industrialized world. The central problem is not the benevolence or egotism of our despotism, but the despotism itself. Pereira Gray cites Byrne and Long's (1976) study as an authority-laden extreme of behaviour. In fact there is every reason to think that these volunteer doctors from the Manchester area were quite representative of us all. The main thing to our credit is not the fraternal style of our work, which has hardly developed as yet for the general run of patients, but our wish to escape from our despotic position.

What evidence is there of our quality as employers and organizers of our own little bureaucracies? Are we really sure that our secretaries and receptionists do not want national pay scales and agreed terms of service? What about the massive flight to deputizing services? What about the rules of behaviour so often imposed by general practitioners, trying (usually vainly) to match patient demand to the service they wish or are able to provide?

Our turning point from talk to action on any substantial scale was the 1966 package deal. This was a big step away from the independent contractor status. We had 65 years in which to prove that we would or could finance the buildings, staff, and equipment necessary to good general practice, out of our personal incomes. By 1966, the Government had stepped in at our invitation to rescue us from our own squalor, and together we knocked out the material foundations from our traditional autonomy. Since then we have helped to form teams (bureaucracies) of our own, all the other members of which are salaried. They quite reasonably wonder why we should not be also.

Pereira Gray's assumptions about the alleged impersonal and lacklustre qualities of salaried medical staff are so astonishing that I am surprised to see such a thoughtful and responsible man commit them to print. Most local hospital consultants are well known to local people. They are just as likely to be recognized in the street as a general practitioner. Most of them give personal attention to patients, and if there is sometimes no choice of consultant, this more often than not reflects impersonal referral by the general practitioner. The assertion that relationships with patients become more remote at the more junior levels of hospital staffing contradicts all the evidence I know of. Salaried local authority medical staff in maternity and child welfare services have provided standards of continuity, accessibility, informality, and a readiness to listen and be concerned with minor problems that have on the whole compared favourably with what general practitioners offer, and the same applies to family planning services. The most questionable aspect of the Court report (1976) is its endorsement of accelerated dismantling of the salaried community child health services at a time when there are not enough general-practitioner paediatricians with both time and a primarily preventive, anticipatory, and educational outlook to replace the old service. We all hope the College will remedy this, but at the moment we are in no position to boast of our achievements either in immunization or in anticipatory surveillance.

Dr Gray's article opens for discussion the whole question of how (not how much) we are paid, and thereby how our relations with the State and our patients, our conceptions of disease and the appropriate role of the doctor are formed. All of us have a responsibility to conduct that discussion for what it is, a part of medical science inseparable from its other more traditional components. We should recognize that *no system of payment can in and of itself create motivation to meet the health needs of the people.* But each system determines the conditions within which this motivation is punished, rewarded, or ignored. Whatever system we support, we each have a duty to look at all aspects, not only those favourable to our case. Whatever we propose must be matched against the evidence we already have of the effects of different payment systems on the perceptions and behaviour of doctors and patients (Abel-Smith, 1976).

These conditions apply just as much to proposals for salaried service, whether universal (Medical Practitioners' Union, 1977), or limited to particular areas with special problems of medical recruitment, such as the large city centres and the South Wales valleys. Granted that the doctor no longer carries his tools in one pocket and his decisions in one head, and that he depends both on a primary team and the support of secondary and tertiary hospital referral systems, he is already in a hierarchy and a bureaucracy. He is also in close and continued contact with a listed population at risk, unlike every other level of the service. The key to a structured, salaried, and rationally planned service, without alienating bureaucracy or stifled initiative, lies in the development of organized links between primary teams and the patients they serve.

There are two dangers at the moment. If the medical establishment continues to be so obsessed with defence of untenable positions in private or autonomous practice it will remain incapable of negotiating a reasonable and responsible contract for the majority of doctors, both general practitioners and consultants, who have neither the desire nor the opportunity to work as shopkeepers. Secondly, it may fail to develop, or perhaps continue to resist, organized links with the local public. Without these links we shall be accountable upwards and delegated downwards, precisely the reverse of our preferred and effective position. "We must be accountable to someone", wrote Alastair Wilson (1977); "why not to the people we know, our patients?"

The forms of this accountability remain to be discovered and tested by all of us in the field. The aim must be to create first new custom, then new law. I see no easy answers, but it is a worthwhile beginning even to start asking the questions. Our College is not, after all, the Establishment. That is why it has been and still is so alive and interesting.

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JOB DESCRIPTION OF COURSE ORGANIZERS

Sir,

At a recent meeting of course organizers in the Trent Region there was some discussion on a paper defining the job description of a vocational training scheme course organizer. It was generally felt that the time had come for a proper job description to be written so that future course organizers will have a clear idea of what the job involves.

Another important aspect is that the present system of payment for course organizers by the DHSS has developed over the years without a rational basis and the job itself has never been properly priced by the Review Body. The Trent Region course organizers feel that it is time that this was done but that it is necessary to collect evidence in order to make a proper evaluation.

I have been asked by the course organizers in our region to invite the views of other course organizers and

interested parties to write to me giving me their views.

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DOCTORS AND SOCIAL WORKERS

Sir,
It has taken me eight years to find and read *Helping the Aged. A Field Experiment in Social Work* (Goldberg, 1970) which was recommended to me by an academic social worker. It is strange that in the same week that *World Medicine* (1978) lampooned the social workers because of their recently formulated job description I should find myself with a good word to say for a group of people of whom I am usually fiercely critical.

However, it was a delight to read this study, which was the first controlled field experiment in Britain. Although there may be some minor criticisms with regard to the method, the study was extremely sophisticated and its findings, although a surprise to the authors, will confirm the suspicions that general practitioners have had over many years.

The study was led by a social worker and included a physician and statistician. Its aim was to assess the social and medical conditions of 300 old people in a local authority area and determine their need for help. Half of these people were randomly selected to receive help from trained case workers; the other half, also randomly chosen, remained with experienced local authority welfare officers.

Three general and seven specific hypotheses were formed and a separate group of assessors was used who at no time were in contact with social workers. Two examples of hypotheses in the general group were as follows:

1. That more clients in the special group will show positive changes in their social and medical conditions than the comparison group. This was only partially upheld.
2. That fewer clients in the special group will be admitted to institutional care than in the comparison group. This was not upheld.

Examples of the specific hypotheses were:

1. That fewer clients in the special group will deteriorate in ability for self-care and household capacity than in the comparison group. This was not upheld.
2. More people in the special than in the comparison group will develop interests in activities such as clubs, work groups, holidays, home, library, church contacts, and hobbies. This was upheld.

We talk a good deal these days of audit, and the discipline and care shown in this attempt to assess the effectiveness of social work is both instructive and salutary to any of us who are at present involved in measuring our own performance. It is therefore a book which I feel, although eight years old, deserves to be read or re-read.

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JAMES MACKENZIE LECTURE

Sir,
May I congratulate Dr D. J. Pereira Gray on his Mackenzie Lecture 1977 (January *Journal,* p. 6), especially for emphasizing the importance of knowing the patient, from personal contact, in his home environment. One hesitates to comment but I have a fear that in placing emphasis on the behavioural aspect of general practice he does a disservice to medicine, and general-practice medicine in particular, in apparently underrating the importance of a knowledge of pathology and the basic medical sciences.

He speaks of pathology as "the behaviour of organs, tissues, and micro-organisms", but pathology is the study of disease processes, and the organs and tissues in which these take place are those of our patients for whom we seek to make the earliest possible diagnosis. Unless we enter the patient's home with full medical knowledge, including the basic medical sciences, we will find ourselves unable "to care for many patients with coronary thrombosis, acute heart failure, strokes, croup, pneumonia" and other conditions which he quotes, and, what is perhaps more important, we will be unable to differentiate those whom we should not attempt to care for at home. Similarly, we will find ourselves at a loss in explaining to a patient the nature of his disease, the need for further investigation or surgical interference, or even be unable to supervise the healing of the tissues he has damaged in his home accident.

It must be about one hundred years since Osler said, "As is our pathology so is our practice". I believe we should regard this statement to be just as true now as it was then and that it is right that we should first be taught human anatomy, physiology, and pathology in order that we can begin to understand the symptoms later to be presented to us.

I do not believe our task is "to concentrate on those symptoms which are most common in our patients today" but, in our aim to practise total medicine within the framework of general practice, to appreciate the importance of any symptom or set of circumstances which is presented to us at any time. A knowledge of scientific medicine does not prevent us from looking under the bed to see whose shoes are there.

May I also express the hope that with a better shared knowledge of medical care in the patient's home we will reach a greater liaison and understanding with all our hospital-based colleagues and stop this terrible schism which is being allowed to develop in some quarters.

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EMPLOYMENT OF PRACTICE NURSES

Sir,
Our practice nurse recently showed me an article which appeared in the September 1977 issue of the *Nursing Standard,* the official newspaper of the Royal College of Nursing. This article commented, amongst other things, on the position of nurses employed for treatment room work in health centres. This article implied that whilst a state registered nurse works in a health centre, her employer would be the area health authority (AHA) and her salary would be at the staff nurse grade. Similar provisions would apply to non-state registered nurses.

It is, of course, open to the general practitioners working from health centres to employ their own ancillary staff, and this includes nurses, and there is no obligation for such nurses to enter into a contract with the AHA. Furthermore, the Royal College of Nursing itself recommends that state registered nurses employed by general practitioners as treatment room or practice nurses should be paid at ward sister rates—considerably more than a staff nurse employed by the AHA. It is true that the nurses employed by the AHA can contribute to the NHS superannuation scheme and in due course receive a pension, whereas, at present, nurses employed by general practitioners may not.