guidelines to reduce the need for hospital attendance. It would have been interesting to apply these guidelines prospectively as there would appear to be intrinsic difficulties in the suggested protocol.

The main difficulty would be in obtaining the information necessary to apply the guidelines. This is demonstrated by the data presented; epileptic patients are unlikely to carry any information about themselves and, as half the fits occurred outside the home and less than half the cases had transport arranged by relatives, there may be no one to speak for them. Elderly epileptic patients are likely to live alone and even a well-meaning neighbour, who might call an ambulance, could not be expected to have the information required. Finally, patients who are having a fit, or are even post-ictal may not be able to cooperate.

Drs Hunt and Touquet have formulated an idea for the better management of epileptic patients. It would appear that the most crucial improvement would be for all epileptic patients to carry up-to-date and detailed information about their condition.

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Teams for tomorrow

Sir,

Dr Brook's article (June *Journal,* p.285) says nothing new, and those of us who have a continuing interest in primary health care have continually tried to draw attention to the failure of the present system.

It is obvious that no one profession can cope alone and I have stated that there must be a new approach to primary health care.[1] I have advocated a system in which there is complete surveillance of every household in each community provided by three new categories of members of the primary health care team, supported by the general practitioner. The new categories proposed are clinical associate, community nurse and nursing aide, each with well-defined training programmes and roles.[2]

I have also addressed the question of team work in primary health care.[3] It is essential that all the professional members of the team are equal, but the doctor must assume overall responsibility for that is his legal brief. Professional equality allows ideas to be proferred, discussed and rejected or accepted on merit. However, is it of any value talking about a primary health team when the goals of primary health care have not been clearly defined?

Dr Brooks has failed to address the financial implications of the present primary health care system, and of any proposed changes to it. After consideration, I have come to the conclusion that where cost-benefit and cost-efficiency are of prime importance the basic services of primary health care are potentially better provided by suitably trained paramedical staff.[4]

I have recently been in general practice in Alva, Clackmannanshire and I have no doubt where a caring, cost-effective, all-embracing, comprehensive primary health care system lies in the future — certainly not with the general practitioner, as at present.

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Ethical guidelines for sick doctors

Sir,

It became apparent at a recent post-graduate meeting on ethical problems in general practice that family doctors of all ages experience great difficulties in coping with the problems posed by illness within their family or their partnership. A wide range of views also exists regarding self-diagnosis and -treatment.

No one present was aware of any guidelines, either from the College or elsewhere, on ethical behaviour in such circumstances. We believe that such guidelines would provide a framework within which better care for sick doctors and their families could be provided. Our recommended guidelines are as follows:

1. Doctors should be registered with a general practitioner who should not, except in exceptional circumstances, be a partner.
2. Doctors' families should be similarly registered.
3. Doctors should not refer themselves directly to a consultant for an opinion except in circumstances where any other patient would do so, for example venereology clinics or family planning clinics.
4. Doctors should be wary of self-diagnosis and should not initiate treatment with 'prescription only' medications, including antibiotics, for themselves or their families.
5. In general, sick doctors should act as model patients. Any special consideration shown by colleagues caring for them should be regarded as a privilege and not as a right.

These recommendations should not be regarded as comprehensive or restrictive. They are intended to help those who choose to care for sick colleagues to provide the same high standard of medical care we would wish our other patients to receive. We would urge family practitioner committees to forbid the registration of a principal on his or her own list of patients.

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Caritas, quality and general practice

Sir,

Primary health care — an agenda for discussion,[1] the Government's green paper, raises major clinical, educational and political issues. The faculties are discussing this document to enable the College to make an informed contribution towards the Government debate.

However, the document asks more questions than it answers; what constitutes good practice is still uncertain, although a good practice allowance is now being talked about. The College has considered quality in general practice in detail. Indeed the recent policy statement[2] raises many of the same issues as the Government's green paper. The policy statement is an excellent discussion about quality in primary care and its importance, and follows on naturally from the College's consultation document