ability to provide continuity of care for patients or to nurture its future generations if it colludes with the proliferation of transient posts at the expense of traditional partnerships, an experiment that has clearly failed. If this trend is to be reversed, selection into medical school and postgraduate training schemes must ensure a critical mass of entrants likely to be wholly committed to their careers. In addition, rather than accept the demise of the GP partnership as inevitable, we should revive it before it is too late.

Edin Lakasing

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COMMENTARY

When I received this piece from the editor of *Back Pages* I expected to read the usual 'politically correct' opinions one has come to expect from College activists of a certain age.[1] As an older GP I have become used to accusations of exploitation of younger colleagues with many commentators forgetting the experience of a decade ago when a cohort of doctors raised the 'generation X' question as to why they should take on the responsibility of partnership when they could earn just as much in sessional employment or as jobbing locums.

How refreshing, then, to see the honest and penetrating analysis that Dr Lakasing presents as a challenge to current orthodoxy; general practice has a chance of survival if the professional leaders of his generation take heed of his warnings.

I could take issue with his analysis of medical resistance to the NHS in the 1940s, as my suspicions are that the terms of engagement offered by the then Government were initially as doctor-friendly as any offered by their modern counterparts, and that the 'sweeteners' he describes were totally necessary (at the time). Given the command and control environment that most primary care organisations now try to impose upon us, I certainly believe that the independent contractor status works best for us but, more importantly, also for our patients in their survival while floundering within the Byzantine complexity of the 21st century NHS.

Dr Lakasing also has the courage to challenge a relaxed attitude over the 'feminisation' of our discipline by pointing out the dangers that go hand in hand with the obvious advantages of having female partners. Already challenged by the out-of-hours opt out, continuity of care is our strongest feature, especially in dealing with chronic disease, and he is right to point out that such continuity is compromised by part-time working often associated with female doctors and family life.

There is, however, one feature missing from his analysis. There may be a tiny minority of principals who actively exploit younger colleagues by offering only sessional or salaried employment, but the biggest causal factor is financial instability within practices. We still run small businesses and, at a time when we have seen years of rising costs and falling personal incomes, who should be surprised that permanent partnerships as are rare as hens' teeth?

I shall take part-time retirement later this year and will take comfort from this essay that our decision to appoint a partner to replace me will reduce the number of 'McJobs' by at least one.

Brian Keighley

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