(professional and personal), than have them dissatisfied and underperforming or leaving.[1,2] A different way of working means being motivated, rather than stressed, while being able to use lifelong experiences and learn from each other. It would be good to organise domestic General Practitioners with Special Interests (GPwSI) schemes,[3] with GPs enjoying developing their clinical expertise and able to help build a more integrated health service.

Clinical expertise, however, is not the only aspect of general practice; involvement in teaching and management, or simply having less involvement as doctor, *per se*, could greatly raise standards of care. We need protected non-contact time within the working week to stimulate clearly defined roles, responsibilities, and terms of service.

Teaching, research, and management have to be relevant career options, whose status and conditions should receive strong consideration and the same payment in workforce planning and skill utilisation. At present, it seems there is good payment for special clinical interests, but poor payment for academic roles.[4] Changing this is important to counteract the burnout and frustration that is mainly visible in GPs more involved in these activities, and to fulfil the new definition of general practice and GPs.[5,6]

It is really strange that some health ministries in some European countries (as is the case in the one for which I'm now working) are still not applying the European directives on flexibility in the workplace. This concerns a flexible career option as well as reduced normal clinical time when involved in teaching, research, and management. As discussed at EURACT Council when preparing the Educational Agenda (J Heijerman, WONCA Europe Regional Conference, Amsterdam, 2 June 2004), this lack of flexibility is clearly a real barrier to working differently, in different fields, and being able to work well.

Roger Jones[7] wrote about seeing a much bolder attempt to endorse the 'mixed portfolio' approach to general practice, in which patient care is combined with other non-clinical activities. I also think that it would introduce a 'wedge-shaped' commitment with substantial work in early years, tapering to a considerably reduced 'working' commitment in more senior doctors.[8] This would be a chance to reinvent general practice as an attractive career with a progressive career structure.

Flexibility has to suit different stages of life. To permit not having to work absurdly when your forces or your mind are 'rebelling' and, at the same time, allowing doctors more options, could help persuade doctors not to leave the profession for a long while yet.

FRANCESCO CARELLI

Contract Professor
University of Milan, Milan, Italy.
E-mail: carfra@tin.it

1. National Health Service advertisement. No rush to retire for busy GP. *Br J Gen Pract* 2003; **53:** 683.
2. Howe A, Baker M, Field S, Pringle M. Special non-clinical interests — GPs in education, research, and management. *Br J Gen Pract* 2003; **53:** 438-440.
3. Nocon A, Leese B. The role of UK general practitioners with special clinical interests: implications for policy and service delivery. *Br J Gen Pract* 2004; **54:** 50-56.
4. Howe A, carter Y. A young life sadly blighted — the future for clinical academic careers in general practice. *Br J Gen Pract* 2003; **53:** 424-425.
5. Carelli F. New GP contract and European definition. [letter] *Br J Gen Pract* 2003; **53:** 61.
6. Richards TD. New GP contract and European definition. *Br J Gen Pract* 2003, **53:** 155-156.
7. Jones R. The new contract — worth voting for? [Viewpoint 2] *Br J Gen Pract* 2002; **52:** 602-603.
8. Carelli F. New contract and career development. *Br J Gen Pract* 2002; **52:** 765.

Royal Medical Benevolent Fund Christmas Appeal 2004

Another year has passed and, as the festive season approaches, I again write to ask you to consider making a donation to this year's Christmas Appeal.

The Royal Medical Benevolent Fund (RMBF) exists solely to support our colleagues and their dependents who have fallen on hard times. Tragedy can strike unexpectedly and, all too often, does — not least to younger members of the profession and their families. Examples of such unexpected ill-fortune can be found on our website: www.rmbf.org.

For well over 100 years the RMBF has been there to help in times of need; never is that need more evident that at Christmas. A seasonal gift can transform a rather cheerless Christmas into a very happy one, and this is especially true when children are involved.

There was a magnificent response to my appeal last year — over £90 000 — and I very much hope that colleagues and their families will contribute handsomely once again. I ask you to give generously and, on behalf of all those we help. I send my warmest thanks to everyone who gives to the Fund and wish you all a very happy Christmas.

Contributions may be sent to: Christmas Appeal, RMBF, 24 King's Road, Wimbledon, London SW19 8QN, or to the Treasurer of your local Guild of this Fund. Thank you.

SIR BARRY JACKSON

President
Royal Medical Benevolent Fund,
24 King's Road, London SW19 8QN.

Correction

Byng R, Jones R, Lesse M *et al*. Exploratory cluster randomised controlled trial of shared care development for long-term mental illness. *Br J Gen Pract* 2004; **54:** 259-266. Some of the information in Table 3, *Differences between global scores for health and care derived from note audits and questionnaires: intervention versus control,* was transposed. The correct excerpt is shown below; the correct version of the entire table is available online at http://www.rcgp.org.uk/journal.

	Mean at baseline	Mean at follow-up
Outcomes from note audit (n = 304)		
Severity of illness (4-point scale)		
Intervention	2.53	2.34
Control	2.56	2.46
Number of relapses		
Intervention	0.56	0.39
Control	0.66	0.71
Total score for 'process of care' (observed range of 0–24)		
Intervention	7.04	5.69
Control	7.30	6.40