to a chemist because it is more convenient, or because we do not stock the drug which is on the prescription.

I think that all comparisons between dispensing and prescribing costs are likely to be invalidated by the above points.

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Community hospitals

Sir,

In his excellent editorial (June *Journal,* p.226) James Grant urges us to take community hospitals seriously and to see them as important ingredients of the health service of the future. We wholly support his aims but would like to report the results of a survey carried out in Southampton which highlights some of the difficulties in developing community hospitals.

In an undergraduate fourth-year project 145 acute medical admissions to Southampton general hospital were studied. Hospital doctors, nurses and referring general practitioners were interviewed to determine their views about the feasibility of general practitioners caring for these patients in an imaginary community hospital, whose facilities had been defined. For the 90 admission referred by general practitioners the hospital doctors thought that 35% could have been looked after by general practitioners, the nurses 31% and the referring general practitioners 48%. However, consensus that the patient could be cared for by general practitioners in a community hospital was achieved in only 10% of cases. For the 55 admissions coming directly through casualty and the ambulance service the hospital doctors and nurses believed that a similar proportion, 31%, could have been cared for by general practitioners.

Interviews were conducted with over half of the patients admitted. Most lived within five miles of the district hospital and most of their visitors found access quite straightforward. Few had previous experience of a community hospital, but at interview, when asked if they would have felt better or worse knowing that they were going to be looked after by their general practitioner, 26% of the patients said that they would have felt worse, 8% that they would have felt better and 55% that they would have felt the same.

These results suggest that a substantial number of patients admitted to expensive district general hospitals could be cared for in general practitioner units, although the lack of consensus between health care professionals is concerning. Patients cared for in community hospitals tend to be appreciative and supportive of these facilities and it is likely that our results reflect lack of experience with this form of care. Nonetheless, patients' views about the place of care are important, not least because of the expectations they may reflect.

As James Grant points out, community hospitals have evolved in response to local needs and enthusiasms. Conversely, some attempts to get general practitioner units off the ground have foundered on the rocks of intertia and apathy, even before the government white paper[1] and the new contract[2] were published. Studies which will measure the cost effectiveness of community hospitals are urgently needed, as is the resolve not merely to sustain but to develop community hospitals as a precious and essential component of the National Health Service.

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Compulsory admission to hospital

Sir,

Dr McGhee's letter on the compulsory admission to hospital of an alcoholic patient under the 1983 mental health act (July *Journal,* p.301) raises a number of issues which need to be given serious thought before this practice is repeated by other doctors.

In the compulsory admission of a patient to an approved institution the doctor takes a paternalistic role and the patient is deprived of one of the basic human rights, namely the right of self determination. The use of the act is therefore to be regarded with the utmost gravity, as the loss of personal liberty and the subsequent compulsory treatment profoundly affects the doctor–patient relationship. This change in the normal relationship persists until society deems that the patient is capable of making a rational and informed decision as to his or her choice of health care.

In alcoholism the patient is deciding that he will consume alcoholic beverages to a level that other members of society might believe, quite rightly, is irresponsible and to the detriment of his health. Being irresponsible is not in itself a variation of human behaviour that allows the medical profession to intervene in a manner that deprives a patient of his liberty. To impose a medical model on a state that is more socially threatening than relevant to the spirit of the mental health act raises fundamental questions as to the role of the doctor in society.

The iniquitous practice of using psychiatry as a means of political or social control, which has been well documented in the eastern block countries, has been condemned by doctors. However well justified our concerns and fears for our patients, and despite the exhortation by friends and relatives that 'something must be done' if a patient does not satisfy the prevailing criteria for compulsory admission and treatment, we do not have the right to mould the acts of parliament to engineer social conformity, for to do so is not only unlawful but more pertinently unethical.

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Needs of elderly people in residential homes

Sir,

Dr Packham's paper (August *Journal,* p.335) raises an important issue, that lack of medical information hinders medical care, especially for the most disabled.

As a doctor who regularly visits residential homes to make assessments for attendance allowance I consider that access to patients' notes would be most helpful, particularly for obtaining the recent history prior to admission to the home or hospital, information which the staff often do not have. Patients might also benefit financially if earlier establishment of dependency leads to earlier payment of benefit.

The problem is presented as one of maintaining the confidentiality of patients' medical information and of respecting their autonomy. Confidentiality is not an absolute moral obligation and the General Medical Council's 'blue book' lists eight legitimate exceptions. A wide variety of health professionals, including administrative staff, have access to medical notes; allowing such access to residential nursing staff and visiting doctors would not therefore be a major departure.

The straightforward solution to respecting patients' autonomy would be to ask patients if they object to their notes being kept on the premises. The demented may lose a degree of autonomy but they

are the group most likely to benefit from doctors having easier access to their medical records.

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Can general practitioners counsel?

Sir,

Dr Shepherd's spirited response (Letters, July *Journal,* p.304) to our discussion paper demands a reply. Our emphasis on the distinction between counselling and counselling skills was not meant to avoid the issue of whether 'talking therapies' constitute effective modes of treatment, nor to ignore the importance of evaluating their cost effectiveness. Counselling is not self evidently beneficial and while there is more than anecdotal evidence to support the effectiveness of counselling in general practice[1] I agree that there is a need for further research and evaluation.

While counsellors may have a vested interest in perceiving their work to be effective I must take issue with Dr Shepherd's suggestion that the harmful or negative effects of counselling may be recognized more reluctantly by counsellors than by general practitioners, who are legally responsible for the counsellors to be trained and supervised in their work. Training enables counsellors to assess which patients may benefit from the particular help the counsellor has to offer; supervision by a disinterested party helps to promote effective counselling and to protect against damaging consequences. A major reason for our distinguishing between counselling and the use of counselling skills was to protest against 'counselling' taking place without adequate safeguards in the form of training and supervision.

Counselling has become a trendy panacea: if someone is present at a disaster, is depressed, or is having problems at work then someone else (no matter who) should 'counsel' him or her. In our paper we aimed to emphasize that counselling is a helping process underpinned by the core skills of listening, empathizing and reflecting, and that it is a process not to be undertaken lightly and without training. It is undoubtedly a process which would benefit from further research and debate.

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Reference

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Sir,

The point made by Dr Cocksedge questioning the feasibility of prolonged counselling by general practitioners (Letters, August *Journal,* p.347) raises important issues regarding what our branch of the profession should really be concerned with. It reflects the teaching of Michael Balint who urged us to try to tune in to all our patients, not just the favoured few selected for classical psychotherapy.[1,2] Being all things to all men and women is hardly possible, but aiming for it may widen our responsiveness to patients who are seeking our help.

We are gradually moving towards patient-centred medicine, realizing that our patients are greater than the sum of their medical parts. We are no longer obsessed with just making people better; caring seems as important as curing. Somehow we have to integrate all these positive qualities: to combine being a competent body technician with being a guide, philosopher and friend.

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Fellowship by assessment

Sir,

Most members are uninterested in the internal politics of the College but we ought to take an interest when the future of the College is affected, for example by the changes now being proposed for fellowship.

Fellowship was created without too much thought for its function within the College and, as numbers grew, this lack of clarity led to discrepancies in the way different faculties interpreted its purpose. The confidentiality required in the preparation and assessment of proposals for fellowship led to rumours of favouritism and nepotism. The variation in the proportion of fellows in different faculties — 2.1% to 12.8% in 1974; 6.4% to 18.3% in 1987 — did nothing to dispel doubt about the value of the fellowship. Reform was required and in due course the committee on fellowship agreed certain recommendations. However, as a result of internal politics these recommendations have been marginalized in favour of a fellowship by assessment, the nature of which is as yet undefined.

We should pause now, however, and consider whether to strengthen the committee on fellowship, reform a fellowship by distinction, and maintain a standing committee independent of the general purposes committee in the College's constitution, or allow the present move towards fellowship by assessment.

The latter option will lead the College to disaster. By purporting to define the best in general practice, we would be sucked further into the political situation in the National Health Service. Each centrally agreed criterion on which a fellowship by assessment would be awarded will become an issue over which the next battle for remuneration will be fought — not by us but by the General Medical Services Committee. This would be despite the argument that 'many criteria are simply based on consensus and the number of conditions for which explicit criteria of good care exist are limited' (August *Journal,* p.309).

The former option is infinitely preferable. The committee on fellowship should oversee, on behalf of council a decentralized faculty-based operation which seeks to establish the general practice needs of the faculty area, and which 'distinguishes' members whose particular skills or efforts are outstanding in meeting them. The use of a changing faculty fellowship committee and the participation of the nominee in completing the proposal form would safeguard against favouritism and nepotism. The strategy avoids the elitist tag attached to imposition of arbitrary standards and allows adaptation by the College in the face of a changing political, legal, economic and social environment.

Fellowship by distinction or by assessment is an important issue for the future of the College. It should be debated within faculties, within council, and at the College annual general meeting.

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Mispirnt

Sir,

I have enjoyed reading the correspondence about chronic fatigue syndrome. My imagination was particularly stimulated by what I take to be a misprint in Dr Gude's letter (May *Journal,* p.213). His first sentence mentions a viscious circle of inactivity.

He probably meant vicious, but perhaps on reflection viscous is the more evocative reading.

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