PRACTICE OBSERVED

Practice Research

Blood pressure recording by general practitioners in north-east Scotland

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Over the past 15 years raised blood pressure has been confirmed as a major risk factor in cardiovascular disease.¹⁻³ There is evidence that acceptable treatment exists for hypertension and that treatment is effective in reducing mortality.⁴⁻⁶ Unfortunately, hypertension has one characteristic that adversely affects successful management: it is nearly always asymptomatic. This carries implications for the medical practitioner in detection and for the patient in treatment. To detect hypertension a person needs to have his or her blood pressure taken.

Mass screening of everyone in Britain for hypertension has been rejected by the Joint Third Working Party of the Royal College of Physicians,⁷ mainly on the grounds of economy and lack of resources. The report recommends that the general practitioner conduct screening and identifies "high-risk patients" on his list. Apart from the sporadic efforts of a few people in universities and industry,⁸⁻¹⁰ detecting hypertension in otherwise healthy individuals is, by elimination, the responsibility of the general practitioner. The results of studies have shown wide variations in the detection of hypertension by general practitioners. One London practice recorded blood pressures in only 4% of patients,¹¹ whereas another in Thames Valley recorded blood pressures in 9% of patients.¹²

The purpose of this study was to ascertain the frequency with which general practitioners in North-east Scotland took blood pressure readings over 10 years.

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Methods

The medical records of randomly selected men aged 20 years and over from general practice lists in North-east Scotland were retrospectively examined. The objectives of the study were to determine (1) the number of patients who had a blood pressure recorded in the general practitioner's notes at any time during the 10 years 1968-77; (2) the number of patients who had a blood pressure recorded in hospital inpatient and outpatient letters that were in the practice records; (3) changes in general practitioners' habits of recording blood pressure in the five years 1973-7 compared with 1968-72; (4) the pattern of blood pressure recording against the number of doctor contacts, age of patient, and highest blood pressure reading; and (5) the proportion of hypertensive patients detected, followed-up, and prescribed treatment.

From a list of all provincial general practices in the North-east of Scotland, seven were chosen at random. One principal in each practice was asked for permission to study the notes of a sample of their men patients. All practices agreed. The list size and number of principals in each practice were ascertained to determine the size of each sample to be drawn. The size of practice ranged from a group practice of eight doctors to a single-handed practitioner.

The first record was drawn at random from the files of each practice and thereafter the record of every tenth man was selected, proceeding alphabetically until the required sample had been attained. If the tenth record was that of a patient under 20 years of age it was discarded and the next record drawn in its place. The information abstracted, covering the 10 years from 1 January 1968 to 31 December 1977, included the age of the patient, whether the blood pressure had been recorded in the notes, the number and date of contacts between doctor and patient, highest blood pressure found, follow-up recording after the highest pressure was recorded, the time of the latest blood pressure recording, and treatment.

All hospital inpatient and outpatient records except radiodiagnosis were scanned for blood pressure recordings. Furthermore, the notes were classified as "intact" if there was no evidence of missing records throughout the ten years of the study. All ages quoted are the age of the patient on 31 December 1977.

expected to have had a blood pressure reading taken. Analysing those aged 40 and above, however, shows only 44% with blood pressure recordings, a figure similar to that (38%) found by Harlow *et al.*¹³ in a population study carried out in West-central Scotland in 1972.

Of those who had had a blood pressure recorded, 34% (115) could be labelled hypertensive. We used the cut-off point of ≥ 160 systolic and ≥ 100 diastolic to compare with Heller's study.¹⁴ We recognise that there may be some controversy about these cut-off points, especially in the higher age groups. But, even at higher levels of blood pressure follow-up and treatment were unsatisfactory. The fact that 84% of patients with a persistently raised follow-up recording were subsequently started on treatment suggests that knowledge of how to manage hypertension exists. Because of lack of recording and follow-up, some hypertensive patients were not treated.

Some authors have suggested that not all blood pressures taken by general practitioners are recorded, especially if they are normal.¹⁵ The results of our study showed that 34% of all blood pressures recorded were raised and that only 56% of all raised blood pressures had a recorded follow-up blood pressure, so that may be the case. Information in such a study is limited to what is recorded in the notes and may not reflect the true situation. Blood pressure recording in letters from hospital visits added a little information but did not justify relieving the general practitioner of his duty to detect hypertension.

The results of this study do not indicate that general practitioners have changed with regard to hypertension detection over the past 10 years, despite accumulating evidence of the hazards of high blood pressure and suggestions for screening healthy populations. The fact that in our study 90% of men had visited their general practitioners in the previous five years shows that general practitioners have adequate access to the patients on their lists. The opportunity therefore exists for general practitioners in Britain to detect and treat most hypertensive patients. A conscientious effort could meet the challenge and should result in lowered cardiovascular morbidity and mortality.

Conclusions

The medical records of 1000 randomly selected men patients of general practitioners in North-east Scotland were examined for evidence of blood pressure recording in notes over 10 years. Blood pressures had been recorded in 34% of patients.

Diary of Urban Marks: 1880-1949

On returning for the last stage of the examination I was put into the hands of Dr Haviland Hall—at that time president of the Royal College of Physicians. I was taken to a bench and he handed me from a host of others a specimen glass of urine. I was told to examine it and he would be back in two minutes. On his return he said, "Well, what have you found?" "Nothing. The urine is normal," I replied. "Pardon me. It contains sugar," he said. "Excuse me, Sir, it does not. If you dispute me I must ask you to examine it yourself." "Certainly I will," he said and he took the glass and examined it. He then said, "I have found sugar in your urine. It is a sign of diabetes. You must be careful of your diet and exercise." He then handed me the glass and I took it. He then said, "I have found sugar in your urine. It is a sign of diabetes. You must be careful of your diet and exercise." He then handed me the glass and I took it. He then said, "I have found sugar in your urine. It is a sign of diabetes. You must be careful of your diet and exercise." He then handed me the glass and I took it.

pressure increased with age, the number of doctor contacts, and the level of blood pressure. Thirty-four per cent of those whose blood pressure had been recorded had a raised blood pressure, and in just over half of those a follow-up blood pressure was recorded; 28% whose blood pressure had been raised initially were subsequently started on treatment. There was little evidence that the practice of recording blood pressure had changed over the past 10 years.

LDR thanks Professor J G R Howe and Dr J S Berkeley, who helped to establish the origin of this elective study, and Professor J M Richardson for discussion. We are grateful for the unstinting cooperation of the general practitioners and ancillary staff of all seven practices concerned, and to Dr Mary Fulton for constructive criticism of this paper.

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Results

The sample was made up of 1000 patients aged 20 and above, the exact age was known for six patients (table 1). A blood pressure reading had been recorded in the general practitioner's notes at some time during the 10 years for 341 (34%) of patients. The range in the seven practices was from 24% to 38%. Eighty-two per cent of the notes were classified as "intact" (completed at the beginning of the survey and 91% were "intact" from the beginning of 1973 to the end of the study. The most common reason for records not being intact seemed to be failure to return records from a previous practice after a patient had transferred to a new practice. The time of the last recorded visit could not be ascertained from the records of 26 patients. Of the 974 patients with years of last visit recorded, 576 (59%) had been seen in the past year, 813 (83%) in the past three years, and 881 (90%) in the past five years. Forty-one patients apparently had been last seen before 1968.

Blood pressure recordings in intact general practitioner notes and in letters from hospitals over the two five-year periods are shown in table 11. There was little evidence of change in blood pressure recording in general practitioner notes or in hospital contact letters between the two five-year periods. To control for the "cohort effect" in comparing the two five-year periods, we looked at patients in the same age group (40-59 years) for both periods; there was no evidence for a change in the proportion who had had blood pressure recorded (26% in both periods). Table 111 shows the per cent who had had blood pressure recorded by the number of visits to the doctor for the five years 1973-7. Blood pressures were more likely to be recorded by general practitioners in patients with a greater number of visits and in older patients; 74% had had their blood pressure recorded in the past five years (table IV).

If we define hypertension as a blood pressure 160 mm Hg systolic, or 100 mm Hg diastolic, or both, then 115 (34%) patients with recorded blood pressure were hypertensive. Of the 115 with raised readings, only 64 (56%) had evidence of a follow-up blood pressure recording (table V). Twenty-six of these (41%) were within normal limits at follow-up. Eliminating these, 32 out of 38 patients

TABLE IV—Duration of time between last blood pressure (BP) recording and end of study, according to age group

Age group (years)	No. of patients	Time (years) of last BP recording (No. of patients)				
		0-1	1-2	3-4	5-6	7-10
20-39	106	20 (19)	50 (47)	28 (26)	28 (26)	20 (19)
40-59	106	12 (11)	68 (63)	86 (80)	86 (80)	22 (20)
60-79	106	12 (11)	68 (63)	86 (80)	86 (80)	22 (20)
80-99	106	12 (11)	68 (63)	86 (80)	86 (80)	22 (20)
All ages	341	62 (18)	186 (55)	251 (74)	251 (74)	90 (26)

TABLE V—Recording of follow-up blood pressure (BP) and treatment according to highest BP and age in the 341 patients with BP recorded

Age group (years)	No. of patients with highest BP recorded	No. of patients with follow-up BP recorded		No. of patients treated	
		All	Started	Continued	End of study
20-39	106	18 (17)	7 (6)	2 (2)	2 (2)
40-59	106	68 (63)	30 (28)	21 (21)	21 (21)
60-79	106	86 (80)	40 (38)	28 (28)	28 (28)
80-99	106	86 (80)	40 (38)	28 (28)	28 (28)
All ages	341	251 (74)	115 (34)	79 (23)	79 (23)

Age group (years)	No. of patients	No. of patients with blood pressure recorded		No. of patients with blood pressure recorded	
		All	Started	Continued	End of study
20-39	106	18 (17)	7 (6)	2 (2)	2 (2)
40-59	106	68 (63)	30 (28)	21 (21)	21 (21)
60-79	106	86 (80)	40 (38)	28 (28)	28 (28)
80-99	106	86 (80)	40 (38)	28 (28)	28 (28)
All ages	341	251 (74)	115 (34)	79 (23)	79 (23)

TABLE III—Blood pressure (BP) recording in GP notes or in letters from hospital contacts, or both, for the two five-year periods by age group

Age group (years)	No. of patients	No. of patients with BP recorded		No. of patients with BP recorded	
		All	Started	Continued	End of study
20-39	106	18 (17)	7 (6)	2 (2)	2 (2)
40-59	106	68 (63)	30 (28)	21 (21)	21 (21)
60-79	106	86 (80)	40 (38)	28 (28)	28 (28)
80-99	106	86 (80)	40 (38)	28 (28)	28 (28)
All ages	341	251 (74)	115 (34)	79 (23)	79 (23)

* Does not include blood pressure recordings found in hospital outpatient and inpatient records.

TABLE II—Trend of blood pressure (BP) recording against number of visits by age group, for "intact" records over the five years 1973-7

Age group (years)	No. of patients	No. of patients with BP recorded		No. of patients with BP recorded	
		All	Started	Continued	End of study
20-39	106	18 (17)	7 (6)	2 (2)	2 (2)
40-59	106	68 (63)	30 (28)	21 (21)	21 (21)
60-79	106	86 (80)	40 (38)	28 (28)	28 (28)
80-99	106	86 (80)	40 (38)	28 (28)	28 (28)
All ages	341	251 (74)	115 (34)	79 (23)	79 (23)

* Does not include blood pressure recordings found in hospital outpatient and inpatient records.

(84%) who had a follow-up blood pressure recording and remained hypertensive were treated. Overall, 28% (32 out of 115) of patients who had raised blood pressures in their notes were subsequently treated. The treatment most commonly prescribed was a diuretic—11 out of 22 were prescribed a single drug; and 10 were prescribed a diuretic in combination with other antihypertensive treatments. At the end of the study 26 of the 32 patients remained on treatment in addition to two who had begun treatment some time after hypertension was diagnosed. At the end of the study only 50% (13/25) of patients with initial systolic pressures ≥ 200 mm Hg and 35% (7/16) with diastolic pressures ≥ 120 mm Hg were being treated. Eleven men were referred to hospital because of their hypertension.

Discussion

Given the number in the sample (1000 patients) and the age distribution, we think that this is a representative sample of the general practitioner records of men 20 years of age and over who live in North-east Scotland. The results of our study showed that only 34% of the men patients had had a blood pressure recorded in their general practitioner notes during the 10 years. One might argue that this per cent is fairly low because of including a proportion of young patients who might not be

Shortlisting Trainees

Two north London schemes compared

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An elaborate process for selecting a few winners from a large number of contenders must inevitably appear somewhat arbitrary to those whose prospects depend on the result. If the contest was based simply on achieving the highest marks in the IQ test, or the fastest time over 1500 metres, there might be little room for argument, but when it requires comparisons of the personal qualities, experience, achievements, and potential of individuals, the contest becomes more subjective. The judgment of Solomon always to guarantee a fair conclusion.

Such a procedure has to be undergone several times during a medical student's career—most crucially at the outset to be accepted as a medical student; subsequently at intervals for pre-registration and post-registration jobs; then again for specialty posts at junior and senior levels or for partnerships in general practice. The most recent addition to the genre—the selection of candidates for vocational training schemes in general practice—being still in an evolutionary state, may seem particularly unpredictable and perhaps unfair to those most vitally concerned.

Since I became a course organiser three years ago I have been concerned in selecting trainees for two neighbouring three-year schemes, which provide an interesting contrast and perhaps a little enlightenment about the process. Scheme one, at the Whittington Hospital, a district general hospital, had one annual vacancy but a second has recently been added, which runs at six-monthly intervals with a rotation of medicine, psychiatry, obstetrics, and paediatrics. Scheme two, at the Royal Free Hospital, a teaching hospital, has two annual posts that start simultaneously in April, and offers the option of any four out of five jobs in accident and emergency, psychiatry, geriatrics, paediatrics, and medicine, though in practice the choice may be limited by the need to fit in with the plans of other trainees in the scheme.

Both schemes are advertised in the *BMJ* in similar terms, offering an optional preliminary month in general practice and attendance at the half-day release course. As is all too commonly the case, however, the opportunities for attending the half-day course are in effect severely restricted by unavoidable service commitments in most of the jobs. Regular attendance at the half-day course is virtually confined to the third year in general practice, when the trainees join their more numerous counterparts in this area who are the subjects of the various training programmes. One of the main theoretical advantages of the integrated three-year course—namely, continuous contact with general practice training throughout—has therefore been lost from the outset.

So far the two schemes have much in common, but there is a striking difference in the number of applications that each receives, owing principally, I believe, to the absence of obstetrics from scheme two. This consistently results in fewer than 20 applications for its two posts, whereas the single vacancy in scheme one has successively had 37, 37, and 70 applications.

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How we select

The different procedures for selection may in part reflect the number of applications to be considered. At the Royal Free full copies of all applications are sent to each person on the selection panel, with a request to return a shortlist. Such a procedure would be cumbersome, given the number of replies received in scheme one at the Whittington, where instead the applications are kept at the medical appointments office and the selection committee visits the office to shortlist. But in scheme two, as at a rolled and tossed about my past life before me much as it is said that a man who is drowning sees all his past life in the space of seconds.

At the Royal Free the arrangement is different as no specific general practitioner is designated as trainer. The intention is that the trainee should contact several local trainees during his training in hospital and arrange to do his training year in general practice with one of them; the preliminary month is arranged ad hoc. There are about eight consultants on the committee, and three GP representatives, but as none of the GPs has a personal commitment to spend 12 months in close contact with the appointed trainee, whereas the consultants will be more directly concerned, the consultants' opinions tend to carry more weight. In contrast, at the Whittington, when a difference of opinion has arisen over the final choice the consultants have occasionally deferred to the GP trainee on the grounds that he will be spending 12 months with the trainee, whereas they have only six months each with the trainee.

In the absence of any declared policy about the criteria for shortlisting, I have gradually evolved my own. When the numbers of trainees are small I simply exclude the least suitable, and the shortlists are often identical. When there are a large number of trainees only candidates who are shortlisted by at least three out of the five or six selectors are likely to gain interviews.

An early consideration is the candidate's age and experience, and those who have been long-qualified and have had many posts tend to be ruled out first because it often appears that general practice is a last resort rather than a positive choice. Some others who have already done two or more senior house officer posts could satisfy the criteria for vocational training with one or two more jobs plus a training year, and I think that it is inappropriate to appoint them to a three-year scheme. A subsidy is paid out for vocational training, and it seems wrong to encourage some doctors to prolong their training unnecessarily, perhaps "holding their bets," at the expense of others who are fully committed to general practice. Applicants with more experience are occasionally favoured by some consultants but this does not mean they may be more useful to the service. Doctors may also be tempted to drop out of the scheme after a year or 18 months either to pursue a specialty or to do their traineeship early (perhaps depending on whether they have been ruled out of the MRCP examination—membership of the royal colleges of physicians).

In contrast, older applicants who have been "mature students" at medical school and are applying after the pre-registration year often get my vote. Their motivation has already been tested and proved, they have usually made an informed decision in favour of general practice, and they can ill afford to waste time searching for a job every six months; moreover, from the purely selfish viewpoint of the course organiser, their presence in the group on the half-day release course will be a boon to the group, as their experience and maturity enlarges the vision of the group.

With regard to the current preoccupation over "equal opportunities" there seems to be no real discrimination on grounds of race or sex, though in the past there have been several years earlier may fall for reasons already given. The last 10 places on our two schemes went to seven women and three men—seven British and three non-British doctors—which seems a fair reflection of the distribution by sex and nationality of the candidates.

Having come this far, one may still be faced with 20 or 30 suitable applications to reduce to about eight. This is where a personal letter can flesh out the bare bones of the application form—or may already have been powerful enough to override some of the foregoing criteria for exclusion. Such a letter can arouse interest, even compel attention, specifying why this particular person wants this job, how his previous experience and talents will make him indispensable to our scheme.

After all this, the interview comes almost as an anticlimax. Often the shortlisted candidates have been interviewed by the training practice, and they may have already met the consultants and trainees.

The GP and the Medical Student

The background

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In the days when medical schools "exposed" their students to general practice there was a fair measure of agreement between the three parties concerned about the purpose: it was to show students what general practice was like. Before about 1970 there was little evidence that each party was already interpreting this agreement in subtle different ways.

The medical students who were "exposed" thought that it was a good idea to see the way of life of a general practitioner, since many were resigned to the idea that they would soon have to adopt it. The deans, who were most often the people organising the attachments, thought them sensible for the same reason as the students, and welcomed the chance to keep in touch with graduates who had gone into general practice and were willing to take students for a week or two. It was cynically suggested at the time that "exposed" students had been sent to general practice to produce antibodies and work harder in order to avoid having to go into general practice. This suspicion was of course never proved. The general practitioners' attitude was, most often, that they were given a chance to show some innocent but brain-washed students what life was really like.

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so the interview may mainly crystallise opinions already formed, though the candidate's performance under stress may add a dimension and there are occasional surprises. References are consulted only after the interview, and rarely seem to affect the outcome. In the end there are usually one or two clear leaders, and a final decision has to be negotiated.

I must admit to feeling some discomfort about the whole procedure, exacerbated rather than allayed by this attempt to analyse it. It is not so much about whether or not the system is unfair to individuals, which I concede as inevitable, but about the implied necessity of choosing the "best" candidate. If any one of 20 candidates could adequately handle the vacancy it is fair that our well-favoured area should face such an embargo of riches? The very able trainees we appoint would undoubtedly succeed even in less favourable surroundings, and the near-misses will get equally good jobs elsewhere. Meanwhile, of those who started with disadvantages and were the first to be rejected, most will not be the less complete their training eventually, albeit in less satisfactory posts and in less desirable areas with poorer facilities. It is this way to achieve the objective of raising the overall standard of general practice throughout Britain? It is a familiar situation, not confined to medical education. Might the day come when selection will proceed on the basis of which applicants have the greatest need of the excellent teaching facilities available in scheme X, and which applicants could contribute the most to raising the standard of the training group in the less exalted atmosphere of scheme Y?

away from the teaching hospitals, and how not everything of importance was to be found in text books and lectures.

Changes in the seventies

One of the many changes that took place in the seventies in general practice was that it moved into medical schools, and this soon started to upset the broad agreement. The aim of most students has probably not altered greatly, though the context of the attachment has changed for them. They take the presence of an academic department of general practice for granted, and can see the links between its teaching and that of the other departments through which they rotate. For them the journey into general practice is more like changing gear for a while than taking off into a new dimension, as it was for their predecessors. Nor have the general practitioners fundamentally changed their approach. For the same reasons that they always had, they take an immense amount of trouble over the students; and now they offer great loyalty to the departments whose activities they underwrite, though at times they may be a little confused about what is being asked of them on the basis of a framework of theory which still seems strange.

The big change is in the medical school—not necessarily because the schools as a whole have changed, but because responsibility for the attachments is now in the hands of

Thinking About the Unthinkable

Assault

FRANK WELLS

Any general practitioner has on his list a cross-section of the public as his patients. It is therefore likely that there will be a smattering of criminals, a few eccentric, one or two psychopaths, and a large majority of decent citizens who use the services the doctor provides quite reasonably. I believed that I knew a fair amount about the patients I recognised in these minority categories, but I realise now that no doctor can possibly know all the idiosyncrasies of any of his patients, let alone those he recognises could cause problems. However, there I was, working in Ipswich as a general practitioner, secure in the knowledge, as I thought, that nothing unpleasant ever happened to doctors in their surgeries—at least not in Suffolk. I had been a doctor there for years and had never had any trouble with aggressive patients, neither had my partners, nor indeed had any of the other doctors in the town. True, some patients could very occasionally be verbally aggressive, but I knew how to calm them down, and nobody had ever actually been physically violent.

December 1974 was a busy month. A flu epidemic had reached us earlier than we expected, and there was an oil shortage. As a doctor, however, I was having no problems with petrol, though a bit anxious about the central heating at home. The health centre was warm enough—that had gas central heating and well-fitting doors that kept each consulting room cosy. The sound-proofing the doors provided was good as well—almost too good as it turned out. It was my turn to do visits first, followed by the surgery, so we provided a rota for cover during the whole day by dividing up visits and consulting sessions between us, so the day in question must have been a Wednesday.

Hamlet Jones was an odd chap, he had first registered with me more than 18 months earlier, and his notes and the treatment with which he arrived confirmed a diagnosis of schizophrenia. He had attended the surgery on each of the following four days after his registration, and then once a month for nearly a year. Thereafter he had behaved in a mildly irrational but docile manner, frequently attending the surgery with trivial complaints. He came six times in each of the next two months, twice the following month, and then once a month for nearly a year, presumably because he was satisfied with himself. When he came again he told me that he had moved to Felixstowe, over 12 miles away, so I had to advise him to change doctors. He was very agitated and depressed at the time, however, and this advice made him worse. So I kept him on the list for a while, and with the help of the social workers, support from me, and the appropriate drug treatment he succeeded in getting back to work. That was in July, and until November he stayed in the same job—quite an achievement for him.

The next time he appeared in the surgery was to tell me how up he was that the council would not let him stay with his mother in Felixstowe; this was probably a cock-and-bull story,

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of famine for

but we next read in the local paper that Hamlet had recently assaulted two social security officers, so I was alerted to his history of aggression. Hamlet, however, had never been physically aggressive to me or anyone at the health centre, and his appearance that morning was nothing surprising. Hamlet had arrived while I was out visiting, but although appointments were full he knew he could wait and be fitted in. My partners left him to me because I knew him.

Four patients with appointments came first, and one of my partners had a chat with him in between two of them before he went out on his visits. I knew, however, that he was dealing with some papers in his consulting room before he set off. In came Hamlet, bright as a button, but calm and relaxed—or so I thought. "Have a seat," seemed a reasonable greeting to give him, but what followed was totally uncharacteristic.

I do not actually remember what happened next, but apparently Hamlet crashed his head against the top of my own desk, stunning me momentarily, and breaking my glasses. My partner, separated by two closed doors and two examination rooms, happened to come out of his room to set off on his visits, heard the kerfuffle, and came into my room. I was protecting myself from further head-battering by disappearing under the desk—or I may have fallen there, because I still do not remember any of the episode. Hamlet decided to destroy my watch and my coat while he was about it, my partner somehow alerted the receptionists, and police and ambulance men arrived without delay. Meanwhile, however, Hamlet made off.

I recall getting up off the floor, going into my own examination room to tidy up, but then putting out again, and can recall being in the accident and emergency department of the local hospital. I vividly remember having my picture taken by the hospital photographer, mainly because he was positioned

academic general practitioners. This new breed sends the students out with pride and with a real belief that they can learn something important, but it plays down the vocational aspect of the experience. The students have a proper part of undergraduate education because it offers a better opportunity than any other part of the curriculum for learning certain things that all doctors should know.

This change has, I think, created a degree of tension between the teaching practices and the academic departments. The view of the former might go something like this: "We are delighted that you exist because it's good for general practice that you do, and we know that you offer a tough time to your medical school. We will carry on helping you generously; we will put up with the peculiar arrangements that are forced on you and with those which your own objectives demand; we like having students—it keeps us on our toes and it's good for them to see how limited their horizons have been before they come. But please, don't get carried away by your theories and your educational objectives. That's what we wanted in the medical school for. Don't isolate yourself by moving to a position in which we can't recognise you."

The reply from the departments might be: "We hear what you say, and we know that we are absolutely dependent on you to do anything worth while at all. But you have to see that what you are saying undermines our reason for existing. We aren't here just to organise a better 'exposure'. We have to be able to show that our academic position is as valid as that of anyone else in the medical school; and that we have a distinct educational and research contribution which we can demonstrate and defend. We have to emphasise that there is a difference between training certain doctors to be general practitioners, and teaching all undergraduates about certain aspects of medicine by making use of your services. Vocational training has confused the issue because in some ways it is akin to 'exposure'; our aims for students are different and we won't feel comfortable until the difference is properly understood."

A great deal of good will and dependence conceals the tension between these points of view, but it exists and students are often aware of it. They tend to adapt to whoever they are with at the time, with reservations, and in any case they have their own personal objectives for the whole experience.

In the end the tension may be resolved by political rather than educational or professional action. Few schools now pay their teaching practices enough for the money to be of any consequence, but this may not continue indefinitely. With the need of the medical schools to save about the clinical and educational standards of their teaching practices, and with the example of adequate payment for vocational trainers already achieved, there is a strong case for the removal of financial support for teaching students, too. The argument is that financial support should come from the National Health Service, which provides resources for undergraduate teaching in hospitals. If general practices lose money by organising themselves to offer the necessary clinical facilities they should be reimbursed by the NHS for doing so.

The logic is impeccable, and in less difficult times it would probably have brought results fairly quickly. What the discussions proceed we should perhaps think where they lead, because there may be losses as well as gains. We may lose the enthusiastic amateur who looks on the extra work because he wanted to and modified his life rather than his practice. We stand to gain a new kind of professional teaching practice, different in some ways from other practices, keeping to defined standards and paid for doing so. With the numbers involved, the effects on general practice would be great. Teaching in general practice would follow general practice itself away from being a cottage industry.

Students in general practices

Because so many general practitioners take students now it

seemed a good idea to ask some of them to write about what they do and what they try to do with them. In the articles that follow this one, many differences of approach will become apparent, some of them will reflect the personalities of the authors and others the peculiarities of their practices; many will be due to variation in the tasks that are requested, and this is a complicated enough subject to warrant a word of explanation. The objectives of the many departments of general practice are pretty similar, even if they are worded differently. They relate to the ways in which the physical, psychological, and social aspects of the patient's situation affect each other and are in turn affected by his relationship with his doctor, to the kinds and stages of illness that are typical of general practice rather than of hospital practice; to the ways in which "first-contact" and continuing care modify the familiar sequence of history-taking, examination, and investigation; and to the various resources that are available to the general practitioner in his work. Where the departments diverge it is in the more mundane area of making arrangements for these objectives to be achieved.

Departments that send students out in more than one year of the curriculum may allocate different objectives to the different years. Those which, like my own, have only one period, may use more than one practice in the time and ask each to do something different. Some schools give only "intensive" teaching time, when the student has no concern other than general practice; some have only "extended" time—one day a week for several months, with a different focus for each day; and some offer both "intensive" and "extended" courses. Some attachments are residential and some are not; some departments allow comparatively more time for departmental teaching than others; and some practices take students very frequently while others have only two or three a year. All these factors make it impossible to generalise about what a school may ask of its teaching practices, and the time that is available is also determined by the willingness of any practice to operate within the constraints of what the department asks of it. This is the complicated background against which the forthcoming series is set.

Diary of Urban Marks: 1880-1949

Up to 12 years of age I had attended a Board School with my two older sisters. We paid twopenny weekly, and for that sum we were thoroughly grounded in the three Rs. Besides this, we obtained an elementary knowledge of physiology and anatomy and it was no doubt my interest in these which eventually shaped my career. The old Board Schools were the schools about the clinical and educational standards of their teaching practices, and with the example of adequate payment for vocational trainers already achieved, there is a strong case for the removal of financial support for teaching students, too. The argument is that financial support should come from the National Health Service, which provides resources for undergraduate teaching in hospitals. If general practices lose money by organising themselves to offer the necessary clinical facilities they should be reimbursed by the NHS for doing so.

In Leicester, to whom do we owe a scholarship. As I along with the other boys who had been similarly elected, knew no Latin we had to attend for four weeks to learn the language, giving up part of our summer holiday. It was a matter of some importance in the cemetery book by the Reverend James Went—the headmaster. When the school commenced term in September we were all put into the third lower form. But we were not to be deterred by the clever for the ordinary boy in this class. At the end of a month we migrated to the next form, and again in due course were promoted to the fourth. At the age of 16 I was in the sixth form, having in the meantime taken courses in science of which I was very fond. I also used to attend the night classes in science. I had obtained the certificates for elementary chemistry, physics, and biology, light, sound, heat, electricity, and magnetism at 15 years of age from the South Kensington Community Board. Later I obtained the advanced certificates.

directly above me as he took his shots, and because he was remarkably uncomplimentary about my appearance! Then I remember being in bed on the ward, and thereafter everything became clear.

Hamlet was caught, and the assault made banner headlines in the local paper that evening, though no one let me read anything for 24 hours. The nursing staff were firm but wonderfully sympathetic in the circumstances, a fact which I still cherish well. I certainly slept a lot during the succeeding 48 hours, something which surprised my consultant, who always gave me the impression, though he never said so, that I had overreacted to the attack. It was mainly the mood of it, I think, that made me so impression mired, although the care I had was of the highest standard. I was indeed shaken by the experience, and have never felt so unsteady and just plain groggy as I did for the first day after it happened. I had a persistent headache, too, about six weeks, even though two electroencephalograms and a skull x-ray were all normal. I was visibly bruised and contused, and could not sleep properly until new glasses arrived, courtesy of the optician who produced them literally within hours. At times of adversity you discover who are your friends, and the enormous number of visitors I actually received or who were apparently invited from outside the hospital, and indeed from my own family, was satisfying, out of all proportion to the relatively trivial injury I believe I had had. The early arrival of the vicar had genuinely caused me some concern, but he proved to be a great friend, not a prodigious one.

My partners had the difficult job of contacting my wife, who was visiting my daughters' school that day, as they wanted to break the news before she read the news vendors' headlines "Town Doctor Assaulted." They succeeded, and I will always be grateful to them for that, and for easing me gently back into

Diary of Urban Marks: 1880-1949

The sixth form contained many boys, and Mr Went decided to form three branches of it. One was for the ordinary individual who would eventually pass out into business, one to study languages, and the other to devote themselves to science. Each boy in the latter two branches would be taught—beyond—beyond—beyond their speciality either at the university or at the Royal Institution. I was not awarded a scholarship, but I was a member of the science class. The members of this class were taught advanced chemistry by Mr Hillard and advanced physics by Mr. . . . I had a persistent headache, too, about six weeks, even though two electroencephalograms and a skull x-ray were all normal. I was visibly bruised and contused, and could not sleep properly until new glasses arrived, courtesy of the optician who produced them literally within hours. At times of adversity you discover who are your friends, and the enormous number of visitors I actually received or who were apparently invited from outside the hospital, and indeed from my own family, was satisfying, out of all proportion to the relatively trivial injury I believe I had had. The early arrival of the vicar had genuinely caused me some concern, but he proved to be a great friend, not a prodigious one.

The dean said that Robinson knew no Latin nor Greek and he did not do so well on it. Was my dictum correct? With this end in view I asked for an interview with the dean. He invited me to breakfast on the following morning. After the meal was over, in answer to my question he informed me that as far as scholastic attainments went the scholarship should have been awarded to me. But Robinson, a redheaded boy from Leeds, had a reputation as an athlete, and the prize had been given to him with the hope that he would become a Blue.

full-time general practice after recuperating for two weeks. I was not allowed to drive for six weeks, and during the month of January that naturally threw a considerable burden either on my partners, my wife, my trainee, or my student. The support from my wife and family was invaluable, although when I was feeling almost back to normal my wife had great difficulty in preventing me from taking on a full work load; but she was right.

Hamlet was detained in Norwich Prison over Christmas while the police prepared their case, and he was eventually admitted to Rampton Hospital, whence he wrote me a letter; it was in fact a letter of apology but pointed out (erroneously) that I had prevented him from marrying his girlfriend, and that he might do it again in similar circumstances. He concluded that I was not to worry, because it could have been much worse. Indeed it could, but my experience of being assaulted has made me that much more sympathetic to those who are physically attacked than I might otherwise have been, and has given me a great deal of incentive, having found myself involved with the secretariat of the General Medical Services Committee, to ensure that everything possible is done to protect doctors against assault and to help those who have been assaulted.

There is a telephone code for emergency calls in each consulting room in the health centre now, and an emergency buzzer. Any patient known to be aggressive is seen with the consulting room door ajar. The receptionists alert all the doctors if they suspect trouble, and the police respond at once if they receive a day from the Insurances Division of the damage to property, and the premium has not been increased as a result of this attack. I learned a little of the art of self-defence just in case it was ever needed again, but thankfully the experience was never repeated. But I shall never forget the events before and after it, even though I shall never remember what actually happened.

prepared to pay for me in London. I consulted Mr Went and told him the facts. He tried to persuade me to continue trying for a scholarship, saying that my lack of athletics would be overlooked sooner or later. I may say here that the Wyggeston School never insisted on the pupil playing games. I never was interested in them, neither was I to the present day. I held a bar, kicked a football, or played golf or tennis. This may be unique, but I have always enjoyed good health. Like Joe Chamberlain I have never found it necessary to play games.

Mr Went could not placate me, and when he reminded me of the fact that I held a scholarship in the school and he thought that for the honour of the school I ought to proceed my rage knew no bounds. I had then turned 18, and I was anxious as to my future. I wanted to be something and shaping a career for myself. I firmly decided then and there to take the matriculation of London, and asked Mr Went to allow me to join the appropriate class. He absolutely refused, and so I told my father to speak to Mr Bishop—the English master—with a view to getting tuition in that subject. Bishop agreed so long as Went did not know. He used to give me one hour every day after school hours for 10 weeks. All the other subjects I knew. Luckily the January of 1899 when I sat for the examination in Leeds was optional on science or languages. At that time I knew enough science to obtain the BSc of London with honours. Consequently the paper was child's play to me, and in the result I obtained a first class.

I then saw Mr Went again and hearing the result he was extremely amiable. He agreed that I should commence turning botany and biology under the science masters of the time—Hillard and Goodchild having obtained mathematics. A flower or an animal was thrown at me and I was told to follow out the routine examination from a book on either subject. I tried this, but when I asked questions from the masters I was told that they had no time for me. Again I consulted Mr Went and told him that I had decided to go to St Mary's on 1 May. He argued, cajoled, and finally almost dared me to leave, saying that it was impossible for me to pass the Preliminary Science Examination—that is the first Mid-Oxford in London in July. He would not wish me good luck, and we parted in anger.