and effective treatment in order that they may escape the sick role in which they find themselves.

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The exceptional potential of the consultation revisited

Sir,

Dr Middleton (September *Journal*, p.383) has attempted to update the framework published over 10 years ago with a skills centred framework relating to the patients' agenda, the doctors' agenda and a 'negotiated' plan.[1] I found his review concise and relevant to the work of the general practitioner. Nevertheless I was disappointed on two accounts. First, like many other commentators on our framework of the consultation, Dr Middleton omitted an important review of the relevant literature in 1983 which amplified and developed the ideas encapsulated in the original framework.[2] In this academic monograph the issues which the Cardiff framework raised were considered in depth including negotiated plans and the dual agenda approach to the general practice consultation.

The second cause of concern is the omission of an ethical dimension. The ethics of the consultation and the doctor–patient relationship will be brought into sharp relief if the new contract is imposed on us in April 1990. The issue is considered in some detail in the same monograph in a chapter entitled 'The refuge: ethics, practices and problems' and I would urge any serious scholars of the consultation in general practice to consider the content of that chapter in the light of what will happen to us if the government has its way in the 1990s. Never before have general practitioners had to face a government which seems determined to force us to choose between money and the ethics of our discipline. The Cardiff framework of the consultation served to highlight these issues. This may be another reason why it has stood the test of time and is used internationally by doctors in many different cultures.

I welcome Middleton's commentary but his concepts would have held more water if he had been comprehensive in his literature review, moved beyond minor modification of Balint's triad, and related his work to new issues for the 1990s.

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Audit projects for medical students

Sir,

It was interesting to read Neville and Knox's letter (October *Journal*, p.430) about audit projects for students at Dundee since we have recently introduced a similar scheme at Newcastle medical school.

For several years now students have been encouraged to carry out a small project during their family medicine attachment. Despite its being optional the majority of students chose to undertake a project, presenting their results at a seminar in the final week. A common complaint was the amount of time spent on the project, particularly as examination time approached, but the seminar itself was well received. Like Dundee, the topics chosen were many and varied, ranging from 'Characteristics of patients who send Christmas cards to GPs' to 'Audit of asthma care', though strictly speaking few of the projects were audits as such. Nevertheless questions about audit invariably arose in discussion, and the problems experienced by the students highlighted some of the problems of audit in 'real life': the generally poor state of record keeping; measuring only the measurable; opportunity costs and so on.

Publication of the white paper[1] concentrated our minds on the need for a more structured input and we have revamped the project accordingly. Unlike Dundee, we are asking students to carry out their audits on the same topic (which changes each session), though there is considerable room for individual interpretation. We thus hope to build up an archive of audit activity which will be of use to the participating tutors. As the authors state, 'compulsory audit of clinical activity will be the norm for doctors in the 1990s', and few would disagree that early exposure to the idea is important. The state of the art is such that departments of general practice are in the best position to provide the appropriate teaching and thereby to lead the way. It is a particularly exciting innovation since teacher and pupil alike will be feeling their way, adding a dynamic and challenging component to what is already a very different kind of clinical attachment.

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Core data for practice annual reports

Sir,

The paper by Howarth, Maitland and Duffus (November *Journal*, p.463) describes definitions used in a model annual report which were arrived at after discussion with interested parties in Scotland. The Chesterfield trainers workshop devoted some time to deriving definitions for their own use in practice reports and came up with almost identical definitions.

Because of the difficulties of making comparisons between different practices when similar definitions are not used, may I commend these particular definitions to all practices in the UK for their future practice reports and I would urge the College to distribute them widely.

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Continuing medical education

Sir,

I have been following the debate over the UK government's new postgraduate education plans with interest from this