improving and that communication is best learnt through observation in clinical situations.

If the role models that medical students and junior doctors are observing are poor communicators how do we expect these learners to improve? I agree that observation and reflection is an important part of the experiential learning process, as is practising skills. But we know that in clinical situation learners vary rarely receive feedback to help them reflect and improve. Therefore communication needs to be introduced before the students first talk to real patients (theoretical knowledge plus work with simulated patients) and followed up by observation with debriefing so that they can begin to distinguish the good from the poor.

The other problem is that senior medical students and junior doctors rarely discuss management plans with patients; when the latter do they are rarely observed and they learn this important process through trial and error, as well as the memory of how their senior colleagues have performed. The apprenticeship model is all well and good if the tutor is all of the following: a fine communicator, an excellent clinician and a good teacher.

Modern experiential communication skills training does not degrade what is profound in medical practice. It must be continued into clinical settings and refined with practice. Dr Fitzpatrick writes that doctor-patient communication relies on 'establishing a degree of empathy and trust', yet he has previously disparaged the concept of the 'expert patient' and the idea of the 'meeting between experts' that is an important part of the doctor-patient relationship. However, this may also have been written in his role as devil's advocate.

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Your publication of an article entitled Communication Skills by Mike Fitzpatrick[1] has made us uncertain as to the purpose of the Back Pages of your journal. If they exist to offer provocative opinion to your readers, you have succeeded. If they are intended to be based on and knowledgeably informed by the full breadth of current literature, then your success is more questionable in this instance and may mislead your readers.

There is ample evidence that clinical communication can be both taught and learnt.[2] We are not aware of any evidence of the benefits of apprenticeship learning of communication, indeed the reverse has been suggested.[3] To propose that the teaching of communication is in any way 'comic book' does not reflect our experience of current undergraduate and postgraduate teaching at this university and elsewhere. On the contrary, learners and teachers take the task extremely seriously and we have evidence, from course evaluation, of learners' improving skills.

Where Fitzpatrick is appropriately provocative is in his discussion of teaching the on-going doctor-patient relationship, which he describes as heavily influenced by previous mutual interactions. We in no way underestimate the difficulty of such teaching at either undergraduate or Foundation levels, but argue that training has to begin somewhere, in the same way that a cyclist must first learn to balance and steer before attempting to travel any distance.

In our communication teaching with undergraduates, we have not used a Breaking Bad News video for nearly a decade, as we have found live demonstrations and experiential training in small groups using simulated patients much more effective. May we, through your columns, extend a cordial invitation to Mike Fitzpatrick to attend some of these current evidence based courses for medical students. We hope that such an experience will both rekindle his faith in the future competence of our profession and knowledgeably inform further discussion in the Back Pages of your journal.

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The Back Pages exists to publish articles on all aspects of general practice, and allow writers to express more extreme and more personal views, which would not survive peer review. They recognise our view that there is much more to general practice than questions that can be answered by means of formal research. More than anything else they share with the rest of the Journal the duty to inform, to encourage debate, to provoke, and if we can, to entertain. Having two serious letters challenging Mike Fitzpatrick suggests something's working right — and attacks on editorial policy are especially welcome if they reveal that the BJGP *is being read and taken seriously.* Ed.

Continuity of care versus speed of access

General practice is facing a period of uncertainty, with the Government seemingly intent on using its forthcoming White Paper to shake up the core elements of a system that has served the NHS so well over generations. Whatever the outcome of ministers' high-profile 'listening exercise', it is already clear that increasing fragmentation of general practice will be an inevitable consequence of the Government's determination to give private providers a central role in primary care and to expand massively the network of NHS walk-in centres and commuter clinics.

Against this background, Mike Fitzpatrick's comments[1] on the trade-off between continuity of care and speed of access to a GP are a welcome contribution to the debate.