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

CHRISTINE E. BUCKNALL

Goven Health Centre
5 Drumoyne Road
Glasgow G51 4BJ

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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.

NIGEL STOTT

University of Wales College of Medicine
Department of General Practice
Health Centre
Maelfa
Llanedeyrn
Cardiff CF3 7PN

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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.

JOHN SPENCER
PENNY SCHOFIELD
DAVID GREGORY

Division of Primary Health Care
School of Health Care Sciences
The Medical School
Framlington Place
Newcastle upon Tyne NE2 4HH

Reference

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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.

M.G. DORNAN

The Health Centre
Saltergate
Chesterfield

Continuing medical education

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

side of the Atlantic. It seems that the proposals are unnecessarily restrictive and other drawbacks have been noted by Drs Wall and Houghton in their editorial (August *Journal,* p.311).

The Royal College of General Practitioners should review the American Academy of Family Physicians' guidelines for postgraduate education. Membership of the Academy is similar to College membership but in order to maintain membership the Academy requires 150 hours of postgraduate education every three years. These hours may be obtained by attending convention type courses and lunchtime lectures, and from home study courses, case study reviews, teaching and research projects. Over half of the hours must be 'prescribed' credit, that is, the course, or organization providing it must be approved by the Academy in order for the educational content to be considered for 'prescribed' hours.

This approach is fairly flexible. The acquisition of hours, rather than days avoids the tedium of marathon educational sessions (unless that is your preference) and credit is given for personal endeavour. Other specialist organizations have similar guidelines and these are accepted by all the states in the USA which require continuing education as part of their licensing requirements.

Perhaps the College could adopt similar proposals for continuing membership. The College, rather than the government, would then have an opportunity to determine the direction of the future educational activities of its members.

ALAN SEARLE

PO Box 956
Port Orchard
WA 98366
USA

Torture of prisoners

Sir,
I read with great interest the appeal by Dr Beryl Dennis (April *Journal,* p.174). She referred to the strong stance taken by the Turkish Medical Association against torture or maltreatment of prisoners and appealed to doctors to write to the Turkish Medical Association expressing their support for this stance.

At a meeting of the federal council of the Medical Association of South Africa (MASA) in June 1989 two important resolutions were discussed and accepted unanimously.

1. A policy statement by MASA on civil unrest, the state of emergency and detention without trial. This statement expressed the deep concern felt by MASA regarding the unrest situation. It deplored violence from whatever source and deplored the concept of detention without trial.
2. A policy statement on the detention of children. This statement expressed the abhorrence which MASA felt at the misuse of children to attain certain aims and which could as a consequence lead to their arrest. MASA further expressed its opposition to the torture or abuse of children for whatever purposes and again stressed its opposition to the concept of detention of children without trial.

It should be stressed that MASA is a free and independent association of medical practitioners and that membership is entirely voluntary. Membership is open to any registered doctor regardless of race, colour, sex or creed. It has no connection whatsoever with any government or state authority.

It would certainly strengthen our stance if members of Amnesty International could write to MASA (428 King's Highway, Lynnwood, Pretoria 0081, Republic of South Africa) expressing the same support as has been suggested for the Turkish Medical Association.

NORMAN LEVY

501 Medical Square
156 Main Road
Sea Point 8001
Republic of South Africa

New contract

Sir,
We now have a clear idea of our new terms of service. They confirm that the contract is not only going to be very tough but is going to be strictly enforced.

Unfortunately many general practitioners have not read through the new contract and many practices have not carried out a costing exercise to see how well off they will be when the contract is introduced. In my practice, if targets which rely on the patient's cooperation are not achieved, if minor operations in clinically approved rooms are not carried out, and if the doctors who presently carry out paediatric assessments are not credited to do so under the new system, then we will be worse off despite carrying out the same clinical work and having to take on more administration and health checking. We will have to take on more staff without guaranteed reimbursement, we will have to see many more patients most of whom will be perfectly well, we will have to visit elderly patients for what is basically a social assessment or pay someone else to do this, and we will also have to keep more records in order to write our annual report on prescribing habits, visiting records, hours worked, time off, referrals and so on.

By accepting the new contract we are subjecting ourselves to unnecessary work without reward. We will be told what to do and how to do it which is not how professional people should be treated. Without action we will be condemning our patients to a poorer service which does what is necessary badly and offers a great deal of unnecessary activity which many patients do not want.

We must stand up for ourselves and give our patients a properly run, well financed system of health care even if this is at an initial cost to patients. By resigning we would be taking the National Health Service out of the political arena and resignation would not be unpopular with patients if all general practitioners resigned. It would signal our total opposition to the government's proposals, and if we continued to work as we do now but with additional services which patients want such as in-house physiotherapy, patients would support us. The government would have to reimburse patients as it would be politically damaging for them to stand back and do nothing.

In recent press reports the General Medical Services Committee have suggested an annual capitation fee of £75 per patient, but if all patients had to sign with their doctor privately, the actual capitation fee required to provide exactly the same service as at present would not need to be much more than £35 or £40. To that could be added small additional fees to cover physiotherapy, in-house biochemistry and other services useful for patients and provided on the premises. We would be maintaining our independence, and pricing our services appropriately, leaving the level of reimbursement up to politicians who would have to address themselves directly to their electorate, rather than negotiating the level of financing for health services with doctors and health academics.

We need to act together, and general practitioners must discuss with their partners and local colleagues what they consider to be best for their future and that of the health service. We must lobby local medical committee and British Medical Association representatives so that feedback from the grassroots reaches the negotiators. We must be united, otherwise a two tier system will result as many doctors leave the health service and the remaining doctors have the patients with the greatest needs. We must not despair but must do what we know is best for