

# MEDICAL PRACTICE

---

## Contemporary Themes

---

### The Mackenzie report: General practice in the medical schools of the United Kingdom—1986

J G R HOWIE, D R HANNAY, J S K STEVENSON

*This is an edited version of The Mackenzie Report, which looks at the past, present, and future of academic general practice in Britain. The full report costs £3 and is available from Professor J G R Howie at the address below.*

It was not until 1957 that the first independent university department of general practice was created in Edinburgh, and the possibility that general practice might be more than simply a teaching facility for the medical school was thereby acknowledged. Other medical schools were slow to follow Edinburgh's lead, but, encouraged by the 1968 Todd report, first one and then another did so, and by the end of this academic year every medical school in the United Kingdom will have at least one general practitioner appointed to a university post with responsibility for teaching the discipline.

Departments and those who work in them have, and have had, difficulties in establishing the discipline in both practical and academic terms. These have been partly due to the very different expectations and needs of the two contrasting communities (medical schools and service general practice) that departments of general practice seek to serve.

This report describes some of the achievements of departments of general practice. It also discusses the difficulties that they have faced, and are facing, in establishing a proper platform for the evolution of general practice in the medical school setting. We hope that the report will allow discussions about the future of general

practice as a university discipline to be conducted against a more informed background than has been the case in the past.

In preparing the report the authors visited all 24 undergraduate departments of general practice in the United Kingdom and met full time and part time teachers. Additional information has been provided by heads of departments. The views expressed are those of the authors, but the draft manuscripts were widely circulated and many comments and suggestions have been incorporated.

#### Present position

##### STRUCTURE OF DEPARTMENTS

The first independent departments of general practice trace their links to the inner city practices that they inherited and developed in the early years of the National Health Service from 1948. Subsequent developments have reflected widely varying local university and clinical opportunities and needs.

Most of the arrangements made in early years have proved satisfactory in parts and unsatisfactory in others. The model in which a department has sole responsibility for running a practice has proved expensive to service clinically and has demanded a level of clinical commitment which has seriously compromised academic time. The contrasting model in which academic staff have part time commitments (formal or informal) to local service practices has generally been associated with good academic productivity. However, it represents a pattern of clinical commitment which is unfamiliar both to hospital clinical academic staff and to service general practitioners.

*Practice based departments*—This denotes a department which has the sole responsibility for running an NHS practice. (a) The five departments that were founded on the basis of attached practices are the most generously established in terms of numbers of staff employed. All are based on NHS practices of between 5000 and 10 000 patients. They serve either inner city areas or new housing developments, both settings where high clinical demand and social disadvantage normally combine to require a greater commitment of clinical time.

(b) Two further departments which did not have an attached practice initially have subsequently taken on sole responsibility for a list of patients which later became available. The process of change from one system to

---

#### Department of General Practice, University of Edinburgh

J G R HOWIE, MD, FRCGP, professor  
J S K STEVENSON, MB, FRCGP, senior lecturer

#### Department of General Practice, University of Glasgow

D R HANNAY, MD, MRCGP, senior research fellow

Correspondence to: Professor J G R Howie, Levinson House, 20 West Richmond St, Edinburgh EH8 9DX.

---

another has proved difficult. Problems have arisen in defining and providing the level of staffing necessary to guarantee continuous clinical cover and the simultaneous freedom to fulfil the proper range of activities expected of academic staff.

*Practice linked departments*—This refers to a department where the academic clinical staff undertake clinical work in NHS practices principally staffed by service general practitioners. (a) A number of departments have succeeded in negotiating formal NHS partnerships or associations with established general practices in their areas. Although the individual arrangements have (by necessity) sometimes been opportunistic, the closed formal clinical commitments that result make it easier to give priority to academic responsibilities. At the same time there is a constant need to provide a sufficient team of doctors with a principal commitment to the academic role, and to ensure that they work together sufficiently closely to develop a clear and purposeful academic identity. Those departments able to arrange that their clinical and academic roles are undertaken in one building clearly have an advantage, particularly when this building is also sited close to the teaching hospital or medical school. Four departments fall within this broad category.

(b) Two further departments have variants of what is described in the preceding paragraph in not having formal contracts with the NHS in relation to their clinical work. This creates an invidious and unacceptable position for the staff of those departments whose academic and clinical identities are thus not comparable with those of the colleagues with whom they work most closely.

*Part time departments*—A number of medical schools (almost entirely in London) have attempted to establish a department or unit of general practice by engaging a senior academic on a sessional basis, with the doctor concerned continuing to work as a partner and principal in his own practice. This model creates major conflicts in the allocation of time, not only between clinical and academic work but, more seriously, *within* the academic role. Initially regarded as a "better than nothing" option by medical schools and by those who accepted the challenge of the appointments offered, it is an option that does not seem likely to offer a second generation.

*New departments*—The University Grants Committee has recently provided "earmarked" money for new departments in two London schools and two elsewhere in England. Even now, no single model has emerged; London schools continue to have different local needs and responses but the two provincial schools are structuring their developments on the practice linked model, although with the academic staffing levels generally enjoyed by practice based departments.

#### STAFFING OF DEPARTMENTS

*Medically qualified*—At January 1986, 16 professors were in post, 31 doctors held full time senior lectureships, and 23 held full time lectureships. Some 150 doctors held sessional appointments within departments and outside their own practices. These part time appointments ranged from one to five sessions weekly and in combination approximated to 30 full time equivalent posts.

*Staff not medically qualified*—It is regrettable that only four departments employed academic staff who were not medically qualified. This represents an important limiting factor on the breadth of teaching and on the research insights available on a daily basis. In the longer term it also limits the potential for building the links between the medical and social science faculties that seem necessary for a full understanding of health and its problems.

*Teaching practices*—An essential part of general practice's teaching contribution to the undergraduate curriculum is the period of student attachment to service practices (supported in General Medical Council (GMC) recommendation 55). Each year departments in the United Kingdom have to find a four week attachment for nearly 4000 students and depend on the support of service practices to achieve this. In most schools a named teacher in each practice holds a post designated variously as part time lecturer, clinical teacher, or tutor. The commitment of such teachers ranges from responsibility for one to 10 attachments a year depending on local factors. About 2000 practices provide this essential service.

#### UNDERGRADUATE TEACHING

*Clinical content*—The central thrust of the undergraduate clinical teaching of departments of general practice is normally to senior students and in the form of practice attachments supported by tutorial teaching and prepared reading material. Part of the teaching involves introduction of students to the common and important illnesses of general practice which are troublesome in the short term but which usually do not threaten life and are rarely seen in hospital. A second part of teaching involves seeing the early and late stages of acute and progressive illnesses normally seen at particular stages of

their evolution in hospital. A third part involves helping students to gain a greater understanding of the complementary contributions of general practice and hospital medicine to the care of patients, particularly those with continuing health problems such as asthma, epilepsy, diabetes, and arthritis.

*Conceptual teaching*—Issues such as continuity of care, the individuality of patients, the consequences of ill health for families, the influence of social factors on perceptions of health and illness, and the contributions of other health and social agencies to patient care are part of the teaching of many clinical subjects. General practice, however, appears to be the setting in which students often find it easiest to appreciate what is meant by these concepts.

*Vocational teaching*—It is clearly right that all students should have an opportunity to see the work of general practice at first hand and under informed guidance. Teaching is positively planned to contribute to the general medical education of *all* students and not just the half who will later work in general practice.

*Communication and consultation*—Communication and interviewing skills are fundamental to all branches of clinical medicine, and general practice is an ideal setting for teaching them. In many departments these skills are emphasised in tutorial and videotape teaching sessions; in addition, many departments contribute to the teaching of introductory clinical method in association with departments of medicine and surgery, behavioural science, and psychiatry.

*Examinations*—In some schools general practice is now a final examination subject and in others general practice staff are final examiners.

#### POSTGRADUATE TEACHING

*Vocational training*—It is normal for university clinical departments to play a substantial role in postgraduate training and education in their disciplines. For historic reasons postgraduate education in general practice has been centred on the regional advisory network. Successive policy statements from the Royal College of General Practitioners have commented on the need for university departments to be actively involved in all aspects of vocational training for the discipline.

*Continuing education*—With some 30 000 general practitioners potentially seeking continuing education there is a substantial load on university staff in organising and participating in courses and workshops on various themes related to general practice activity. Although much of this is provided locally, many parts of the UK have no easy geographical links with a university, and the need for academic staff to be willing to contribute to professional development on a national basis applies as much to general practice as to any other clinical discipline.

*Innovations*—For preregistration house officers, two centres have constructed rotations for posts in general practice, in medicine, and in surgery. In another centre an attachment of an accident and emergency senior registrar to a department of general practice has provided a two month widening of his clinical experience. Schemes of this kind make possible the provision of general practice experience for intending hospital specialists (as encouraged in the General Medical Council's recent working paper on general professional training).

For more established doctors, in one postgraduate centre and two undergraduate centres, MSc courses have been established. These either use study leave to allow full time attendance for a year or are on a sessional basis over a longer period. Such courses are obviously important because they widen the academic skills of doctors working in full time practice, but they are demanding in both planning and teaching time. Until the long term uptake of this kind of opportunity can be gauged, it is difficult to be certain whether this facility should be concentrated in a few centres or developed more widely.

#### Research

It is difficult for commentators looking at general practice in the mid 1980s to appreciate that when the 1966 "Charter" for general practice was implemented the discipline was almost wholly uncharted in terms of its organisation, clinical content, and procedures. That there is now a body of publications that is substantial both in quantity and quality is due to the efforts of a relatively small number of researchers, many of whom have undertaken their investigative work within or under the aegis of university departments.

#### RANGE OF RESEARCH ACTIVITY

*Clinical research*—Early researches in several parts of the UK extended the original 1956 national morbidity studies and confirmed the range and

quantity of illness presented to general practitioners and their broad strategies of clinical management. Subsequent clinical research has continued at several levels.

*Operational research*—Given the quantity of existing knowledge about health and illness, it is well argued that an important component of research should now be on the implementation of knowledge. In organisational terms work is in hand to examine the structure of general practice, particularly the working conditions of general practitioners.

*Behavioural research*—Studies of the behaviour of patients are a necessary adjunct. General practice research is already attending to these difficult but essential areas which in turn relate to the whole topic of patient expectation and satisfaction.

*Educational research*—General practice has considered the issues of objectives and methods of education in greater depth than have most clinical disciplines.

Such is the sophistication of present day clinical science that it is unfair to expect a general practitioner to make an appreciable contribution to understanding aetiology, investigation, or treatment unless he is able to commit himself to an in depth study of his chosen field in addition to his generalist work. The belief that general practice is an ideal or appropriate place for drug trials is also open to challenge; without objectivity of assessment such studies become investigations of the determinants and implications of compliance rather than of the activity and effectiveness of the drugs under study.

The interface with social science provides a major challenge to general practice research. For many studies concerning concepts such as values and beliefs, relationships between doctors and patients, health and illness behaviour, and the costs and benefits of different strategies of providing care the necessary methods have still to be derived and validated. The academic medical community has to accept the necessity, relevance, and difficulty of this more subjective research idiom. It is disappointing how often the lure of the measurable, as against the important, is preferred.

At the same time as becoming concerned in exploring the technical challenges of his own research environment, the university general practitioner is often personally handicapped by the absence of a tradition of research in the basic training for his discipline. If adequately experienced clinically, he is likely to lack research expertise; if he has entered academic work early he may lack the necessary "feel" for identifying important topics and sensing weakness in existing methods and strategies.

A further difficulty is finding uninterrupted time for thinking, planning, and reading. Heavy teaching and clinical loads together with the diversity of extra duties which have to be shared round small numbers of staff all conspire to make research time the first casualty when, as is so common in university general practice, the day is simply too full to do everything that is required.

## Context

Academic general practice belongs to two institutions—universities and general medical practice—which are very different in style. The universities are hierarchical organisations, whereas general practice is strongly egalitarian; universities emphasise research and theory, whereas general practice has evolved from experience and instinct. In making its contribution to each of its institutions "university general practice" has to accept several natural disadvantages. It is a new part of both; it appears to question the assumptions of each; and in political competition in both settings it has yet to establish an effective lobby.

The difficulties of departments of general practice have in some measure been perpetuated by the reluctance to publicise and list the range of contributions to university and medical life that they and their individual members of staff make.

*Within universities*—The main contribution of departments of general practice lies within the medical school, with the teaching function dominant. Natural overlap of interests with other clinical departments spills over into joint teaching and joint research. The more general contribution to the committee work which shapes the balance of the curriculum and of the medical school image is, however, as important as the more obvious input. Where departments are sufficiently staffed they contribute to curriculum planning, to admission committee work, and to activities such as counselling of students with learning or personal difficulties.

*Within general practice*—Staff of departments of general practice contribute widely to the activities of the regional postgraduate general practice network and are substantially involved with local medical committees as well as the local and national activities of the Royal College of General Practitioners.

Given the uneven spread of universities throughout the UK, the level of local academic support is inevitably variable. It is, however, disappointing that the potentially invaluable supporting roles which local medical com-

mittees, college faculties, and university departments can offer each other are so inconsistently developed throughout the UK. Undoubtedly, this represents insecurity and uncertainty more often than positive intent and reflects longstanding and now rather outdated stereotyping of the activities of each.

*General*—Within medicine and society more generally the bridging and balancing contribution that academic general practice staff are particularly well qualified to make has resulted in their increasing involvement in the activities of area and regional NHS professional committees and in the work of the health departments, particularly in relation to research.

## Academic issues

### THE CLINICAL BASE

Staff in practice based departments have drawn some advantages from working within a clinical model which is familiar both in medical schools and to general practitioners. These have, however, to be counterbalanced by the need to cover direct round the clock access of patient to doctor, in contrast to the hospital model where patient access to senior academic staff is screened by nursing and at least two tiers of junior medical staff.

Staff in practice linked departments, however, enjoy substantial advantages in being able to give priority more consistently to academic activities. In addition, these activities are less likely to be put at risk by events such as holidays or illnesses or by epidemics in the community. On the other hand, experience thus far has been that the departments based on this model have not been given the complement of doctors with a principal commitment to the academic development of the discipline, which is desirable to ensure widely based innovation in research and teaching. Experience has also shown that departments based on this model are particularly vulnerable to having posts "frozen," especially when these posts are not linked to a secure clinical contract.

Despite continuing debates within and between departments employing different systems, a few statements are uncontroversial. Firstly, if a department is to have a practice the practice must employ enough doctors to ensure that it is an academic department with patients and not simply a practice with teachers. Demands for patient care vary regionally but in all settings they extend inexorably into academic time. Just as it is accepted that a doctor may be as busy looking after 2000 as 3000 patients, there is no simple way of calculating the list size that is compatible with fulfilling the expectations and requirements of an academic principalship. It is likely that a figure of below 1000 patients per doctor should be agreed within the profession. Secondly, a practice based department must be supported by sufficient nursing and clerical staff to ensure good care and to allow the opportunity to innovate. Thirdly, if a department is to be developed with linked local practices then all parties must commit themselves to work towards achieving preferred choices of academic and clinical balance. Fourthly, when a university decides to move from one model to another—a change which has often proved unexpectedly difficult—the principal reasons for making the change should be academic rather than economic.

### PERFORMANCE INDICATORS

A large organisation will wish to monitor the efficiency and the effectiveness of its component parts. Efficiency in teaching is assessed in terms of full time equivalent students taught per unit of resource of either staff or cost. A one hour lecture to 100 students is thus 10 times more "efficient" than a one hour group teaching session with 10 students. This system works in the interest of "lecturing" disciplines and against the interest of disciplines that teach at the bedside. General practice, which teaches in the consulting room where a one to one student-teacher ratio is usual, is thus maximally disadvantaged by this method of assessment. General practice clinical teaching is highly rated by students for interest, relevance, and presentation, partly because of its personal nature and partly because it is generally well prepared.

The issue of performance indicators in research terms is more controversial. The view that equates quality with grant money gained and publications in refereed journals has some superficial validity but is disappointingly simplistic. These indicators heavily favour high technology research fields.

General practice research abuts with that type of research only to a small extent. More of its effort is now in the disciplines of applied clinical research and operational research and at the interface between social and clinical science, which is full of interest and importance to a society that is increasingly questioning the place of medicine in the problems of daily living. In this last area of research methodologies have still to be developed that will allow the wants, needs, and expectations of patients to be matched to available resources and to the alternative styles of doctoring and caring.

It is again welcome that current University Grants Committee thinking on resource allocation for research recognises the importance of those difficulties of defining research "goodness," incorporating as it does an evaluative category of "judgment" alongside the performance indicators referred to above.

#### CAREER PATHWAYS

There is no satisfactory career structure for general practice—whether "academic" or "service." The following realities contribute to the problem:

(i) A trainee general practitioner on completing his training can enter a principalship without delay and earn around twice a lecturer's salary.

(ii) A trainee who moves to a lectureship will be appointed without either the academic or clinical experience which a lecturer in a hospital discipline will normally have acquired in registrar, research fellowship, or even senior registrar positions in his subject.

(iii) A doctor leaving a lectureship in general practice may find difficulty in gaining a partnership in a service practice; there is a persisting anxiety over taking on a partner with "academic" traits.

(iv) A doctor leaving a senior lectureship is largely restricted to applying for singlehanded advertised vacancies or to entering a partnership through an invitation from colleagues.

(v) A doctor applying for a lectureship after several years' experience of general practice will be ideally qualified for a lectureship in terms of clinical experience but is unlikely to be willing to accept a lecturer's salary.

(vi) A doctor applying for senior lectureship from general practice is now unlikely to meet the conventional and appropriate expectations that a senior clinical lecturer should have a higher research degree or equivalent published work, unless he has previously worked in a lectureship or other training academic post, or has unusual personal and academic credentials.

A potential solution to this "career pathway" problem may lie in the wider development of experimental one year research fellowships. Doctors would benefit individually whether they follow careers in "academic" or in "service" practice. The service side of general practice would benefit substantially from a cadre of principals with one or more years of academic experience. In much the same way academic general practice depends for its future on its lecturers and senior appointees having an adequate experience of service general practice. Such an arrangement would allow progress from traineeship to senior registrar/research fellow, from which a wider range of options (equivalent to those in hospital disciplines) would remain open. As well as broadening the background of candidates for university posts, it would open the way to bridging the gap which regrettably persists between university general practice and the regional advisory network. It would also strengthen the basic training of those service general practitioners who wish to teach (undergraduate) and to train (postgraduate).

#### CRITICAL MASS

The fourth area in which further thinking is needed concerns the minimum size of an academic department, the mix of disciplines to be represented, and the desirability of having formal links with other departments—all topics which will become increasingly relevant if funding continues to fall. A minimum of four tenured medical staff seems essential, and the addition of one or two social scientists and at least one research fellow appears to be desirable. A research nurse, possibly with a clinical contract, would add a valuable dimension. A department of four to eight academic staff offers genuine academic viability and the opportunity to develop interdisciplinary as well as interdepartmental links.

#### TEACHING PRACTICES

An attached student adds some two hours in a day to the work of a teaching practice. In practices that take more than occasional students the commitment to undergraduate teaching often precludes other sessional (remunerative) work; it also reflects a substantial willingness to help in the education of medical students.

#### Funding

The opportunist way in which structure and staffing levels were originally determined and funding acquired may have been acceptable in times of economic growth and, indeed, was often the only practical alternative to no development at all. The limitations of this approach to planning have, however, become increasingly evident. The absence of agreed principles or formulas for determining appropriate levels of funding is a great problem. Indeed, this now represents the most serious single

handicap to the proper maturing of general practice as a university discipline.

#### THE PRESENT

Wide differences presently exist in the cost of university departments of general practice and in how they are funded. Some of these differences reflect the fact that practice based departments earn money for the care of patients registered with them; at the same time they cost more because of the need to administer the patient care given. It goes without saying that the cost of departments also reflects the number of staff who have been appointed to them. Some medical schools invested money in departments when this was being encouraged by the University Grants Committee and the General Medical Council; some have recently been given "earmarked" money from the University Grants Committee. Others have been supported in large or in small measure by commerce, by charitable trusts, or by the pharmaceutical industry. Different local arrangements with family practitioner committees have maximised permitted levels of reimbursement for patient care, and other arrangements have allowed indirect health service financing of activities which support academic work. Regrettably, in some areas general practice teaching has received only minimal support from any of these sources.

In recent years there has been an understandable pressure to base university funding on a per student unit-cost basis which would logically become consistent for faculties of medicine wherever situated and for individual disciplines within faculties. Inevitably, this kind of basis for funding can only be approached slowly and recent University Grants Committee reports on resource allocation separate "teaching," "research," and "special factors." This is a helpful concept for general practice.

No discussion of the basis for funding faculties of medicine can proceed without looking simultaneously at the funding of teaching hospitals by the NHS. For this discussion one full time equivalent (FTE) clinical student refers to the equivalent of one student undergoing clinical teaching for one year on a full time basis.

At present:

(i) The University Grants Committee "cost" of one FTE clinical medical student is £6500 a year.

(ii) The NHS contribution to clinical student teaching, assessed using the SIFT (service increment for teaching) formula in England and Wales (the equivalent in Scotland is ACT—additional cost of teaching), is now at least £20000 per FTE student a year. This sum is a projection from the post hoc rationalisation of the differences in the 1975 costs of "teaching" and "district" hospitals which were identified in the Resource Allocation Working Party report of the DHSS published in 1976. In part this sum supports the "higher level of medical and nurse staffing" enjoyed by teaching hospitals and the clinical departments based in them. Some of this increased funding represents staff at training grade levels and some represents higher levels of staffing by consultants whose contracts are intended to include teaching time.

It is a historical, if illogical, reality that there is no equivalent NHS support system available for undergraduate general practice teaching. In addition, because the SIFT/ACT money represents established and already allocated money, it is not readily available for redistribution and it appears to be legally impossible to make NHS support available to general practice departments by a mechanism comparable to SIFT/ACT.

Consequently a hospital clinical department can expect to receive, for each full time student that it teaches, a sum of about £6500 from the University Grants Committee, plus support from the NHS (through SIFT) for higher staffing levels—costable at an unspecified part of at least £20000 a year. In contrast, general practice departments have to base their budgeting for academic purposes solely on unsupplemented UGC allocations.

Basic NHS patient care income from the NHS thus contributes partially but usefully to the cost of the academic and ancillary staff manning a "university" general practice. But with smaller than average list sizes per doctor an important gap is left between salaries paid to senior clinical academic staff and income derived from clinical work. This gap widens as list size per doctor falls and practice overheads increase.

NHS regulations offer little scope for discretionary help to university practices. The only concession available is to pay full "basic practice allowance" (an element providing around one third of net remuneration) for 1000 patients per academic doctor as against the 1500 or so operating de facto in normal service practices.

#### TARGET FUNDING

Any workable formula has to be able to accommodate: (i) the variations in university department structure which will necessarily persist for the immediate future—for example, the practice based and practice linked

options; (ii) the calculation of a realistic patient load for doctors working in practice based departments (demand per patient varies substantially both between and within cities); (iii) the desirability of supporting an academic training grade; (iv) a level of "overhead" funding for the administration of an attached practice which is compatible with the development of forward thinking systems for delivery of patient care; (v) the need for reasonable remuneration of service general practitioners who undertake attachment teaching of students in their own practices.

Whether target list sizes in practice based departments should be half the area average (or lower, allowing for the reality that clinical work expands if time is available for it) needs further discussion. Where an existing practice is larger than target additional clinical staff may have to be employed, perhaps working exclusively in patient care.

Estimation and provision of a proper remuneration of part time academic staff teaching students in their own practices has been a longstanding need. Although it is difficult to generalise, part time general practitioner teachers are commonly requested to provide one four week attachment for each senior student in the school concerned. It is difficult to value or to cost attachment teaching, but the presence of a student will add about two hours to the day's work of a teaching practice. At that level a four week attachment might equate to 40 hours teaching. At £10 an hour this equals £100 a week. This would be equivalent to around £4000 for a 40 week teaching year, similar to the present postgraduate training fee.

#### COSTING

A department teaching a four week course to 150 students undertakes 600 weeks of teaching, which equals 15 FTEs a year. Additional teaching activities are likely to bring the figure to around 20 FTEs per department a year. There are various ways of costing the package outlined in the previous paragraph. A target annual budget in the order of £400 000 per department seems a reasonable basis to work from. This sum equates with a figure of £20 000 per FTE student taught—around three times the UGC FTE clinical student allowance, but probably still much less than the de facto UGC+SIFT/NHS resources available to hospital clinical departments.

#### IMPLEMENTATION

Approximately one third of the money as costed above is already provided within the university block grant although it is not always made available to fund the teaching that is being done. About half the remainder can be earned from NHS patient care carried out in a typically sized practice based department. (Practice linked departments will cost less because of lower overheads.)

The remaining element equates with the SIFT/NHS analogue and the committee of heads of departments of general practice have attempted to raise this money from the Department of Health and Social Security/Scottish Home and Health Department. Support in principle for an NHS contribution being made has been expressed but no legally acceptable mechanism for its implementation has been identified.

It appears that one feasible, and so far unexplored, way of channelling NHS money to departments of general practice might be through redefinition of the level of, or conditions relating to, the "basic practice allowance" elements of remuneration as in paragraph 12 of the Statement of Fees and Allowances payable to general medical practitioners.

Different levels could be set (i) for doctors in full time academic posts with principal status in practice based university departments, (ii) for academic staff holding principal status and working in linked practices, and (iii) for doctors working as full time NHS principals and taking students on attachment. Limits would need to be set on how many posts could be recognised in each category, but these are predictable in terms, on the one hand, of the number of departments of general practice which exist and, on the other hand, in terms of the number of students in medical schools. Continuing with the outline estimates discussed above, it appears that the money required to compensate for the absence of a SIFT analogue would be unlikely to exceed £4m.

Implementation of such a proposal would require the support of the General Medical Services Committee and would imply the overall acceptance by the general practice community of two main principles: firstly, the desirability that there should be adequately funded departments of general practice in medical schools, and, secondly, that practices that accept medical students on attachment should be properly supported for doing so.

## Lesson of the Week

### Os subtibiale mistaken for a recent fracture

ANTHONY CORAL

There are a large number of accessory bones in the foot and ankle. They may be mistaken for fractures if their characteristic location, and usually smooth outline, is not recognised.<sup>1</sup> The os subtibiale is an uncommon accessory bone that occurs immediately distal to the medial malleolus. I report an unusually large example of this bone that was mistaken for a fracture.

#### Case report

A 38 year old Spaniard presented with a one day history of pain and swelling over the medial malleolus after a "twisting" injury to the left foot. There was no other medical or surgical history. Examination showed that the man was nervous and had a tender swelling and bruising over the medial aspect of the ankle. The initial radiograph (figure) showed a smooth, rounded bone, 1.5 cm in diameter, at the posteroinferior aspect of the medial

**Determining the sites and appearances of the accessory bones in the feet and ankles is important; failure to recognise them may lead to unnecessary fixation and immobilisation**

malleolus. He was taken to theatre, where a curved incision was made over the medial malleolus. No haematoma resulting from fracture was seen, which was interpreted as indicating that the "fracture" was an old one. The bone was reduced with difficulty using two K wires and a tension band because it would not take a screw. The inadequate reduction was evident during fluoroscopy. The patient made a good recovery. The initial films were returned for reporting when postoperative films were obtained (figure).

#### Discussion

Accessory bones occur frequently in the foot and ankle. They are usually asymptomatic. The os subtibiale is an uncommon accessory

St Mary's Hospital, London W2 1NY

ANTHONY CORAL, MB, MRCP, registrar in radiology