachable, not in a factual sense, though, but about relationships . . . Continuity of care and the doctor-patient relationship, there are always cases from which you could teach these two things.
>
> I ask him how he would teach the doctor-patient relationship.
>
> With the doctor-patient relationship it's how you react to individual patients, and there's always one who comes into the surgery who I might find reacted hostily to me and me to the patient, others who are seeking reassurance from the doctor no matter who the doctor is, and so on.
>
> (G.P. 02)

The method of teaching obviously affects the type of topic which can best be illustrated. The Edinburgh doctors' responses suggest that they felt that in the surgery they could always teach (that is, discuss), the doctor-patient relationship because the theory was that the doctor had a relationship with every patient.[1] The topic could therefore be raised with students in relation to every consultation. For the same reason, primary diagnosis was singled out as being slightly more difficult to teach since 'primary diagnosis needs special patients' (G.P. 02). Primary diagnosis required patients who presented to the doctor for the first time, and so its difficulty lay in the fact that the doctor might not have new patients, or more accurately, patients presenting with new problems.

The comment that the course objectives were easy to teach is taken also to imply that the doctors were in basic agreement with the

[1] As outlined in the seminars of the department (fieldnotes).

orientation of the course. In the interviews the staff were not asked how they interpreted the term social, which would have been a most revealing exercise. From their comments, the importance of family background and other social factors were not brought up as much as the researcher had anticipated. The tutors seemed to have what the researcher identified as a directly 'Balint' interpretation of 'social'; they talked about the role of the doctor as father figure, counsellor, and of the doctor offering 'reassurance'. Implicitly, the acceptance of the view that the doctor-patient relationship could be discussed, a controversial opinion amongst general practitioners, also supported the idea that the doctors were Balint orientated.

The same questions were asked of the Glasgow part-time teachers, and their responses indicate similar reasoning regarding the 'teachability' of certain topics. Their course was identified as more 'clinical', and most of the tutors did indeed reply that they found psychological illness difficult to teach, and acute illness easiest, although the latter was not always seen as the most important. One tutor, unusual in that he expressed considerable interest in the psychological aspects, explained why he felt they were difficult teaching material:

> I like the psychological parts of medicine, the grey areas, some feel inadequate in this aspect. It's difficult to teach this because you have to show a student something, and it's difficult to show different grades or types of anxiety, for example, whereas a urinary tract infection you can show them the complete list of symptoms.
>
> (G.P. 11)[1]

[1] This doctor may not have actually shown students the patient's inflamed urinary tract, or the infected urine. Rather, he meant that symptoms of physical illness conditions could be easily identified, verbally.

Another made a similar point about the difficulty of teaching the inter-personal side of general practice, but added 'I don't feel that any time should be spent talking about it; it comes out in the teaching' (G.P. 19).

For the same reason that psychological illness was difficult to show to students, chronic illness was highlighted by two doctors as difficult to demonstrate, since its particular quality was the slow change over time. (However one other doctor pointed out that chronic patients were good teaching material since one could 'line them up' that is, one could count on them being available, unlike patients with acute illness.)

In answer to a further, more direct question about the course orientation a majority of the Glasgow department said that they were happy with the clinical emphasis of the teaching. Some responded with sentiments which echoed those of the clinically orientated service practitioners:

> I'm very much a man of the clinical era, I think clinical competence is important. Of course we know the background and the family and have a relationship with patients but so do consultants. They [the students] should know this and it's important, but allied to clinical medicine.
> (G.P. 16)

Another answered even more forcibly:

> The inter-personal side is not teachable and in fact I am most satisfied with the course. We should teach medicine not sociology. We teach cases of medicine which don't go to hospital, and ones which have come out of hospital. The doctor-patient relationship is a load of rubbish, I think, it doesn't exist. Patients get a sympathetic hearing but I think a lot must hate my guts.
> (G.P. 12)

Two doctors said that they were more interested in teaching 'whole person' medicine, although one pointed out that it was more difficult. The Glasgow tutors were also asked whether they thought the inter-personal side of general practice could be taught; most said that it could not be taught, that it was unteachable, that one has to see it - again reflecting very closely the service doctors' views.

Despite the apparent congruence of the part-time staff's views with their respective course orientations, the matter was not felt to be resolved by these few questions. One further piece of evidence from the Glasgow Department of General Practice is relevant to this discussion. The department conducted a small study with tutors and students, asking both groups to rank various aspects of the course between 0 and 5 (Hannay, Barber and Murray, 1976). Both tutors and students ranked the 'clinical content of course' as seventh out of eight, while the students ranked 'social aspects of illness' first, tutors placed that feature fourth. Standard deviations indicate that there was considerable agreement over the assessment by the tutors, while less among the students, particularly over the relative ranking of the clinical content of the course. Two points can be raised from this little study. The first is that the evidence suggests that the Glasgow tutors were not as convinced about the importance of the clinical orientation of the course as was thought to be the case from the author's research. The second point is that in the discussion, Hannay and his colleagues at no time compare the findings to the intended orientation of the course. In fact, this particular finding is not discussed in the paper.

Other evidence from that study supports the researcher's findings.

Disagreement existed between the tutors over the importance of the vocational aspects of the course, and over the importance of seeing patients in the surgery. As one would expect, both tutors and students emphasised the importance of seeing patients in their homes with time for discussion afterwards.

Medicine in the Community

All part-time staff were asked their views on the department's policy of not teaching general practice but 'medicine in the community' or 'medicine in the setting of general practice'. It proved a difficult question for a few. A small number of tutors did not appear to understand the rhetoric, and did not make the distinction between a course on 'general practice' and one on 'medicine in the community' which was made by the full-time staff members (and which was implied in the question). Thus one answer to the question was

> I don't understand this argument of not teaching general practice - the students learn how to deal with people, how to talk to people, how to talk . . .
> (G.P. 07)

The rest of the sample stated more definitely that they agreed with or disagreed with the department's policy. A minority from both departments (totalling seven) thought that their department's policy was correct, that not to teach general practice was 'proper', as one doctor described it. 'Those that need the course most are those who don't go into general practice' G.P. 21 said, a view entirely in keeping with the

official policy of his department.

Others were more ambivalent, appreciating the argument yet not necessarily abiding by it. G.P. 02 was not unusual when he said:

> I've always had difficulty with this part of the department's policy . . . You have to abide with the department to a certain extent but I don't think it does the students harm telling them about general practice.

Answers to a further question fed back into the issue of whether or not the doctor agreed with department policy on teaching medicine in the community.[1] A typical response to a direct question about a vocational element of the teaching was that it was thought appropriate to show general practice off at its best to students, either through one's enthusiasm, for example, or by emphasising that it consisted not only of trivial medicine. Most tutors thought this was right and proper, although some were more conscious than others that it went against department policy. One doctor, for example, was asked whether students should be more encouraged into thinking of general practice as a career; the fieldnotes record 'he sparked into life a bit and said emphatically "yes they should plug it a bit more"'. He continued:

> I was told that the course was not where to do it, it would be done in some sort of careers guidance course. I think the students are quite keen to know about the career prospects and I tell them quite a bit myself, how to run a practice and so on.
>
> (G.P. 04)

A similar point was made by a tutor from the other department:

[1] Several of the Edinburgh staff mentioned that the policy of the department had changed and that some vocational teaching was now permissible.

> The growing assurance of a third-year student does not result only from his greater knowledge and his conviction that what he is doing is important. It results also from the fact that in the third year he is relatively isolated from some of the diagnostic and therapeutic uncertainties he will encounter later.
> (Fox, 1957, p. 101)

Later, however:

> It is usually only in retrospect that he catches a glimpse of the uncertainties he might have encountered . . . For example, reviewing the charts of patients he examined in general surgery as a junior, a fourth-year student was 'amazed to discover' that some of the cases he saw were never resolved.
> (Fox, 1957, p. 102)

Fox sees the increasing responsibility given to the final year student as crucial to his growing realisation of the scope and limitations of medicine. Scottish medical education is paced rather differently. In the absence of any comparative research it is the researcher's impression that the student's 'break-through to uncertainty' may not occur until after graduation, that is, when he has entered the pre-registration year in hospital (this is when students are first given any real degree of responsibility).

From the evidence available, then, it seems that both the pre-clinical and clinical teaching conforms to a certain type of pedagogy. That, on the whole, teaching tends to emphasise the factual, the simple rather than the problematic. A central feature of this kind of pedagogy (what Bernstein calls 'collection code' pedagogy [as opposed to 'integrated code'] Bernstein, 1971), is that knowledge is organised into a hierarchy. Facts are taught before principles, and only later in the socialisation are students introduced to 'the mystery of the discipline' which is 'incoherence not coherence' (Bernstein, 1971, p. 57).

> Dr X's ideas about teaching certain subjects which should be tackled were good, and stimulating, and have helped G.P.s focus on things, but I find the students too many and it should be an apprenticeship, although there's a logistic problem, I know. I have a running argument with Dr X about this.
> (G.P. 15)

The majority thought that there should be some vocational element to the teaching (more did in Edinburgh than Glasgow); most of these doctors, as already hinted, thought it would be difficult to teach without vocational undertones.

> I had mixed feelings when this was mooted, but I decided that . . . [head of department] was right all along. Inevitably the enthusiasm and interest will wash off on the student, it's bound to, but with the attachment then one teaches attitudes, ways of speaking to patients, how to be intentionally rude . . . The vocational aspects are implied all the way down the line . . .
> (G.P. 11)

Some felt that the vocational aspects were of prime importance; 'It was something that always concerned me, that most students go into general practice and yet none is taught. It was something I was glad to do' (G.P. 07). As telling, however, were the doctors who felt that they were expected just to teach 'experience'. 'I don't see it as teaching, I just go down to the department and be myself' (G.P. 08).

In relation to the policy of not teaching general practice, the Edinburgh tutors were asked if they were given a briefing before starting to teach in the department. Eight out of the ten reported that they had little or no briefing prior to teaching, other than a description of what the course was about. Some mentioned being given papers about the course (it seems likely that all were), and some tutors also attended a particular set of teaching meetings held in 1970-71 when

the teaching programme was being re-thought. So generally, tutors were not given much opportunity to become socialised into the 'official' perspective of the department, but left to work out for themselves and between themselves the implications of teaching 'medicine in the community'. Given this, it is not surprising that a number of part-time staff expressed a viewpoint which was contrary to that of the department.[1]

The Paradox of the Part-Time Teacher

Teaching in these two departments of general practice was carried out largely by the part-time staff. It was they who portrayed general practice to the students, and they who acted, as one doctor put it, as the window of the practical work of the department. Thus their view of the course and the teaching was important, for it was they who translated the written objectives into practice. And yet it was felt that their influence on the outcome of the teaching tended to be treated lightly. Although the full-time staff became socialised into the particular rhetoric of academic general practice (and even among

[1] It would be unfair not to report that full-time staff (particularly the heads of department) did try and keep channels of communication open with part-time staff by meeting groups of them. The part-time staff reported that they found teaching time consuming and although some were invited to attend other department meetings, felt they had no time.

full-time staff there were variations of interpretation of the official policy), the part-time staff of one department reported little prior, or anticipatory socialisation to the particular perspectives of academic general practice, and a minority in both departments seemed unclear about their department's teaching policies. In some ways, the part-time staff resembled the service general practitioners interviewed, both in their statements about general practice, and in their beliefs about the teaching of the subject. They can be seen as middlemen, standing between the service doctors and the academics, for some of them had also developed an understanding of the demands of the academic department, and its particular requirements in terms of what it was expected to teach.[1] Overall their difficulty, if one can define their position in problematic terms, was that they were caught in one of the paradoxes of academic general practice. The departments had adopted a particular rhetoric concerning their courses. They argued that they were not teaching 'general practice' but 'medicine in the community'. At the same time, they required additional help with the actual teaching, and employed general practitioners, selected as being in some professional sense 'good' doctors. Yet these doctors were not being employed to teach general practice, that is, to teach 'experience', to show students what practice was like, which is typically the role of the part-time tutor (Sheps, 1965). Instead, they were expected to teach 'medicine in the community' which, it has been suggested, was a form of teaching which was intended to distance the doctors and students

[1] They were, however, not marginal! Their commitment was clearly to the service group of general practitioners and their relatively minor commitment to teach did not appear as identity threatening.

from a wholly vocational exercise.

The extent to which the non-vocational policy could be pursued varied, since the two courses clearly differed in what they required of the doctors. The Edinburgh part-time staff liked the surgery teaching. It involved them in little prior preparation, for the chances of a former patient attending were high, and two of the three topics could be easily covered. Slightly more difficult was 'primary diagnosis', since this required a new complaint. Beyond relating the theme of the week to the relevant patients, the tutors were not required to illustrate the topic in any other way at the surgery.

It was obviously difficult to enforce a policy of completely non-vocational teaching in the Edinburgh course, for an on-going surgery is a demonstration of a general practitioner in action. Even if the intentions of the tutors were to focus upon the themes alone, the situation allowed the students to read the 'hidden curriculum' (Snyder, 1971). Liam Hudson, a psychologist, describing his own university education, spells out the process:

> My suspicion, though, is that every generation of students is susceptible to its teachers' presuppositions, and that these presuppositions are potent to the extent that they are unspoken. It is assumptions, prejudices and implicit metaphors that are the true burden of what passes between teacher and taught. Facts, skills, details are in comparison ephemeral, in the sciences especially, but in the arts as well. They are also identifiable - and rejectable. What the teacher spells out, the pupil can question. What he assumes, especially from a position of unchallenged legitimacy, his pupils will tend to swallow whole and unawares.
>
> (Hudson, 1972, p. 43)

Because it was a surgery, the staff were dealing in 'hot' medicine (Atkinson, 1977). That is, as opposed to 'cold' medicine where the

patients have been previously vetted and diagnosed (at least differentially) by the doctor concerned with the teaching, the Edinburgh doctors had no control over the patients who attended their surgery. They were obliged, therefore, to act as general practitioner to the patient, and to handle each consultation as routine, only later switching to the role of teacher. The student had the difficult task of abstracting the surgery 'teaching' out of the everyday reality of general practice work. As a strategy for teaching 'medicine in the community, it was, by this argument, less easy than in Glasgow.

There were further difficulties with this kind of teaching raised by members of the department, but which were also brought to the author's attention by a further piece of fieldwork. Students were interviewed after a teaching surgery in Edinburgh. They reported that after some of the consultations they had no idea what was going on. What appeared to happen was that much of the doctor-patient interaction remained at the level of the unspoken, especially in instances where the doctor had prior knowledge of the patient upon which he acted at the consultation. Yet, the department writes in one course programme, 'When, as frequently occurs, patient and doctor have had many consultations over a number of years, the significance of past events . . . is often naturally and spontaneously demonstrated both by patient and doctor to the student concerned'.

The problems with surgery teaching are no doubt similar to those faced to a greater degree with the attachments. In order to make the consultations understandable to the student, the doctor has to articulate, if he can, the private knowledge he holds about the patient. It can be easily imagined that this time-consuming and difficult task is not always carried out, and that students sometimes remain 'outsiders' to

the interaction.

In Edinburgh, however, the full-time staff were able to exercise more control over part of the teaching, and therefore have more influence over the 'definition of the situation' - in the seminars, at least. One can imagine that part of the reported inter-staff disputes in the seminars focussed around the particular emphasis or interpretations the various staff wished to accord students accounts of patient's problems, and hence the respective definition of general practice.

In Glasgow it has been indicated that the department's teaching policies were sometimes modified by the practitioners to suit their own views about teaching general practice. On the whole, the teaching presented more practical difficulties. Patients had to be selected in advance, and doctors were required to demonstrate in a more tangible way patients' conditions (both physical and otherwise). Some conditions, it was pointed out, were less amenable to such demonstration, and so the range of conditions and patients which the tutors used was reportedly fairly limited at times.

Glasgow teaching was less directly amenable to a vocational interpretation. The general practitioner was removed from his everyday work reality. He was not sitting in his surgery, and the approximation to 'doing his rounds' with the home visits was only slight. Furthermore, the department adopted an approach which relied on 'cold' medicine; this meant that the doctor had already diagnosed the patient and need be less concerned with the patient's diagnosis when he introduced them to students. For these reasons, it can be argued that it was easier than in Edinburgh to avoid teaching 'general practice', and to focus the student's attention on selected aspects of general practice work.

Unlike Edinburgh, too, the actual teaching was more of an unknown quantity to the department. The full-time staff could, given the 'case-method', exercise little control over the teaching situation, and in this sense alone, did the Glasgow teaching resemble the attachment style.[1] One can conclude that in both cities, the dependence by the departments on part-time staff was so great that the price to pay may have been that of complete control over the teaching. The weakened control by the full-time staff was paralleled by a potential dilution of teaching aims as they were transformed into teaching practice by the part-time staff. This is one of the most vulnerable features of the courses as they were organised.

The final point of the chapter concerns the relationship of practical experience to university knowledge. The point has been often made that professional training is at variance with the skills required for practice (see, for example, Becker, 1972, for a summary of the literature on this point, also next chapter). By implication, then, the role of the practitioner will find less and less place in the university, as Mayhew argues:

> It is a paradox that the more professional education buries itself in science, principle, theory and research, and the greater the prestige of the particular school, the more difficult it is to maintain the role, and usefulness of the practitioner in teaching students.
>
> (Mayhew, 1971, p. 27)

If academic general practice wishes to take on the characteristics of

[1] The Glasgow head of department reported meeting with part-time staff each year, but direct influence over the topics can be minimal.

high status knowledge, that is, to become increasingly theoretical, abstract and 'at variance with the real world of practice' (Young, 1971b), then the role and training of the part-time staff will have to be viewed more seriously by academic departments. At present, until these part-time tutors can be persuaded wholly by the rhetoric of academic general practitioners, and changes take place in the structure of the courses, then the teaching will not necessarily conform to the official orientations outlined by the various general practice departments.

This chapter has offered the views of the part-time general practice tutors about the courses. It has suggested that in a number of ways, the tutors' perceptions of the courses and of their role in the teaching differed from the previous perspectives presented. Although the chapter was concerned only with their views, and not their practice, the implication was that the teaching did not always conform to the official policy. The final empirical chapter of the thesis introduces the Edinburgh data. This offers the last perspective on the teaching of general practice to be considered - that of the students. It also presents data on general practice teaching.

Chapter Nine

THE EDINBURGH DATA

ASPECTS OF ONE TEACHING SITUATION

Introduction

In this final empirically-based chapter will be presented some aspects of the data gathered during an early period of the research in Edinburgh.[1] The chapter will be divided into two parts which both, while remaining distinct, relate to the themes of the thesis. The first part of the chapter reviews the teaching of selected aspects of general practice teaching, relying upon material gathered from participant observation and also student interviews.[2] The chapter will begin by reporting on the teaching of the 'social' perspective. This allows us to follow from its articulation at grass roots level one particular ideological construction of general practice, through to its appearance on the course syllabus, and its presentation to the students. Students' comments on the teaching methods used by the department will be amplified in this first part of the chapter.

The second part draws upon the description of the teaching of the

[1] As well as interviewing full-time and part-time staff in the department, the researcher attended the seminar group of one member of staff for two consecutive spring terms, and 'visited' other seminar groups. During the first period of observation, she also interviewed the twelve students of the seminar group, and attended one post-surgery discussion of each student and teacher. Student interviews were tape-recorded.

[2] The data on which the analysis is based is special, since similar material was not gathered from any of the three remaining departments. While observation yielded rich and varied data, the student interviews were restricted to questions about the course; students were not asked about broader issues - for example, how they conceived general practice.

subject, and compares it to the dominant mode of teaching of the undergraduate curriculum. Using Bernstein's concepts of codes of curricula, some contrasts will be drawn between the two types of pedagogy. The chapter will end by drawing the reader back into a consideration of some more general features of general practice teaching.

Teaching the 'Social' Approach

In a previous chapter it was argued that each of the four general practice courses studied took a particular perspective of general practice; two courses were oriented around a 'clinical' perspective and two around a 'social' perspective. When the academics' views of their courses were considered, it was suggested that the distinct perspectives were not as sharp in every department as anticipated. Nevertheless, two departments took a consistent line.

Edinburgh, one of these departments, took a 'social' approach. That is to say, the course syllabus and the staff views were both consistent in that they were offering a perspective of general practice which would emphasise the social aspects of general practice work. The fieldwork carried out in the Edinburgh department offers a glimpse of how this approach was transmitted to students. Although the discussion is brief, it illustrates both the particular interpretation the department placed upon the term 'social', and also

the manner in which staff selected from the discussion those aspects of cases they wished to emphasise.

Typically, a seminar would be initiated by a tutor asking a student to describe a patient he or she had witnessed at the surgery during the previous week. After the student's presentation, discussion would revolve around the patient's problem for a few minutes, after which one of the doctors would either present a further example himself or ask another student to do so. The discussions seldom came to any conclusion; they were characterised by numerous questions which were put to the group by both students and doctors, only a few of which would receive an answer. The extended example from the fieldnotes which follows will give the reader a feel of the discussion:

(Dr F is full-time in the department, Drs G and H are part-time)

Dr F — We're going to look at a different aspect of general practice, the continuity of care, which the other doctors will know more about than myself. This is when you start with being a paediatrician when the child is young, go through to being a geriatrician when the person is old. It's care over a long period of time, and you may need the help of other people . . . we're starting by looking at your own patients.

Dr G — Richard's seen his patient.

Student 1 — She's just died, I only saw her twice.

Dr G — She was 63, a widow - well, you tell it.

Student 1 — She had leukemia, she felt tired and went to the doctor, became bed-ridden, and wanted to regain her strength. The illness brought a lot of responsibility on to the daughter.

Dr G — She had agreed to go into hospital because Dr X said that he had something up his sleeve, this triggered off her agreeing to go to hospital.

Student 2 — Did she know she was going to die?

Dr G — No.

Student 3 — Are we going to discuss this, it's an area I'm interested in?

Student 4 — Would it depend on the patient?

Student 5 — In the . . . [hospital] it's one of the consultant's policies to never tell the patient, only the near relatives. It's the medical profession's responsibility. The G.P.s should tell them, they always say. Is this passing the buck?

Dr F — What reasons do they give?

Student 1 — It's best because he knows the family.

Dr F — He knows them and they know him, this leads to a relationship.

Student 6 — A relationship over time.

Student 5 — The patient may like to hear it from a senior man. The patients aren't told concrete facts, you're just left to deal with it.

Student 7 — We're arguing very theoretically, could we have some examples from your experience?

Dr F — If you want my problems, I've got one at the moment . . . [change of case history].

(Fieldnotes, 9/2/73)

The particular orientation of the department was highlighted in the seminars on the doctor-patient relationship. Although some service doctors felt that this could not be taught, the department devoted two seminars to discussion of this topic. Indeed, from the first contact with the department, students were encouraged to think in terms of 'personal relationships'. The student-teacher relationship was written into the course aims: 'It is a feature of our programme that the individual student is for a substantial part of his time, in a one-to-one relationship with a general practitioner tutor'. The relationship between doctor and patient was identified by the use of terms such as trust, dependence, and reassurance. Support for the patient, for example, was not envisaged as financial or material help, but in emotional terms. The doctors did not see these emotional aspects of the relationship as outwith their control; indeed, they felt they had the ability to manipulate this link with the patient as much as they did his 'trust'. In a debate about the extent to which a patient should become dependent upon the doctor, the tutor outlined the parameters of the dependence to the students:

Dr F	The amount of dependence varies from time to time.
Student 1	Some may always need it, others not, so you ration it?
Student 2	You can refer [patient] to a psychiatrist?
Dr F	You must share the load, not pass it. Miss X is very dependent, her personality is disturbed and I've allowed her to become very dependent and have shared this with the social worker. I've not passed the buck.

(Fieldnotes, 28/2/73)

If the patient was seen to be over-dependent, the doctors put forward a variety of strategies with which they might attempt to change the

balance of the relationship. During one lunch-time discussion prior to the seminar, a doctor described the following strategy:

> A doctor has to be father/husband/friend and so on to the patients who come along, and this can be very wearing, you can only take so much. What I do is refer the patient to a specialist, who might only see her for two weeks, but the break is just enough so that when she returns to me I can take up support again.
>
> (26/1/73)

Reassurance of the patient often seemed to be fulfilled by the doctor's presence or apparent interest in the patient. A typical example was a case (brought up by a student) of a lady with asthma, whose symptoms left when she knew the doctor was coming. 'What treatment did she get?' asked Dr A. 'She got no treatment', replied the student. 'No <u>other</u> treatment' said Dr B. 'She got the doctor' (26/1/73). (Balint called this the 'drug "doctor"', Balint, 1971.) A case which nicely illustrates some of the above features concerned an overweight female patient who presented with the problem of insomnia. The doctor in charge of the case decided that it was 'a typical case of a physical illness being used to bring up another'. The patient's weight was discussed, and then a student stated:

Student	I don't know why she came.
Student 2	Was she happy?
Student 1	Yes she had a good laugh.
Dr H	As soon as we started taking an interest in her, the symptoms went away, except she needed to stop taking her tablets.
Student 1	Where did she get them from?
Dr H	It was a repeat prescription.
Dr G	Would it be best talking to her?
Dr H	Yes . . . but half an hour of her was enough.
Dr G	It's the price you pay - pills or the doctor.

(Fieldnotes, 2/2/73)

Here, the doctor's apparent interest in the patient is an acceptable reason for the patient's return to health. Dr H spells out the 'cure' - half an hour with the doctor.[1]

In a previous chapter, it was suggested that the term 'social' could be interpreted in a number of ways. Even from this brief account of one seminar group, it becomes clear that the term social had a distinctive meaning. It did not, for example, concern public health measures or social policy. Instead, the seminar discussion reflects a strong Balint orientation. This was identified by the rhetoric and concepts used by the staff, terms which were therapeutic in origin, and typically associated with the writings of Michael Balint and his colleagues. Just as Dingwall argued in his study of health visitor training, that the teaching was intimately bound up with the delineation of boundaries between health visiting and other occupations (social work and nursing, for instance, Dingwall, 1977a), so too were these seminars involved in creating for students a particular perception of general practice through an insistence upon the importance of the family relationships whilst playing down the clinical features of the consultations.

Students sometimes commented that the surgeries were boring, that it was all 'flus and sore throats' (S 6) or 'they were mostly sore throats' (S 3). Nevertheless, in the seminars the routine and the minor complaints were omitted from the discussions - and students never commented upon them, and seldom introduced a more 'clinical' interpretation. It seemed that students recognised the message of the

[1] Elaborated in an unpublished paper by the researcher entitled: 'Talking about Relationships'.

department. Through these comments, one can begin to understand the influence of the academic general practitioners. Despite their small numbers they (and the part-time teachers) interpret for the students their experiences of the surgery. Their interpretation is as powerful as it is selective. Some students did not appear to realise that what was being presented to them as 'general practice' was in fact only one way with which to view the consultations. One could argue that in the sense that some students thought that a social orientation <u>was</u> general practice, the course was successful.

> General practice is interesting because even when they come in with a broken arm and nothing else you must manage them in terms of the social and family circumstances which I find interesting.
>
> (S 2)

> I know some people don't like general practice, but it tends to a great extent to depend on the G.P. you are attached to; I thought it was all snivelling kids and low backache, but it turned out to be different.
>
> Why?
>
> A lot of them turned out to be care problems, not just medically caring but for the whole patient. I'm surprised at the number of people who present with a psychiatric problem whether independently or connected to their medical pathology. So much more scope for dealing with patients as people than I actually imagined.
>
> (S 1)

Yet in their comments about the courses, others made a distinction between general practice as it was talked about in the classes, and their own views about what constituted general practice. That is, they did seem to recognise the selectivity of the courses. General practice was not necessarily primarily concerned with relationships; rather they felt that it was this aspect of the work

upon which the teachers had chosen to concentrate.

> I think his attitude of my being there [at the surgery] is not to learn medicine, to learn you will give an antibiotic in a certain case, but more to observe what's happening between him and the patient, and how he treats each patient, how he manages each patient, his attitude towards each patient.
>
> (S 10)

> The course has helped in a psychological and social way but not in a physical, we see people in a more normal environment. There's more emphasis on how the doctor relates to the patient than on diagnosis of disease.
>
> (S 8)

These comments must remain at the level of speculation since the student numbers were so small and were not necessarily representative of the larger student body. Nevertheless, the fieldwork has begun to illustrate the process by which a particular perspective is transmitted to students. The process involves selection of particular features of the overall experience of the consultation. At the surgeries staff members may have already focussed the students' attention on to aspects of the patient's biography. The seminar served as a reinforcement of this, by repeatedly asking students certain questions about the patients, by ignoring student demands to explore other interpretations of the event. A more detailed analysis of the seminars would no doubt lead to a refining of these above statements.

Students' comments on the two main methods of teaching used in the department (surgery attendance and seminars) are worth considering, since they illustrate the students' beliefs held about types of medical knowledge. Like other 'uninitiated' - for instance, the service general practitioners - most felt that learning was intimately bound

up with on-site experience. The seminars, for this reason, were therefore not seen as vocationally useful (and neither were they seen as a medium for the presentation of facts, another student preoccupation.)[1] Referring to the seminars, two students elaborated upon these deficiences.

> You can't take a case and bring it into that sort of group and detach yourself from the people involved and talk about it, you just can't do that. You can make a general outline which is not very helpful at all, and talk in broad outlines but you can't get much further than that.
>
> (S 6)

> What do you think of the seminars?
>
> It's a pleasant afternoon; it's not very profitable, I like the interesting cases others have seen, but the concepts they discuss I can't get to grips with, I haven't a clue what they're getting at, getting things into boxes when they shouldn't. They should make it practical . . .
>
> (S 8)

[1] Becker and his colleagues have argued persuasively that the students' first concern in higher education is with making out (Becker et al, 1961, Becker et al, 1968). That is to say, that the students' priority is with the educational process rather than with a commitment to their future in the profession. Making out in particular concerned seeking out material which would help the students over the examination hurdles.

The general practice course at Edinburgh extracted from the students a variety of emotions, ranging from fascination to boredom. Overall, their attitude could be summed up as one of ambivalence. From the interviews, it appeared that subjects were judged according to the criterion of usefulness. But usefulness came in several guises. 'Making out' Scottish-style, varied in one respect with that reported of the American medical students. Like their American counterparts, these students searched for relevant material (usually factual) which could help them tackle the examinations; unlike the American students, however, if their search for factual material was unsuccessful, compensation could be found in the shape of gaining vocational experience (cf. Sheldrake and Berry, 1976). The students' ambivalence to the general practice course, then, centred upon their uncertainty as to whether the course fulfilled either of these criteria of usefulness.

One of the goals of the seminars reported by staff was the exchange of views and opinions about general practice. A number of students recognised this as a departmental objective but dismissed it as particularly worthwhile from their point of view. The students, on the whole, did not recognise the value of what they felt was abstract, that is, non-factual, material. To them it was 'just people talking'. The acceptance of the notion that one can learn through discussion is perhaps the single most important break from traditional beliefs about professional learning. This move away from the understanding that learning has to be based in the work situation characterises the perspective of the academics, but was recognised by only a minority of students. One, whose views were reminiscent of the service general practitioners in that he believed that teaching was concerned with the transference of factual material, was the atypical student in that he did perceive the value of discussion. His response to the questions about the seminars is worth quoting at length:

> I enjoy them. I enjoy talking and seeing the interaction of the members of staff and their viewpoints, and the students too. They have a marginal teaching quality as there is very little you can teach about general practice, but there is a lot to discuss which is why I find them interesting.
>
> What is the difference between teaching and discussion?
>
> Teaching is teaching factual information and there is little of this in general practice. It's a question of attitudes and attitudes modified by experience which is why it's interesting to listen to the G.P.s who've had experience, but it's equally valid to listen to the students who don't have the experience but do have the ideas. Therefore it's interesting because there's little factual stuff; some stuff like what sort of facilities are available so they know when they're a doctor they exist, but this sort of thing is minimal in general practice, which can be seen by the exam which can be answered as a matter of opinion.
>
> (S 1)

The majority of the students felt that the surgeries were a more worthwhile part of the course, precisely because they understood vocational learning to be based at the work place. Thus although surgeries did not provide useful factual material, nevertheless, they did offer some insight into the work of the general practitioner.

> Well, we are told that G.P.s are more personal in their approach, you just can't imagine that by being told, you've got to sit there and see him talk to his patients, talking about their families and problems and everything.
>
> (S 6)

Previous chapters have documented the debate over the vocational orientation of the general practice courses. The Edinburgh course was arguably less vocationally oriented in its official aims than some. However, in the previous chapter it was noted that not only were some of the part-time teachers willing to treat the course as a kind of career preparation, but also that the non-vocational policy was in fact difficult to implement when part of the teaching was carried out in the surgery. Students' comments on the value (or usefulness) of the surgery teaching indicated that they, too, regarded the surgery sessions as offering an insight into a possible career.

> What do you think of the surgery teaching?
>
> You're not learning very much; it's not very exciting but you are gaining some insight as to what it's like in a general practice, the sort of people and problems you come up with.
>
> (S 9)

> With Dr X, I've a good idea of how one G.P. does his job. I don't think I've had any major surprises about general practice, but I think it's all becoming clearer to me, going to his practice and watching him work.
>
> (S 5)

As a teaching method, surgeries were not universally applauded, and students outlined some of the limitations as they experienced them. One has already been anticipated when it was suggested that the students might find interaction difficult to follow if it was based upon private shared knowledge between the general practitioner and the patient. Several students commented that they did experience problems in understanding some of the consultations:

> There were times when he's made a diagnosis which I wouldn't have made from what had been brought up at the clinical examination, sometimes I was quite surprised he just made a diagnosis, just like that, when I thought there wasn't enough information . . . it must just be experience.
>
> Did you ever question him on it?
>
> No, I just put it down to experience.
>
> (S 10)

The student's last comment, that he did <u>not</u> question the doctor, but merely made assumptions, is revealing, for it highlights one of the weaknesses of this form of teaching. The surgery teaching appeared to rely upon <u>student</u> initiated rather than <u>doctor</u> initiated discussion. When students were asked about the surgery teaching about half the class made the point that unless <u>they</u> asked the doctor about a particular consultation then little information might be offered by the doctor.

> There's no after surgery discussion; it's 5 [p.m.] to 7, and I push off at 7. He gives a history if it's appropriate before hand; during and after it's up to me to ask about treatment.
>
> (S 9)

> I think it would be useless to just go and sit there and watch what's going on and not ask anything and then come away again.
>
> (S 2)

One can readily understand why this should be so, since the doctor might find it difficult to articulate aspects of his accumulated wisdom about the patient, and more generally, his 'rules of thumb' for dealing with particular situations. Nevertheless, such a method requires that the student plays a more active role in the teaching process than is usually required at an undergraduate level. An uninquiring student for whatever reason (shyness, non-interest), would gain far less from observing a surgery than would the student who was prepared to question the doctor.

It is interesting to note that even in Edinburgh, where the tradition of teaching general practice groups through seminars is longer than most, that students still regarded such a method as illegitimate. Such a finding reaffirms the statement that to understand learning as an activity which can be carried on outside the workplace is itself a learned perspective, and one critical to the process of the development of an academic branch of a practical profession.

Types of Curricula

Earlier in the thesis it was mentioned that the general practice courses appeared deviant in the medical curriculum. They avoided the use of lectures, and unlike most specialties of the clinical year, the subject did not form any part of the professional examinations. Referring to the material presented above, the second part of the chapter initially examines the deviant status of general practice teaching at Edinburgh. It returns to issues related to courses which have been mentioned earlier, in particular, the examination and the lack of theoretical base of the subject, and suggests that these affect the presentation of the subject, creating a different form of pedagogy from that more typical of the undergraduate curriculum. Thereafter the chapter concludes with some more general statements about the development of academic general practice.

In order to compare the pedagogy of the Edinburgh general practice department with the broader curriculum, there follows an outline of the more usual mode of teaching clinical subjects.

Teaching in the pre-clinical years is largely confined to the use of didactic methods of teaching. The teaching is based upon codified knowledge; the form of the examination, dominated by the M.C.Q. where one answer only fits the question, supports the hypothesis that, at this level, teaching is dogmatic. In the clinical years, bedside teaching is introduced to complement the continuing lectures. Students are divided into small groups, and accompany the clinician on his ward rounds. During this time, they have the opportunity to observe clinicians at work, exercising what is claimed to be professional 'vision' (Foucault, 1973), the uncodified skills of clinical judgement.

Yet despite the role of bedside teaching in the transmission of such indeterminate skills, the one detailed study of clinical teaching, based on fieldwork carried out in the Edinburgh medical school (Atkinson, forthcoming)[1] suggests that the consultants conduct the teaching in a highly structured manner, in which similarities with basic science teaching can be readily identified. Atkinson's discussion of clinical teaching in medicine and surgery emphasises the formality of the teaching. As he described it, discussion revolved around the diagnosis of the complaint, and possible tests and routine investigations which might confirm the diagnosis. Once a decision had been arrived at the group moved on to another case and that particular one was not referred to again. Atkinson points up the problem solving aspects of this teaching method. Students were expected to work through a series of hypotheses in search of the 'correct' solution. No real discovery took place since each case had been previously considered by an experienced clinician. Thus the students were witnessing 'cold' medicine (Atkinson, forthcoming).

Rather than students being shown a variety of cases of one condition, they were introduced to as wide a range of conditions as the hospital population would allow, the assumption being that one case of pernicious anaemia is like another, one appendicitis like the next. In this manner the students were introduced to a cut and dried version of medical practice, one which implied that a definite diagnosis could be reached through the correct technical procedures, that each case was 'one-off', and that each case had a solution. Atkinson refers to

[1] Atkinson studied the bedside teaching in two major specialties, medicine and surgery, and interviewed students taking these subjects about their perceptions of bedside teaching.

this form of socialisation as 'training for dogmatism', a phrase which underlines the fact that each consultant presents his point of view as the only, and correct one.

No other ethnographic studies exist of British clinical teaching. However, support for the more widespread use of this kind of pedagogy comes from two sources. The first, evidence from Flexner, suggests that this style of teaching may have changed little since he studied medical schools over fifty years ago. Discussing the British teaching he wrote:

> 'Listening to a succession of bedside expositions,'
> he wrote, 'not infrequently quite chatty in substance
> and tone, one is struck by the positive note . . .
> rarely is the unknown, the problematic, the profounder
> question, the historic background, attended to.'
> (Flexner, 1910, quoted in Ellis, 1956, p. 813)

Further support comes from America where, although the timing of medical training is different (students take medicine as a second degree), indications are that the structure and the style of pedagogy have similarities with Scottish teaching. In a classic paper on the socialisation into medicine 'Training for Uncertainty' (Fox, 1957), the author studied the changes in the student's perception of medicine as he travels through the first four years of 'undergraduate' training. Fox argues that only in the final years does the student come to grasp the complexities of the discipline, and only then does he appreciate how the apparently simple can in fact be seen as problematic. She calls this new perception a 'breakthrough to uncertainty'. Her description of the student's experience bears close relation to Atkinson's account. Referring to a third year student who has yet to be 'initiated', she writes:

> The growing assurance of a third-year student does not result only from his greater knowledge and his conviction that what he is doing is important. It results also from the fact that in the third year he is relatively isolated from some of the diagnostic and therapeutic uncertainties he will encounter later.
>
> (Fox, 1957, p. 101)

Later, however,

> It is usually only in retrospect that he catches a glimpse of the uncertainties he might have encountered... For example, reviewing the charts of patients he examined in general surgery as a junior, a fourth-year student was 'amazed to discover' that some of the cases he saw were never resolved.
> (Fox, 1957, p. 102).

Fox sees the increasing responsibility given to the final year student as crucial to his growing realisation of the scope and limitations of medicine. Scottish medical education is paced rather differently. In the absence of any comparative research it is the researcher's impression that the student's 'breakthrough to uncertainty' may not occur until after graduation, that is, when he has entered the pre-registration year in hospital, (this is when students are first given any real degree of responsibility.)

From the evidence available, then, it seems that both the pre-clinical and clinical teaching conforms to a certain type of pedagogy. That, on the whole, teaching tends to emphasise the factual, the simple rather than the problematic. A central feature of this kind of pedagogy (what Bernstein calls 'collection code' pedagogy (as opposed to 'integrated code') (Bernstein, 1971) is that knowledge is organised into a hierarchy. Facts are taught before principles, and only later in the socialisation are students introduced to 'the mystery of the discipline' which is 'incoherence not conherence' (Bernstein).

Having formed a clear idea of the dominant pedagogy of the medical school, it is instructive to contrast with it the teaching of the general practice course in Edinburgh. In many respects it is very different to the kind of presentation associated with the rest of the undergraduate curriculum. Diagnosis is discussed very often without reference to clinical tests of any kind, while doctors suggest a wide range of factors to be considered when dealing with each patient. Further, the uniqueness of the patient's career is emphasised, and the discussion revolves around not the case but the patient. The concept of 'one solution' to each case does not emerge. Instead, a variety of interpretations serves to underline the general approach to be taken when dealing with any problem. Textbooks are not central to the teaching, and indeed it has been argued that the course is deliberately constructed in such a manner as to avoid dogmatic teaching.

General practice teaching, then, resembles the polar extreme of collection code pedagogy, what Bernstein calls 'integrated code' pedagogy (Bernstein, 1971).[1] A crucial difference between these two styles of pedagogy is the socialisation process of the students into the discipline. Whilst in the former 'collection code' pedagogy socialisation was gradual, and based upon an hierarchical control of knowledge, the latter is typified by the early initiation of students

[1] This interpretation of Bernstein's ideas directly contradicts Armstrong (1977); he suggests (wrongly it is felt) that the entire curriculum of the clinical years conforms to integrated code curriculum. Bernstein argues that integrated code curricula require overarching and unifying principles, with no competitive resources or strong subject identity existing between the disciplines. The would appear to rule out the clinical years with their strong specialty rivalry for resources, students and teaching time.

into the 'deep structure' of the discipline. By this is meant that students are taught the basic principles for creating knowledge. Thus during the course (or throughout that kind of curriculum) there is less emphasis on factual states of knowledge and more on how knowledge is created, 'ways of knowing'. When the general practitioners argued that the social factors were important, or that (as one doctor summed up a particular case) 'whatever it is we're dealing with it's a family situation, this is very important, the relationship with the family will depend on how you as a G.P. deal with the situation', they were essentially offering the students general principles of practice from which the students were then left to work out the specific applications.

This kind of approach has implications throughout the whole educational process. In integrated code pedagogy, authority relationships between teacher and taught are less rigid, while the boundary between what counts as valid knowledge and not, is blurred - that is, the frame is weak. Typical of integrated code is group teaching or self-regulated teaching, rather than didactic methods being used. In this way the student, having been presented with the general principles is left with the burden of sorting the information and creating his or her own hierarchy of relevance.

In the light of this interpretation, general practice teaching can be understood as being of a very different nature to traditional medical teaching.[1] Following from it, the students' difficulties in coping with the subject can be more readily understood. By the time they have

[1] It would be wrong to suggest that general practice is the only subject in the medical curriculum as more fitting integrated code approach; other subjects might be behavioural sciences, or community medicine.

reached the clinical years, medical students have learned the hidden curriculum of university life, the methods for selecting relevant knowledge in any discipline, the criteria of relevance and the rules for managing examinations (see Miller and Parlett, 1973, for a detailed study of students' search for 'cues'). Their search for examinable knowledge, often in the form of 'scientific facts' (as opposed to 'everyday facts' [Sheldrake and Berry, 1976]) is confounded in the general practice course where they are not taught the 'what' but the 'how'. As they responded at the end of a seminar in answer to the question 'Tell us what you want to know about', 'The facts, less waffle'.[1]

The Examination

The plight of the student is taken up by Ravetz (1973) when he discusses the teaching of an 'immature' discipline, a discussion which leads us back into a consideration of the nature of general practice knowledge. 'Immaturity', as characterised by philosophers of science, is seen as the absence of 'facts', or textbook knowledge (Ravetz, 1973;

[1] The students were not always as blatant as this, quite often confining their dissatisfaction to mutterings rather than outspoken statements. From fieldnotes, a further example: 'Walking back with the students from the seminar, I asked them if the seminar just attended was typical. The students agreed. One said they were not factual enough. 'I know they said that they weren't going to teach us factual stuff but it's that sort of thing I'd like to learn, for example, what are the ancillary services. I didn't know what the Marie Curie home was until today'. The example also illustrates the point made earlier (and a criticism of the Chicago approach) that students do not simply learn to pass examinations, but have some interest in subjects in themselves, perhaps if they are thinking of pursuing a career in that specialty, for example. (Fieldnotes, 29/2/72).

Kuhn, 1974). According to Ravetz, disciplines which by this definition evidence the greatest immaturity, 'are those which attempt to study human behaviour in the style of the mathematical-experimental natural sciences' (Ravetz, 1973, p. 366). Immature fields have difficulty with research since they adopt a model of research which is unrealistic to the state of knowledge of their own discipline. Teaching, too, presents problems. Because the discipline has not yet reached the dogmatic stage, teaching (according to Ravetz) is less predictable, ranging over a number of issues from methodology to abstraction. Since students are trained to expect doctrinal teaching they find the transition to this new set of skills and attitudes 'unsettling both intellectually and emotionally' (Ravetz, 1973, p. 381).

There is much in what Ravetz writes which can be immediately applied to general practice, and the state of its knowledge. The classification of general practice as an immature science is further secured by Ravetz' discussion about another problematic area, the form of the examination. The solution he suggests that disciplines usually take, imitation of mature disciplines, is in fact the solution adopted by general practice. Within the medical school, high status is given to examinations which form part of the professional examinations. Although unusual (in that most general practice courses were not examinable), in Edinburgh the general practice department ran a class examination, and required some form of written paper to be completed. For the students, examinations at this stage typically took the form of written papers (short notes, essays), combined with practical examinations and orals. In general practice, the department set an essay question in the form of a 'problematic situation', to which the student had to respond. Ambivalence over the procedure, however, was

evidenced at the beginning of the eighth seminar of term, when the full-time lecturer introduced the matter by saying 'We are obliged to give you an exam but that's the only reason why' (Fieldnotes, 24/2/72).

The researcher was allowed by the department to look through the examination papers, which were divided into three groups - the top five papers, the bottom five and the remainder. Afterwards, a full-time lecturer was asked about the marking of the papers, for it was difficult to see what criteria were being used to judge the answers, apart from length of answer! G.P. 26 explained the situation:

> It depends upon how many conclusions he [the student] makes and how many he jumps to. We assess competence and non-competence, and also the ones with the top marks get class prizes, but in fact we shouldn't do both as we are doing or looking for two different things. We shouldn't have the exam at all, we should have feed-back to the student: the exam is asking them how they would act in a given situation and there should be an opportunity to go over what they've said, give them a chance to defend themselves. It's not factual information we're after, you can't write it, or have set answers. It's not only factual it's how they write it.
> (G.P. 26)

Clearly the examination presented members of staff with difficulties. It was seen to be important to have an examination. However, this commitment jarred with the pedagogy the department had adopted, since an examination requires the staff to make value judgements about the answers. Given the staff intended teaching a 'perspective' rather than 'facts', their approach to marking seemed to be to give more marks to those students who understood the perspective. This kind of impression marking is no doubt carried out by many departments setting essay questions, yet the general practice department felt vulnerable in this respect, since they emphasised to the researcher on several occasions the 'objectivity' employed in their marking, using such services as blind cross marking.

Understanding the Edinburgh Course and Beyond

Professional work, as other forms of behaviour, is guided by the practitioner's own rules of thumb and recipes for action. These remain on the whole unarticulated, and yet learned in the course of work and serve to make manageable the day to day work. It has been a complaint of some researchers (for example, Becker, 1972) that a gulf exists between the knowledge required to carry out professional work and the theoretical kind of knowledge conveyed to students on a vocational course. The first explanation of the department's teaching is that they were teaching practical 'experience'. That is to say, contrary to what Becker and others have argued, the general practice department's teaching intended to convey to students how family doctors thought and worked in practice. Unlike other departments, they were transmitting the rules of practice. From this followed the emphasis upon the importance of personal experience, when doctors can ignore the textbook procedures if the situation demands it, and the apparent inconclusive nature of the cases. To return to Bernstein's terminology, through the pedagogy of the department they were revealing to the students the 'mystery of the discipline', at a stage in the socialisation where other subjects withheld such information. The students, taught to look for the 'facts of science' failed to recognise the relevance and the legitimacy of the department's teaching, since they had little experience of handling such information.

But there are other explanations which should also be considered. Why did the academic general practitioners choose to teach in this way, for there is evidence of a certain choice in setting up the teaching in the form it took? By not conforming to the dominant paradigm the

academics were making a point about their subject, they were creating a certain distinctiveness about it.

We could extend this argument by suggesting that the general practitioners were attempting to increase the mystique and therefore the social control of their subject. The notion that knowledge is linked to social control is of course at the centre of Marxist writing on the curriculum (Entwistle, 1979). An alternative theoretical statement in this area has been presented by Jamous and Peloille (1970). These authors, addressing the major issue of the manner in which occupations achieve varying status, introduced into the discussion two concepts as explanatory variables - indeterminacy and technicality. Their ideas have been discussed elsewhere in some detail by the researcher and two colleagues (Atkinson, Reid and Sheldrake, 1977) but are worth brief repetition. Jamous and Peloille argued that a critical feature of any profession was its balance of indeterminacy and technicality.[1] Indeterminacy referred to the degree to which professional knowledge consisted of tacit knowledge, rules of thumb and the like which could not be made wholly explicit, or formulated into rules or prescriptions. This knowledge, then, was not reproducible through formal teaching methods such as lectures, but through apprenticeship, where as we have seen, the rules of practice are not required to be made explicit or articulated.

Determinate knowledge, what Jamous and Peloille call 'technicality',

[1] Jamous and Peloille are ambivalent over whether they are considering professional claims, or making some objective assessment of a profession's knowledge and its ratio of indeterminacy to technicality. This is one of the more contentious parts of their argument.

was essentially the opposite; knowledge which could be codified in terms of public rules, procedures or techniques; such knowledge could be made publicly available through a textbook or working manual. The implications for professional recruitment are obvious.

The authors argued that professions contain both kinds of knowledge but that professions (or segments of professions) with greater degree of indeterminacy maintain greater social control within their profession (and also in society at large) since a portion of their work lies outside the accountability of others. Thus, members of those groups or professions could maintain more control over their work, recruitment procedures, and so on.

General practice work has been characterised as comprising of mundane and routine medical work, which in Jamous and Peloille's terms would be seen as highly technical; that is, it is suggested that much of the medical treatment that general practitioners dispense could be simply codified. The notion that general practice was simply the practice of minor medicine was refuted in the seminars of the Edinburgh department by the consistent reference to the importance of personal relationships between doctor and patient, and to the personal element in diagnosis, and the resultant uncertainty of their work. At a more general level, the Scottish academic general practitioners countered the notion by choosing not to teach 'general practice' but 'medicine in the community'. Whether the courses were oriented clinically or socially, one could argue that they chose to emphasise the indeterminate features of general practice rather than the determinate. Thus the clinically oriented courses stressed the special clinical features of acute and chronic infection, while those socially oriented, the social factors, whose strength and weakness lay in their indeterminacy. None

of the courses set out to teach the routine medicine, or indeed the routine, practical aspects of running a practice, for it is here that delegation is taking place in general practice, and that a greater technical element is seen to exist.

A successful claim to greater indeterminacy in their work would yield professional rewards, in terms of greater prestige within the profession. Acceptance of this claim (if it happened) would also emphasise the divide between the general practitioners and the paramedical groups (for instance nurses) with whom the general practitioner increasingly worked, and also the lay members of the public, all of whom argue that they too can treat the minor medical conditions that are currently associated with general practitioners' work (Jackson, 1970b).

If the general practitioners are making this kind of professional argument, it would imply a very deliberate strategy on their part to achieve greater standing in the profession. It is difficult to judge how 'conscious' such a decision is, particularly when studying a series of happenings such as the setting up of courses which have taken place over a period of time, and in a number of places. However, a number of factors combine to suggest that there was deliberation in these moves. Firstly, the information that the Edinburgh department abandoned lectures early on, and changed to small group teaching should be seen as significant, particularly because this department acted as a model for others. Secondly, courses consistently avoid teaching the treatment of minor clinical ailments, the 'coughs and colds of general practice' as one doctor described them. Thirdly, virtually all the general practice courses which existed in the United Kingdom showed within all the regional variations, a unanimous decision to teach non-didactically.

The Indeterminacy of General Practice

Another proposition worth considering is that general practice is more concerned with indeterminate knowledge than hospital based disciplines, and that through some kind of objective test this could be shown. Hospital medicine does rely for its diagnosis more heavily upon technology, and the disciplines practised in hospital do on the whole have a body of accepted knowledge, which makes the subject more amenable to lecture based teaching.

This hypothesis is difficult to prove because we slip back into the realm of professional claims. Certainly, many service general practitioners would support this distinction with hospital medicine. They have argued that unlike hospital medicine, general practice was a form of medicine in which the person figured largely. Thus both the doctor and his relationship with each patient were important. Furthermore, unlike hospital diagnoses, the patient's environment provided significant information for the general practitioner's diagnosis and management of the condition. These features gave general practice its indeterminate qualities, for these features (they argued) proved difficult to cast into a reproducible form. Doctors in the study contrasted general practice with hospital medicine which, they said, was context free, concerned with cases not patients and involved one-off handling (thereby making the individual less important) - see diagram.

Service General Practitioners' Conceptions of General Practice/Hospital Medicine

General Practice	Hospital Medicine
Not specialised, variety	Specialised
Sorting clearing/trivia medicine	Serious medical
Psycho/non-medical	Medical
Environment	Context free
Patient	Disease
Doctor's personality important	Not important

In the seminars, academic staff in the Edinburgh department supported the general practice/hospital medicine distinction. They repeatedly emphasised to students that general practice was not 'black and white', 'cut and dried'. This emphasis on the indeterminacy of general practice has received support from other academic general practitioners. A professor of another general practice department, writes that 'Much of the clinical work, especially of general practice, is concerned with uncertainties - "grey areas" - as well as with hard data, and against this background the limitations of the lecture method in education for general practice are more clearly appreciated' (Knox, 1974, supplement). From an American academic (in a department of community medicine and family medicine) one finds a repetition of these ideas. Primary medical care, he argues, is different from specialist care in a number of ways. He charts out the differences, of which the two most significant are as follows:

	Primary Care	Specialist Care
Professional requirement	Comfort with ambiguity, especially diagnostic	Comfort with certainty and the impositions required to achieve it
Skills	Interpersonal interaction	Technical procedures

(From Barr, 1980, p. 126)

There is no first hand data to present the specialist's perception of medical practice but it seems likely that they would refute the notion that hospital medicine is inherently more technical than general practice, despite the indisputable reliance upon technology. Firstly, if one accepts the Bernsteinian concept of curricula, one must separate out what is taught of a subject and its subsequent practice. Thus merely because students are introduced to many subjects of clinical medicine in a way which implies their technicality does not mean that the practice of those subjects is similar. Although Bernstein was more interested in the socialisation processes themselves than the end result, he does not deny that students may come to appreciate the 'grey areas' of clinical medicine at the end of their training.

Secondly, the concept of 'clinical experience' is derived from hospital medicine, and not general practice. Foucault in his discussion of medical practice, emphasised the 'gaze' of the clinician, which became more highly developed in the organisation of medicine last century. But it was the hospital clinician he was referring to, not that of the community based physician (Foucault, 1973).

Finally, although the use of technology in hospital is seen as assuming that hospital medicine is more 'technical' in Jamous and

Peloille's sense of the word, (since science is typically equated with the production of 'hard' data), ethnomethodologists have studied such everyday assumptions. Underlining the similarities of science with common sense, Elliot has shown how even the use of scientific tools is finally based on the individual judgement of the user.

> Not only does the scientist observe describable events in his laboratory. His response to them itself exhibits quite common-sense features. For example, though he is much concerned with 'accuracy', he does not spend long periods staring at a dial to make sure he's seen its pointer's position 'accurately'. One or two brief stares are enough for his purposes . . . It is most important here to distinguish very carefully between the scientific ideal of accuracy on the one hand, and how this ideal is sanctionably incorporated into actual research performances as managed accomplishments.
>
> (Elliot, 1974, p. 25, emphasis in original)

This chapter has offered one account of undergraduate general practice teaching. It has outlined selected aspects of the teaching, arguing in particular that certain ideological features are reflected in the teaching. The chapter has ended with a more general discussion about the direction in which general practice teaching has developed. It remains for the conclusion to sum up overall argument of the thesis, and to make some general comments about the future of general practice.

CONCLUSION

This study has considered the introduction of general practice into the academic curriculum and into the academic community. Throughout the analysis, particular features have been underlined as of special importance in their effect on the shaping and formation of academic general practice. This conclusion merely restates these features, outlines the difficulties of such research, and indicates further areas to which sociological research could be directed.

1. The research brought together various branches of sociological inquiry to study the process of intraprofessional development. In particular, it united the literature on the professions with that concerned with curricula.

2. The study was concerned to extend the previous studies of the process of specialisation. In so doing, it concentrated upon elaborating the manner in which professional boundaries were created, both in terms of the actors' identity and also the epistemological, specialty, boundaries.

3. The study suggested that specialty development was not arbitrary but closely related to changes in the broader social structure; in particular, specialties needed both professional and political support to become established.

4. The study suggested that becoming academic performed an important, legitimating function for the emerging specialty.

5. The study suggested that crucial factors in the process of becoming academic were
   - 5.i the development of a positive academic identity
   - 5.ii the development of a body of knowledge

5.i The study suggested that a critical feature for the staff of the departments was the formation of a positive academic identity. For this to develop successfully, it was argued that certain features carried special weight within the faculty; in particular, previous career (whether academic or not), assessed stature, and the alliances negotiated within the faculty. Furthermore, recruitment into academic departments was underlined as a continuing problem. No strong recruitment policies emerged, but it was suggested that as long as academic staff placed more weight upon candidates' service rather than academic credentials, then general practice staff would have problems within the faculty.

5.ii The study suggested that members of the academic branch could be understood as being in the process of constructing their own body of knowledge, through the development of the courses, through the writing of textbooks, and ultimately by creating a received view of the discipline.

6. While it was argued that the academic branch of the subject performed a legitimating function for the broader specialty development, the study also highlighted the interactive nature of the relationship between the service and the academic groups.

7. The study suggested that it was important for academic staff to maintain a positive relationship with service members. This was shown to be difficult in as much as academic staff had difficulty in fulfilling the criteria of service membership.

8. The study suggested that the courses developed by the academic departments reflected the influence of service general practitioners. In particular, the two distinct ideological positions held by service general practitioners could be identified within the course syllabuses.

9. The study suggested that the courses could be placed along a continuum of teaching methods, ranging from reliance upon the traditional apprenticeship to those courses more dependent upon structured teaching methods. However, it was suggested that the courses were unusual in that none were based upon lectures.

10. The study suggested that the academic general practitioners were constrained both by service notions of teaching and by institutional notions of high status knowledge.

11. The study suggested that this could lead to a dissonance between the method(s) of teaching adopted by the teachers and the form of assessment common within the medical school.

12. The study suggested that the staff of larger departments showed some internal disagreements over the purpose of the teaching. It was suggested that this was symptomatic of a subject where there was no received view.

13. It was suggested that the construction of theory was largely carried out by the full-time teaching staff. The part-time staff, who performed the majority of the teaching, had less influence over the creation of academic general practice. It was suggested that until the part-time staff became more fully integrated into the departments, then the discrepancy between the official view of the courses and the actual teaching would remain.

14. The study suggested that the academics developed a distinct perspective of their subject; in particular, it was suggested that unlike their service colleagues they believed that more generalised, theoretical statements could be made about general practice.

15. Associated with this, they believed that the teaching of the subject could be divorced from its immediate work context, and that the teaching could be structured.

16. The study suggested that the content of the courses was deliberately structured to present general practice work as indeterminate. It was argued that this should be understood as one method of gaining higher status within the profession.

17. The study suggested that along with other specified subjects the teaching of general practice appeared deviant in one curriculum. It was suggested that this deviant position was in part fostered by the department as one way of staking out a professional position.

18. The study suggested that two specialty arguments could be identified within general practice, and also within the rhetoric of the courses offered by academic departments. At present they co-existed, and it was difficult to argue that one was dominant. It was suggested that on certain grounds the 'social' orientation could be understood as the stronger. Any possible strengthening of the social perspective within the broader profession would have immediate consequences upon both the development of the 'specialty' of general practice, and also upon the structure of the medical curriculum.

19. The study suggested it was difficult to sustain the vocational/non vocational division in an actual teaching situation.

Future Research

There is an overall lack of detailed knowledge about academic branches of professions. This study would have benefitted considerably by drawing examples from other professions and occupational groups, but overall, such studies do not exist. Little is known or understood about the manner in which academic branches of professions develop, change, and are restructured. More sociological interest in specialty development is required. Few have critically studied successful socialisation. Sociologists should look for examples not only to

established professional groups but also to the field of developing professions. Related to the study of the formation of intraprofessional groups is another neglected area, relationships within professions. If more occupational groups are developing academic branches then the identity problems outlined in this research will have a more general applicability.

While sociologists have focussed their attention on the students' experiences of professional training, little interest has been shown in the curricula themselves. This study has underlined the importance of critically viewing curricula, of not taking their form and content for granted but of considering the implications of the particular form and content of syllabuses. Again, studies from other branches of medicine and other professional groups are needed for a sociology of the curricula to develop further.

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APPENDICES

A. Sampling and Methodology

B. Sample and Non-respondents - a Comparison

C. Questions

D. Letter of Introduction

Appendix A

SAMPLING AND METHODOLOGY

Sampling Procedure

The underlying rationale of the sampling procedure was to interview as typical a sample of general practitioners as possible. For the purposes of the study, the doctors were divided into three categories; those with full-time teaching appointments in university departments (called academic general practitioners in the study); those service general practitioners with part-time teaching commitments with the academic departments (thereafter called the part-time teachers), and service general practitioners with no connection with the undergraduate curriculum at all at the time of the sampling.

Because of the small numbers involved a total sample of the academic staff was attempted. In the event, ten out of the twelve staff of the departments were interviewed. One doctor left his department before the interviewing commenced to take up a post in a Canadian university, while three attempts to visit the twelfth were confounded for domestic and 'timetabling' reasons.

A sample was drawn from the latter two groups using standard sampling techniques. A three quarters sample of the part-time staff was taken from the lists of part-time staff provided by the two departments. Twenty two staff out of the thirty were contacted, either personally or by letter, and asked if they would agree to being interviewed. All agreed.

The sample of forty service general practitioners was reached with the help of the Executive Council lists in Glasgow and Edinburgh which lists all general practitioners currently in practice. A sample was taken of Edinburgh and Glasgow doctors with the practices of part-time staff excluded from the sample. The doctors were all approached by letter. The response rate from the two cities differed by a few percent, Glasgow having a slightly lower response rate of 63%, with Edinburgh 69%. The overall response rate was 66%. Although not exceptionally high the rate was consistent with other recent studies using general practitioners as respondents (see Cartwright, 1978). Appendix B compares the respondents and the non-respondents.

Methodology

Three main types of research methods were used for the collection of data for the study - interviews, participant observation and the collection of historical material. Thus the research strategy was to collect data from varied sources, material from each source being used to confirm (or otherwise) evidence gathered from other sources.[1] The technique is known as 'triangulation' (Zelditch, 1971). Two of the methods of data collection used in this study were those typically associated with interpretive sociologies - interviewing and participant observation. Both seek out different forms of reality, and both make

[1] Atkinson points out that although this technique is widely used in the social sciences, there is little discussion in the literature about how to handle contrary evidence (Atkinson, personal communication).

different demands upon the researcher (and those being researched) - see McCall and Simmons (1969) and Filstead (1971) for a documentation of these methods. For the purposes of this research each played a distinctive and valuable role. Each will be described briefly.

All four general practice departments in Scotland were visited more than once, and all the academic staff interviewed, on more than one occasion with the exception of one staff member. Relations with one department were more strained than others, while the researcher was a post-graduate student, but on the whole the attitude of all staff, and indeed all the doctors was helpful and interested. Interviews with the service general practitioners and part-time teachers were largely initiated by letter, but once contact had been made the interviews went well. General practitioners are not used to being asked questions, and to relinquishing control of the situation, but they are used to talking to young women, (one of their largest categories of regular consulters).

When relying upon interviews as the main method of collecting data one must of course be aware of their limitations. There is no way to avoid the issue that all accounts are highly situational (although one can introduce certain measures to check for this, such as comparing one informant's account with another's). Obviously this issue must vex those intent upon seeking the 'truth' considerably more than if one understands that such a reality does not exist. The point to be underlined here is that the researcher was not interested in seeking out an objective image but <u>was</u> interested in professional rhetoric and vocabularies of motives. Having said that, one is left with the problem of the status of the interview material <u>vis-à-vis</u> the practical actions

of the general practitioners. Mills pinpoints the relationship between talk and action as the 'central methodological problem of the social sciences' (Mills, quoted by Deutscher, 1971) and this thesis offers no way forward with the problem. There was no attempt to relate the ideological perspectives of the doctors interviewed with their practices at work.

However, there is a growing body of literature, largely stemming from the general practitioners themselves, which relates to general practice work. Studies are sometimes descriptive, at other times they offer in a quantified form, patterns of behaviour of general practitioners relating to particular aspects of practice (for example, prescribing behaviour, the use of appointment systems, and so on - Fry, 1977b). From the material of these studies, one can begin to substantiate the interview findings, although as yet no study which divides doctors into those 'socially' and 'clinically' oriented and then studies their work behaviour is known to exist.

Observation

Two terms of observation of seminars was carried out in one general practice department, in the Spring terms 1972, 1973. Although in the final analysis little weight was placed upon the material gathered at this stage in the study, the period of observation proved most useful in sensitising the researcher to the criticial issues of academic general practice. Indeed, surprisingly early in the research basic hypotheses were formed, important concepts isolated, and categories developed (cf. Geer's 'First Days in the Field' [Geer, 1969]), a process well

understood as central to grounded theory approach (Glaser and Strauss, 1968). In these first few months of contact with academic general practice, the debate over whether the courses were vocational was first heard, as was the use of the phrase later to be understood as significant, 'medicine in the setting of general practice'.[1]

Observation (in which the researcher took a passive role, sitting in the seminars, notetaking), was carried out during the seminar teaching of one general practice department. As others have found using a similar technique in medical schools (Becker et al, 1961; Miller, 1970; Atkinson, forthcoming), when 'walking the wards' or attending lectures or seminars, it is difficult for the (young) researcher not to become caught up in the student perspective and for both staff and students to categorize the researcher thus (thereby blocking off channels for staff/researcher inter-action).[2] In this instance, attempts were made to achieve a neutral position in the department, particularly as the researcher was equally concerned with the staff perspective. It would be true to say that throughout this phase of data collection the students remained overall less concerned about the researcher's presence than did - some - staff.[3]

[1] Although concepts were detected as important early in the research, they and the implications of their use were not necessarily understood. This came later.

[2] Corrigan makes a similar point regarding research in educational institutions (Corrigan, 1979, p. 12).

[3] The most obvious recorded instance of a doctor changing his behaviour because of the researcher's presence involves a part-time teacher who took part in the seminars. Students also saw these doctors at their surgeries, and after requesting permission the researcher attended a post-surgery discussion with each student. During the discussion the doctor carefully went through the various cases seen, pulling out particular thematic points from all relevant cases; when asked afterwards how typical that session had been the student said that the doctor went through everything in greater detail when the researcher was present.

A Comment on Data Collection Methods

The data for the interviews and the participant observation was collected by notetaking during the interviews and periods of observation, the full transcripts being written up immediately after the event. Such a method of data recording can work well with practice, although inevitably the quality of the conversation, the hesitances of speech, and the half started sentences, are sometimes lost. In the early 'seventies, when this study was initiated, notetaking was still a common method used by social scientists of recording data particularly for unfunded projects of post-graduate students. Today, with taperecorders having become more compact, portable and cheaper, notetaking has become replaced by tape recording interviews, and notetaking now has a curiously old fashioned air about it.

Appendix B

RESPONDENTS AND NON-RESPONDENTS - SERVICE SAMPLE

The overall response rate for the study from the service general practitioners was 66% (20 doctors). Although a higher response rate would have been desirable, it is suggested that this rate is comparable with other studies using general practitioners. Cartwright, in an overview of professionals as responders, noted that the response rate for the studies from doctors dropped over a sixteen year period (from 1961-1976); that there was little difference between general practitioners and consultants as responders, and that nurses (midwives, health visitors and nurses) had an overall higher response rate (Cartwright, 1978).

Cartwright studied the little information she had on her non-responders and suggested that the following differences could be found; better qualified doctors were more likely to respond, while respondents were more likely to be non-single handed and younger. Cartwright also noted the importance of the topic of the study.

Little can be found out about the non-respondents for this study, except from information available in the Medical Register for the year in which the sample was taken. Given that the letter of introduction stated that the topic of the research was educational, one would expect a bias of respondents towards those with more further qualifications, and this in fact was found to be the case:

One or more further qualification	
Respondents	50%
Non-Respondents . . .	25%
(Irvine and Jefferys 1971 study - Respondents .	46%)

It was also not surprising to find that few of the non-respondents were members of the Royal College of General Practitioners, since the Royal College has always sponsored both an interest in research among general practitioners, and also an interest in education, both undergraduate and postgraduate.

Member of the Royal College of General Practitioners

Respondents	25%
Non-Respondents	5%
(National Figure of membership . .	33%)

As Cartwright also found, there was a preponderance of singlehanded general practitioners among the non-responders - 55 per cent of them (11 doctors) being noted in the Medical Register as singlehanded (see Table 10.i). Slightly fewer were practising where they qualified (80% as compared to a respondents' percentage of 92.5%). One difference which emerged was that of the overproportion of women who responded. Hence men made up the majority of non-responders, with only 15% being women. A national figure for the percentage of women doctors in general practice was, for the year of the sampling, 11.3%, which suggests rather than the non-respondents being atypical, it was the respondents who included an overproportion of women. There have been very few studies on how the gender of the doctor influences their perceptions of general practice. It was felt that the gender of the doctor was not a critical factor when considering their educational views.

Table 10.i

Comparison of Types of Practice of the Service Sample with Figures for England and Scotland

Type of Practice	(percentages)		
	England	Scotland	Service Sample
Singlehanded	18	15	17.5
2 doctors	21	20	20.0
3 doctors	25	27	25.0
4 doctors	18	19	12.5
5 doctors	9	10	7.5
6 or more doctors	8	7	17.5

Figures 1st October 1974. Figures exclude doctors with 'limited lists' (e.g. resident in homes, schools, or other institutions, doctors who provide only maternity medical services or partners of those doctors).

Annual reports of the DHSS and Home and Health Department, Scotland.

Appendix C

Interview Questions - Service General Practitioners

1. What are the important recent developments in general practice?
2. Do you think general practice is more of an art than a science?
3. Do you think that general practice is different to hospital medicine?
4. Are you a member of the Royal College of General Practitioners?
5. Do you think the College has been important in any particular field?
6. How should general practice be taught to undergraduate medical students?
7. How would you organise a course?
8. What could general practice contribute to the basic education of every doctor?
9. What is the most important part of your work?

Interview Questions - Part-Time Teachers

1. How did you start teaching on the fifth-year course?

2. Are there any aspects of the teaching which you find easier or more difficult to teach?

3. Do you think that the 'interpersonal' features of medicine should be brought out more?

4. How do you feel about teaching 'medicine in the community' and not 'general practice'?

5. Do the students ever criticize your methods of managing patients?

6. Do you mind being criticized?

7. Do you think general practice is different in content to the hospital specialties?

8. Are there any particular difficulties in being a part-time tutor, either *vis-a-vis* your practice or the university?

9. How important is the Royal College of General Practitioners in undergraduate education?

These nine questions represent the main issues of the discussions with the tutors, although in some cases other questions were also asked about these topics. Every doctor, however, answered these questions, which were addressed to him at some time during the interview.

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29th November 1974

Copy of Introductory Letter to Service General Practitioners

Dear

As a lecturer in the above Department, my research is concerned with recent developments in General Practice, in particular its inclusion in the undergraduate curriculum. So far I have interviewed General Practitioners working within the University context. Now I should like to sample the views of doctors practising in the community, on these and related matters. Would it be convenient for me to come and discuss these issues with you at the surgery? The interview would take about twenty minutes.

I have set aside time to interview a sample of General Practitioners in Edinburgh; 16th to 20th of December (inclusive dates), and the first week in February. Perhaps you could complete the slip below indicating a date and time suitable for yourself in December, or saying if you would prefer to leave the interview until February.

I look forward to meeting you,

Yours sincerely,

Margaret E. Reid

I would prefer to be interviewed in December and suggest .....

..... as the most suitable date and time for myself.

I would prefer to be interviewed in February.

Signed .....