contract between the proposed neighbourhood nursing unit and the practices whose patients such units would serve. We are told that 'doctors who preferred not to negotiate such an agreement would receive only those nursing services which the neighbourhood nursing managers themselves decide to provide'. We find it hard to believe that such an approach would be uniformly successful, and can evisage a hardening of attitudes among colleagues which would do little to promote teamwork.

The report is also critical of directly employed practice nurses. Apart from the report's assessment of the cost of such staff, which is inaccurate as has been explained by Dr Arnold Elliott of the GMSC, what reason could there be for reducing the number of nurses working in the community, given the report's earlier acceptance of the need for greater provision? The answer to this question, and perhaps a clue to the proposal for written contracts, may lie in the sympathy expressed with the view, ascribed to the Royal College of Nursing, that 'as a matter of professional principle, nurses should not be subject to control and direction by doctors over their professional work'.

Although it is not made clear where clinical responsibility would rest, the report suggests that the provision of appropriately trained practice nurses, under the supervision of the neighbourhood nursing unit would reduce the need for general practitioners to employ their own nurses. We suspect that this is the reverse of the experience of many doctors, who find that the only solution to managerial restrictions of the role of nurses employed by the local health authority is to employ and train their own.

Is the main need of the community nursing services a better managerial structure? Are not most of the nursing and medical problems in the community more to do with resources than chains of command?

The implication of the report is that the proposed managerial changes could be introduced at minimal financial cost. Therefore, it is argued, because they are free, any such improvements must be worth having. The increase in the level of personnel required by the report's recommendations is estimated at 1.5% which, it is claimed, could be paid for by reductions in the cost of paperwork and travelling.

Can they seriously suggest this? The National Health Service has recent painful experience of the expense and difficulties associated with managerial reorganization. If the implementation of the report's recommendations does have a significant cost then an important area has not been addressed: whether such money would be best spent in that way.

By all means let us support the establishment of an experimental trial of the neighbourhood nursing model, but we shall require much firmer evidence than this report provides before accepting its proposals.

Perhaps the final word should be given to a nurse quoted in the report as saying that any further fundamental changes in organization were needed 'like a hole in the head'.

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Reference

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Practice profiles

Sir,

Dr Thompson writes (August *Journal,* p.381) to challenge the findings of Frances Hanson and myself about claim rates for items of service and other characteristics of elderly doctors in Kensington, Chelsea and Westminster (April *Journal,* p.165); his grounds are that they do not apply to himself and his practice.

Unfortunately one case proves nothing, particularly as Dr Thompson's practice is in Croydon. We did say that we had no idea how far our findings might hold in other areas, and of course we know how lightly he carries his own years. He suggests that the low rates we reported were due to lack of clerical staff, absence of team work, poor premises and a mobile population rather than to the doctors' age. Our tables show that many of these features were in fact especially strongly associated with single-handed elderly doctors; moreover, in the two-doctor practices, those with at least one partner aged 65 years or more had lower rates than the rest. We can assure Dr Thompson that we do not believe that doctors automatically make fewer claims when they reach the age of 65 years, but he should not dismiss the findings as no more than a coincidence. The underlying reasons are almost certainly complex and may be unique to the area.

Our surprise with regard to maternity services was at the large number of doctors who made no claims at all, even for referring patients to an antenatal clinic. His account of his nocturnal obstetric activities misses the point.

It would be useful if Dr Thompson or anyone else could demonstrate that elderly doctors in areas less unusual than Kensington, Chelsea and Westminster behave differently. The necessary data are sitting in the files of family practitioner committees all over the country waiting patiently to be analysed.

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A 'herald wave' of type A influenza of the H1N1 sub-type

Sir,

It appears that recent outbreaks of influenza A in Singapore and Kuala Lumpur and also more recently a single isolate in England were caused by the H1N1 subtype of the virus which shows considerable antigenic drift from previous strains.[1] Influenza A of the H1N1 sub-type has been prevalent since 1977 when it caused 'red flu' epidemics. Since then its activity has been on the decline, the majority of infections being caused by the H3N2 virus (derived from the 'Hong Kong' influenza virus). It has been noted that new viral strains isolated in the northern hemisphere in late spring do not cause epidemics in that hemisphere during the succeeding months, but affect the southern hemisphere during this period returning to the northern hemisphere six months later.[2,3] The Public Health Laboratory Service noted a single isolation of the A/England/42/72 strain in England in 1972 which caused outbreaks in the southern hemisphere in succeeding months and was responsible for winter influenza in Britain in 1972/73.[4] This so called 'herald wave' of influenza A has been observed in several long term studies[2-4] and it is reasonable to assume that it is a true phenomenon inherent in the nature of the virus or its epidemiology.

The recent isolation described above may therefore indicate that the northern hemisphere will be plagued next winter with moderate to large epidemics caused by this new H1N1 virus. It would therefore seem prudent to ensure that this new viral strain is incorporated into influenza vaccines given in the next few months in order to reduce influenza morbidity and possible mortality in the northern hemisphere next winter.

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2. Fox JP, Hall CE, Cooney MK, Foy HM. Influenza virus infections in Seattle families 1975–79. *Am J Epidemiol* 1982; **116:** 212-227.
3. Glezen WP, Couch RB, Taber LM, *et al.* Epidemiological observations of influenza B virus infections in Houston Texas 1976–77. *Am J Epidemiol* 1980; **111:** 13-22.
4. Public Health Laboratory Service. Standing Advisory Committee on Influenza. Influenza surveillance 1972–75. *J Hyg Camb* 1977; **78:** 223-233.

The power of relationships

Sir,

Believing that spinal manipulation can alleviate sciatica, I have in the past agreed to my patients seeing an osteopath. I have now discontinued this practice because of a disquieting development of osteopathy which is not widely publicized.

A female patient of mine consulted the osteopath for back pain. Several months later I discovered that he had moved on from skeletal manipulations to a 'deep soft tissue manipulation' of the abdomen. The lady suffered severe abdominal pains for a week, but was reluctant to come to the general practice.

I confronted the osteopath, who said he had diagnosed a 'displacement of the uterus to the right' by abdominal examination and sought to correct it. Although I pointed out that medical training considers any palpable mass arising from the pelvis to be potentially pathological, for example a large ovarian cyst, the osteopath was unrepentant, indeed hinted that his training led to superior diagnostic abilities. He went on to say, 'As holistic medicine gains in popularity, osteopaths are extending their treatment to include soft tissue manipulation, naturopathy and diet.' I am currently checking one of his severely restrictive six-week diets with a National Health Service dietician, but I make the point here that doctors have no control over the treatment or advice given once our patients consult a practitioner of 'alternative medicine.

Dr Pietroni's call for a 'cautious introduction of alternative therapies' (April *Journal,* p.171) is unrealistic; the floodgates of quackery have already opened. I doubt that Balint would have flirted on the fringe, but would instead have focussed on why patients turn from general practitioners to pseudo-experts, and perhaps on why general practitioners turn away from patients.

My call would be to encourage general practitioners to understand the concepts of spirituality better so that they do not dismiss as neurotic those who look beyond themselves for a meaning and purpose to life. Is the skill of the quacks to appear to provide a whole person treatment while in fact merely giving an hour of 'relationship' while rubbing their feet, dangling pendulums and asking about the east wind?

The British Medical Association have shown courage and wisdom in resisting the tide of 'holistic' medicine. But let us not dismiss the whole phenomenon without looking deeper for its causes. If the NHS has failed to meet certain needs by encouraging five-minute appointments, what wider resources should we be looking to if not to fringe medicines?

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Patients' expectations of primary care

Sir,

The simple survey carried out by Donald and Gillian Gau into patients' attitudes to their doctors, practice staff and the consultation (Letters, May *Journal,* p.227) has a lesson of vital importance to the future of general practice and the training of general practitioners.

The survey demonstrated a mismatch between doctors and patients when asked the question 'What were your expectations from your doctor/practice and have these expectations changed?' Doctors and practice staff felt that patients wanted to be cured or made better; patients wanted to be listened to and taken seriously. In other words the patients were expecting a degree of care from their doctor and not always a solution to their problems.

There is much discussion at the moment about the Government's green paper[1] and the future structure of general practice. The 'good practice award' is talked about with emotions ranging from fear and rage to smug self-satisfaction. Parameters for this award abound, for example age–sex registers, recall systems and repeat prescribing systems. What worries me about this is that we seem to be losing sight of the fact that general practice is about caring for people and not always about running an efficient health machine.

A couple of months ago a patient of mine was berating the treatment his family had received from another doctor while they were away on holiday. It seemed the doctor had acted correctly from a medical point of view, but the consultation had lacked sensitivity. My patient turned angrily to me and said, 'If you doctors don't care, then you're nothing.'

Perhaps it is not lack of factual education that is wrong in general practice but that doctors are unable to cope with the demands put upon them by the patients who need care. Perhaps as a profession we have to look at how we teach doctors to care and to cope with the emotional demands put upon them.

Approximately 70% of all consultations are for self-limiting illness. Why then do the patients come? If they want a sympathetic ear this suggests that they know they have a self-limiting illness but nevertheless need care and reassurance from the doctor. Having somebody care about you is flattering and reassuring and many of our patients may come for a dose of this, rather than a prescription from a disinterested doctor.

I feel we are in danger of becoming bogged down in the measurables — immunization uptake rates, prescribing habits, practice facilities and so on. These are so essential to modern general practice that they should be mandatory anyway. What really helps patients is support from a doctor who cares about them as human beings and who is prepared to care for them in order to allay their fears and reassure them of their worth.

Primary care is about caring for the primary person in the consulting room; the patient.

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Reference

1. Secretaries of State for Social Services, Wales, Northern Ireland and Scotland. *Primary health care: an agenda for discussion (Cmnd 9771).* London: HMSO, 1986.

Sir,

I was interested to read the account by Drs Gau and Gau on the expectations of patients in their general practice survey (Letters, May *Journal,* p.227). They mention that whereas doctors thought patients wanted to be cured, 70% of the patients surveyed wanted to be listened to and taken seriously, and they then go on to conclude that patients were more interested in the process than the outcome. I would like to argue that being listened to and taken seriously may from the patient's point of view be an outcome and not a process at all.

This illustrates the dilemma that faces the College in its quest for quality of care in respect of outcome — who defines outcome, the patient or the doctor. The findings of Drs Gau and Gau that patients wanted to be listened to and taken seriously will come as no surprise to