Letters

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Backing Bush

Why should readers of the *BJGP* be subjected to your and your contributors' glib views on the recent US presidential election?[1,2,3] At least one of your readers is happy that Bush was re-elected. Kerry voted against the 1991 war against Iraq. Had he been in power then, we would have faced a Saddam in charge of a 'greater' Iraq enriched by Kuwait's oil wealth. He was often ambivalent in his support for the war on terror, managing to portray himself as being both against it and critical of it not being fought with more vigour.

In Bush we have that rare thing, a politician who says what he means and does what he says. I am grateful for his, and Blair's, resolve to overthrow Saddam's regime. I don't mind you disagreeing with me. I do mind the cosy assumption of so much of the media that the re-election of Bush is 'perplexing' and that only an idiot could support him.

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2. Frey J. Book Review. *Br J Gen Pract* 2004; **54**: 966–967.
3. Goodman N. A book and a Bush. *Br J Gen Pract* 2004; **54**: 969.

GPs on the move

Ballard, Robinson and Laurence[1] uncover some interesting factors that have made French GPs relocate to practice in London. As an English GP who moved from her London practice 4 years ago, I was particularly interested to see if I had any motives in common with those found in the study. I was unsurprised to see that personal factors remained the main driving force for the migration of these French GPs. This was also my main motivating force, as well as the issues that face GPs in the UK in the inner city. Furthermore, I currently work as a university faculty GP, in a teaching practice in innercity Hamilton, Ontario, Canada, where I see many doctors who have also migrated from their countries of origin. This population has moved for personal reasons also, but their stories tend to be that of persecution or hardship in their country of origin, and a desire to migrate to a better economic future for themselves and their families. Another factor pertinent to Canada, is that many Canadian-trained doctors also migrate, mainly to the US. It seems that the impetus for the migration of these doctors would mainly be financial — in the US the remuneration for GPs is very handsome indeed compared to the Canadian system.

I think that a follow-up study to address the issues of migrating GPs should look at why GPs specifically choose to leave the UK. Literature that exists in this area consists of a survey from 1990–1994[2] that concluded that areas with a high deprivation rate and with high needs had higher than average exodus rates of GPs (for example 7.8% in Kensington, Chelsea and Westminster). A more recent study of a qualitative nature might help to address the concerns of the GP recruitment and retention crisis that are highlighted by the authors in their introduction. After all, shouldn't we be trying to find out why GPs want to leave their places of professional origin, rather than finding out why other GPs want to come to the UK?

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1 Ballard KD, Robinson SI, Laurence PB. Why do general practitioners from France choose to work in London Practices? A qualitative study. *Br J Gen Pract* 2004; **54**, 747–752.
2 Taylor DH Jr, Leese B. General practitioner turnover and migration in England 1990–94. *Br J Gen Pract* 1998; **48**: 1070–1072.

Dirty magazines

I read with great interest Dr Charnock's[1] paper about bacterial contamination of waiting room magazines. I wonder whether he made any attempt to differentiate between titles? Were there similar numbers of bacteria on *Readers Digest* as *The Field*? Is *Cosmopolitan* as dirty as *Good Housekeeping*?

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1. Charnock C. Swabbing of waiting room magazines reveals only low levels of bacterial contamination. *Br J Gen Pract* 2005; **55**; 37–39.

The act of communicating

I read the discussion paper on communication skills by Professor Skelton with interest.[1] Having been involved in the teaching of communication skills to medical students and GP registrars for some years I feel that the paper raised interesting issues about the subject and its future. Traditionally the model of medical expertise used to design teaching (and assessments) considered the three domains of knowledge, skills and attitudes. A fourth domain of problem-solving skills was later added. In this model, communication and consultation