personally or a practice team member. However, it is unlikely that any other member of the existing primary health care team will have the time to take on this work. Practice nurses will be busy not only with the routine work of dressings, injections and venepuncture but also with the health promotion sessions and registration checks required under the terms of the new contract. District nurses are fully occupied dealing with the minority of elderly patients requiring regular nursing care, while most health visitors can only just manage to fulfil their requirements for visiting children without having to take on a new caseload from the other end of the age spectrum. Thus, it seems possible that the job will either not get done at all or will be carried out in a piecemeal and inconsistent fashion.

Given the constraints on general practitioners and their existing staff, provision should be made for additional manpower to ensure that the surveillance programme is carried out properly. Previous studies have shown that non-professional staff can successfully perform the assessments after appropriate training and that such 'link workers' could probably be recruited from the same pool as home helps and nursing auxiliaries, attracting a similar salary.[10,13] Working full time, each link worker should be able to complete at least two new home assessments each day, making a total caseload for annual surveillance of around 300–500 patients. This would be sufficient to satisfy the requirements of a group practice with a total list size of 10 000–12 000 patients. Link workers could be allocated to smaller practices on a sessional basis with appropriate provision for reimbursement. As family practitioner committees face cash limited budgets and increasing pressure to limit the allocation of ancillary staff to practices, the prospect of employing a new team member may not at first sight seem very attractive. Nonetheless, they should consider it seriously, for by so doing they will not only help general practitioners to satisfy the terms of the new contract, but will also have a golden opportunity to provide health authorities and social services departments with the information on needs in the community which family practitioner committees are required by government to collect.[14,15] This policy is being pursued by at least one family practitioner committee, which as part of a larger elderly people's integrated care scheme involving a social services department, a district health authority and the Helen Hamlyn Foundation, is facilitating the establishment of an agency to employ link workers on behalf of general practitioners (North Kensington Elderly People's Integrated Care Scheme: a service overview. Royal Borough of Kensington and Chelsea, 1990). Other family practitioner committees seem likely to follow suit.

In addition to manpower, materials will also have to be provided. At the very least, these should include the necessary data recording forms, but ideally checklists and standardized structured interview schedules should be supplied. At present there are no accepted standards and these will have to be selected, piloted and evaluated in a number of settings before being made more generally available through appropriate bodies. There should also be provision of training in how to carry out the screening programme, including call/recall systems and the appropriate use of the instruments and record forms.

The only way to resolve the uncertainties about the value of the requirement to carry out annual assessment of elderly people will be to ensure that there is a comprehensive evaluation programme based in a variety of settings. This too will require substantial resources and those responsible for advising government about the future development of general practice should ensure that these are provided. In the meantime, there can be little doubt that unless personnel, materials and training are made generally available to primary health care teams, the scheme risks not only imposing a large and unjustified burden on general practice but also failing to benefit the very people for whom it has been designed.

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Academic departments of general practice at the crossroads?

At a time when academic departments of general practice are entering a new era of importance in education and success in research, there is growing concern about the survival and development of the discipline. The problems centre around a haphazard career structure and inadequate financial resources for the expansion or indeed the continued existence of the departments within medical schools. In 1986 the Mackenzie report,[1] prepared by three senior academic general practitioners, summarized the state of the discipline and emphasized some of its inherent problems. Many of these problems are unique to this discipline, as emphasized by both the Academic Medicine Group[2] and the government.[3]

The attractions of full-time academic general practice are threefold: first, the opportunity for teaching within the undergraduate medical curriculum and for postgraduate teaching; secondly, the facilities for carrying out research into primary health care; thirdly, the time and opportunity for innovation and experimentation in clinical practice with some of the profession's creative thinkers.

The balance between these three components to the academic role — teaching, research and clinical practice — and the relative importance of each, are difficult for academic general practice to determine because its task is not defined and this reflects the nebulous nature of general practice itself.

Problems multiply because of considerable differences between academic and service general practice. Academic general practitioners often feel that they need to be active clinicians to have credibility. This is particularly true for new lecturers with no previous experience as a principal. Academic practices tend to be in inner city areas, and trying to maintain a high standard of care adds to the burden of workload. Conflict may appear if different standards of care seem to apply between academic and service practitioners, for example better access to services for academic practitioners.

Career grades are achieved early on in service practice, with all principals being equal, at least in theory. Most academic departments, however, are hierarchical, from lecturer up to professor, with little security of tenure at the lowest level. There are considerable financial disparities both among academics and between academics and their contemporaries in service practice. Is this why there are 10 applicants for a lecturer's post, compared with 65–100 for some service vacancies?

We, as lecturers, do not feel radically different to our service colleagues, but maybe we are. We certainly feel as pressured for time and have as wide ranging commitments. We are not as independent, however.

Having become a lecturer it is often difficult to adjust to the new responsibilities of university work. Many departments are small and do not have the 'critical mass' of staff and resources which enables junior staff to receive an adequate introduction to teaching and research. Job definitions for junior staff are rare. This lack of training in both teaching and research (especially the latter) is the first major problem for the new academic general practitioner. The 'see one, do one, teach one' philosophy of clinical medicine, often becomes 'think about it, teach it, research it', often with unspectacular results and feelings of isolation. New lecturers have to learn the art, craft and science of general practice simultaneously.

Success in universities means research output with quality more important than quantity. This presents great conflicts for all academic staff since the demands of the clinical commitment (the patients are always there) and of the teaching workload (the students are always there) seem more absolute. When new to the post or when feeling stressed we are likely to retreat to what we have been trained to do, that is the clinical work, or what we can muddle through, that is the teaching. Good research in primary health care includes sound sociologically based questioning as well as evaluation of a scientific hypothesis. This requires specific skills for which further training or collaborative work is required.[4]

How relevant is research in general practice to our service colleagues? General practitioners receive little training in research and audit as undergraduates or during vocational training. The climate for valuing research in general practice is poor and consequently general practitioners feel threatened and become defensive about research and audit.

The hierarchical nature of the university departments of general practice means that assessment of its staff is necessary, especially for them to move upwards. It is difficult to set up criteria for assessment when the posts have no aims and no real definition exists for the discipline. By default we slavishly follow the hospital specialties and adopt research output and the achievement of higher degrees as the sole criteria.

The MRCGP qualification was originally designed to be taken by new or experienced principals with a view to improving standards among those established in practice. That approach has failed now that the MRCGP is seen as the prerequisite for the newly trained general practitioner to obtain a job. Similarly, is a PhD or MD necessary for a career in teaching undergraduates or in research? This higher 'degreeism' could isolate academic general practitioners further from the reality of the discipline, alienating them from service colleagues. If the default assessment, that is research output, is adopted then of what value is teaching or clinical initiative?

What will happen to those academics who cannot achieve success in research? Many junior staff have no aspirations to be a professor, but would feel that their time in academic practice has enriched their own skills and has enriched general practice itself. Their chances of returning to service practice may be impaired. Practices may be wary about taking on ex-academics: 'Can they cope with the workload of the real world?' 'Will they threaten us with their bright ideas?'

If some academics cannot move out into service practice they may leave general practice, to the detriment of the discipline, or they may remain in post too long, to the detriment of themselves and their department.

In order to improve the whole discipline of general practice, a close relationship needs to develop and continue between academic and service practice. Myths and suspicions[5] need to be confounded to enable exchange of people, ideas, teaching and support between the two.

Protected time is much needed by all general practitioners involved in educational, audit, research and health service activities. This is fundamental to the structure of academic departments whose full-time staff are also general practitioner principals, yet is wholly ignored by the government in the new contract.

The Mackenzie report[1] proposed that assessment should be based on the concept of 'rigorous thinking' as evidence of 'scholarship' and should include many of the contributions, other than research, that departmental members might make.

Clear aims and objectives need to be set for academic staff, particularly those at early stages of their careers. Their training needs must be addressed, particularly in the area of research.

Most important of all, academics must emphasize that they are not in ivory towers but in an exciting and stimulating branch of general practice that wants to listen to the needs of service practitioners, share support, inject enthusiasm and demonstrate some of the immense potential of primary health care.

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