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Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

What price academic general practice?

SIR,—It was encouraging to read that the president of the Royal College of Physicians is so positively in favour of the development of academic general practice (14 June, p 1545). Nevertheless, we believe that Sir Raymond Hoffenberg presents an incomplete picture of the contribution which academic general practice can make, and in many instances is making, towards undergraduate medical education. General practice teaching constitutes far more than a form of prevocational training and should not be thought of as merely an exposure to community morbidity. Indeed, a recent report has suggested that 16 of the 20 undergraduate educational objectives specified by the General Medical Council[1] cannot be achieved without appropriate inputs from academic general practice.[2]

General practice is a setting in which undifferentiated problems present at early stages of development, where there is a complex mixture of clinical, psychological, and social components and where the many symptoms presented may be accompanied by few clinical signs. This provides students with the opportunity to develop their powers of clinical reasoning, since they need to be appropriately selective in history taking, examination, and the use of laboratory and other services, which should stand them in good stead whatever their eventual career choice. As a generalist discipline general practice can also offer the student a unique opportunity to integrate much of his previous teaching by bringing together basic and behavioural sciences, preclinical and clinical knowledge. On the other hand, general practice can teach students to recognise without shame the limits of their personal knowledge, the necessity of tolerating appropriate degrees of uncertainty, the importance and professional uses of the doctor-patient relationship, and the need to blend scientific and humanitarian approaches. Again, all of these attributes will be useful in any clinical setting.

We also take issue with Sir Raymond's assertions that "Clinical medicine is best learnt through apprenticeship" and that the "physicianly approach" is best suited for inculcating clinical skills. It is a fascinating irony that these statements appear in the same edition of the journal as two papers which once again highlight the deficiencies of the apprenticeship method as a means of developing the essential consultation skills of doctors (Dr Peter Maguire and others, p 1573, 1576). Although skilled clinicians are very important as role models, the most effective medical teachers need to possess the ability to understand the learning needs of their students, to be able to analyse and articulate the components of sound clinical method, and to be able to select the most appropriate means of instruction.

ROBIN FRASER
BRIAN R MCAVOY

General Practice Unit,
University of Leicester,
Leicester Royal Infirmary,
Leicester LE2 7LX

1 General Medical Council. *Recommendations on basic medical education*. London: GMC, 1980.
2 Association of University Teachers of General Practice. *Undergraduate medical education in general practice*. Exeter: Royal College of General Practitioners, 1984. (Occasional Paper 28.)

SIR,—I enjoyed reading Sir Raymond Hoffenburg's thoughtful leading article commenting on the MacKenzie report. However, I found some difficulty in recognising the general practice that he described as being the specialty in which I practise. He comments that "teaching in general practice gives the student a chance to see those minor but important disorders that do not reach the teaching hospital and that the episode that brings the patient into hospital has a beginning and an end, both of which are the responsibility of the general practitioner." Only 10% of patients with epilepsy are followed in hospital outpatient clinics. In my own practice 95% of the patients with asthma, 90% of those with hypertension, and 80% of those with diabetes—including 60% of insulin dependent diabetics—are cared for by the primary care team without help from our consultant colleagues.

I do not think that epilepsy, diabetes, hypertension, and asthma are minor disorders. Increasingly the Royal College of General Practitioners is defining protocols for care of serious chronic disease, and GPs are encouraged to audit their care against these protocols. Clinics for the care of asthma, hypertension, chronic arthritic disease, diabetes, and other chronic disorders are becoming widespread in general practice.

The patients that students see in teaching hospitals are not those with serious conditions. In fact it is not usually the "condition" that governs contact with the hospital at all. Patients who are referred are often those in whom a crisis occurs in the care of a particular condition. Therefore, students in teaching hospitals are taught on patients who are going through some sort of a crisis. If they are to be taught the clinical course of important conditions and the routine care, follow up, and control of these conditions that can be done only in general practice.

E MARTIN

Bedford

Why it takes so long to build a hospital

SIR,—Dr S J Surtees's account of the delaying tactics that held up phase II of Eastbourne's district general hospital is, in the circumstances, a