Three problems remained: first there were suggestions that a shorter handbook was needed for day-to-day work in surgeries; secondly there were continuing questions about agreement between the GMSC and the RCGP; and thirdly the RCGP policy statement had concluded: 'Urgent attention should be devoted to the provision of agreed developmental schedules and improved record systems.'

In 1983 the GMSC and the RCGP set up two parallel working parties with cross-representation. The GMSC produced the new cards and the College the new Handbook. The cards and the Handbook were designed to supplement each other and they are now available from both organizations. They will be reviewed and updated in future through the Liaison Committee of the College and the GMSC. It will thus be possible to take into account new research findings as they appear and some impressive results of general practitioner research in this field are already in the pipeline (Hooper PD and Curtis-Jenkins GM, personal communication). The new Handbook and cards seek to answer these three problems, and as the General Medical Services Committee, chaired by Dr Michael Wilson, has now formally welcomed the Handbook,[8] they appear to have succeeded.

The next phase must now be to place high priority on courses for general practitioners and trainees and continued educational updating in the future.

At this time, when joint agreement has at last been secured between the two general practice organizations, it is appropriate to note the contribution of a group of general practitioners including Curtis Jenkins,[9] Hart,[10] Hooper,[11] Pollak[12] and Starte[13] who have made important clinical contributions and also a group of general practitioners who have been active within the professional organizations to produce the four policy statements and reports which have appeared during the past eight years (Drs Carne, Donald, Donovan, Pereira Gray, Horder, Irvine, Pickersgill, Sykes, Waine and Walker).

It is a pleasure to see the two national organizations of general practitioners working together for the benefit of children. In the words of the Handbook: 'The Royal College of General Practitioners and General Medical Services Committee both agree that this work is important and should be integrated within general practice as soon as possible.'[14]

Doctors may obtain the handbook and record cards from the Information Department, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU, or from the GMSC Secretariat, BMA House, Tavistock Square, London WC1H 9JP. One handbook and two record cards (one male and one female) cost £1.00 including postage; 100 cards cost £3.00 (plus £2.50 postage and packing); 100 A4 cards cost £8.50 (plus £2.50 postage and packing).

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Information for patients

THIS issue of the *Journal* includes the first discussion paper produced by the College's Patients Liaison Group. It argues the case for an increase in the amount of information for patients in the list of general practitioners prepared by each Family Practitioner Committee (FPC). It also has suggestions for the content of the leaflets describing the services offered by practices, which general practitioners themselves prepare.

This report by the Patients Liaison Group is an important stage in the development of the College. But how important is it in the evolution of general practice? Does its significance go beyond the practicalities of family practitioner lists and practice leaflets? Is it simply an extension of the current fashion in consumerism to the National Health Service? Since in many parts of the United Kingdom patients have no real choice of general practitioner within the NHS, will it be effective even in its limited aim of providing useful information for patients moving to a new area? Yes, the document does have a significance beyond its limited aims. It indicates the interest the College has in the development of a new relationship between patients and doctors, and it also indicates that the College is prepared to be controversial in promoting this change.

The discussion paper describes in practical terms what this new relationship means. Patients expect to receive

information upon which they can base decisions concerning their own health, and doctors expect patients to take responsibility for these decisions. Practice leaflets are just one way in which doctors can inform their patients. The Quality Initiative and the involvement of the College in the *Well-being* series on Channel 4 television are other aspects of this general desire to make health and provision of health care subjects of open discussion and debate.

The provision of information to patients in the form of practice leaflets carries risks. The most obvious of these risks is that the General Medical Council may consider a leaflet to be advertising. In addition, there may be unexpressed and atavistic fears that providing information diminishes the doctor's mystique, or, more prosaically, that describing the services of a practice in a form which can be evaluated makes doctors vulnerable to criticism. While recognizing these fears, it is hoped that the provision of information can be increased.

The experience gained from establishing patient participation groups should allay many of the doubts and may prove useful for considering how practice leaflets might develop. Each patient participation group is different: the precise function and the composition of the groups vary from place to place. This diversity is inevitable and desirable. The flexibility of general practice in meeting the different needs of different locations is one of its strengths: pluralism and individualism rather than stereotyped uniformity is to be encouraged. The role of the General Medical Council should be to establish guidelines within which an experimental approach to the provision of information can be explored and described. General practitioners are already showing an interest in the subject, as evidenced by the increase in requests to the Central Information Service at the College for examples of practice leaflets.

The compulsory production of practice leaflets must be resisted as it would be counter-productive. Leaflets might be seen as contracts and any deviation from the described services as the basis for legal action. It is to be hoped that the general practitioners elected to the General Medical Council will be able to draw attention to this issue.

While the discussion paper does not have the official status of College policy, it is the latest indication of the direction in which the College wishes to move. The involvement of patients in all aspects of health care should be a major issue for debate.

Computers in general practice: a personal view

IS the computer a devilish invention, to be avoided at all costs, or is it God's gift to general practice? Will its use lead to the destruction of practice as we know it, or will it instead take us on to a medical Utopia? Admittedly, nothing in life is clear cut. Nonetheless, I often feel that computers produce an unrealistic polarization of doctor types: at one extreme there is the enthusiast for the new technology prepared to ruin his family life by spending hours with his home computer, and at the opposite extreme the fervent reactionary prepared to do almost anything to avoid considering how the silicon chip might be used to help in his practice.

The computer is here to stay and, whether we like it or not it will increasingly be used in general practice. Although computers will have many benefits if used correctly, there will also be many pitfalls to trap the unthinking user. We must understand developments, we must experiment with ways of extending our role as general practitioners, and we must exploit to the full the potential of the computer. But how?

We have already seen the widespread introduction of microcomputers into routine practice procedures such as the registration of patients and recall systems. The first programs to help us with problems in prescribing are appearing and being developed. Computers are helping in the diagnosis of certain conditions, and also being used to take the initial history in certain situations.

Where will all this lead us? Can we envisage a situation where the computer first takes the history, then directs the doctor as to which parts of the patient to examine so that he (or more likely she) will be able to enter the findings into the computer, enabling it to arrive at the correct diagnosis and the preferred management plan? For most of us this would be a nightmare, and I cannot believe that the patient would be better off.

The great strength of general practice is in the successful marriage between technological medicine on the one hand and a personal continuing relationship on the other. The first aspect demands that we investigate and adapt for use all of the technological advances which will help us to diagnose illnesses and manage our patients more effectively and efficiently. The second aspect demands that we develop empathy for our patients which will produce a lasting relationship of trust, so that the patient will seek help in the early stages of the problem.

If these two aspects of practice are successfully combined, then I believe that general practice will be assured of a central place in the health care system for the next century. Of course, our role and tasks may well be different from those of today, but we will have survived if we have responded to the changing needs of the society we serve.

What are these needs? What are these changes? What will our role be? We can all ask the questions, yet the