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## Grooming for general practice

Sir,
Dr Styles defined many of my own misgivings about general practice training in his excellent William Pickles lecture 1990 (July *Journal*, p.270) and I agree with his proposed modifications to medical education.

I would, however, like to suggest a small alteration in terminology which I find helps me overcome a large psychological barrier to the overall aims of training for general practice and that is to the word 'training' itself. This finite term, meaning 'teaching a specified skill' implies that, once learnt, there is nothing more to learn. I prefer the word 'grooming', defined in the *Oxford dictionary* as 'preparing or training (a person) for a particular purpose or activity (was groomed for the top job)', as it enables me to broaden my attitude to teaching the trainee.

Nevertheless, I realize that we cannot rename trainers grooms, in case the trainees feel that they are being treated like horses.

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## Research for all in general practice

Sir,
Your editorial (September *Journal*, p.357) does not do justice to its title. If 'Research for all' is to mean what it says, research must become a routine activity for every practice. How can we plan our work to achieve future objectives if we do not know where we are starting from? Despite all its serious errors, the new contract does at least oblige us to set targets and measure their attainment, and this involves systematic, standardized recording of clinical events, related to an enumerated base population. The contract can and must be revised to bring it in line with the experience of those of us who have been doing work of this kind for 20 years or more, none of whom appear to have been consulted; but the positive features of the contract will remain, and will surely be extended to wider and more clinically interesting fields.

Spurred by the requirements of the contract, over half of all practices are already using computers to record clinical data, and within the next two years the remainder will probably join them. Competing computer systems will fall in number, and converge in format. Exasperation with futile processes undertaken merely because they are paid for will spur us to produce the evidence we need for a contract which measures outcomes, regardless of how they are attained. Many intermediate outcome measures are already available: blood pressure in hypertensive patients, glycosylated haemoglobin levels in diabetics, body mass index in the obese, number of fits in epileptics, hospital admissions in asthmatic children, and so on. The minister of health should be interested in ends and not in means. He should want to know the proportion of a population whose blood pressure, body mass index, peak expiratory flow rates and tobacco and alcohol intake had been recorded, not whether clinics are held which claim to be able to change these indices.

Training in sophisticated research methods, and a career structure for academic general practice, are real and important problems, worsened by the philistine times in which we live. They must be addressed and the Royal College of General Practitioners should help university departments to solve them, but that is not the most important task. Research is a systematic search for relevant truth, and testing of truth by active search for error; no more, no less. Without research of some kind, no practice can get itself beyond passive response to patient demand. Research in these simple terms is not an intellectual luxury, an option for enthusiasts, but a necessity for everyone in socially responsible practice.

All general practitioners are now undertaking research in their own practices; sharpening up the definition and age structure of their populations at risk, looking at population related rates for some clinical activities, and publishing what they find in an annual report. We ought to be helping them, not just in practical ways, but by assisting the birth of a new kind of clinical and social imagination, which no longer regards research as a minority option. Our great opportunity is not the recruitment of a few more professionals, but the accession of 30 000 absolute beginners.

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Sir,
Your editorial clearly described the difficulties experienced in performing research work in general practice, particularly now that the bureaucracy of practice is diverting attention from clinical work.

Mention was made of the Syntex awards and the research units, and of James Mackenzie, but of no others. You ask why research is not yet an integral part of the culture of general practice, and I think the answer must be that the mind of a researcher is rare anywhere. You should also realize that it takes many years for a general practitioner to obtain 'respectability'. For example, I was one of the first to observe tremor reduction by beta blockade,[1] but my publication caused little stir initially because I was only a general practitioner.

Whereas James Mackenzie's research and that of William Pickles were limited to specifics, John Fry's studies have covered a remarkable range of common diseases, and have affected patient management more widely than any other research I can think of. Having met Pickles, and seen Fry's method, I must conclude that research depends upon an unusual combination of mental properties: tenacious curiosity, the ability to identify events requiring examination, wide and critical reading of the work of others, and the construction of a methodology for recording and analysing data. Some of these properties can be taught, but the devotion of time and effort outside the already demanding hours of consultation and administration require unusual energy, restriction of other interests, monastic seclusion, a legalistic balance of judgement concerning the results and literary skills in producing a paper.

It seems to me that one of the main areas for which general practitioners are perhaps uniquely suited is the longitudinal study of the ageing process. My own work[2] has shown that changes in the internal environment, which lead to the diseases of ageing, and which lie on a scale between apparent normality at one end and gross disturbance at the other are fundamental to our understanding of atherosclerosis, age-related obesity, essential hypertension, type II diabetes, cancer, and so on. We no longer live in a time when one has to decide whether one has a disease or not: instead, diseases are to be expected in later life when what matters is not so much their presence but the rate at which they progress.

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## General practice in London

Sir,
The study by Powell (September *Journal,* p.372) on the need for and provision of general practice in London is useful in pointing out once again the wide variety of need within the city and in showing that the terms 'inner city' and 'deprivation' are not synonymous.

It seems strange then that 'good quality' general practice is described solely as health centre group practice. Surely a variety of need demands a variety of answers. The large health centre model of practice is not always the most appropriate model and the more personal small practice may be more accessible in deprived areas and therefore more suitable. The suggestion that the proportion of general practitioners born outside the UK should be used as an index of 'poor quality' is remarkable. Might not non-UK born general practitioners be more acceptable and appropriate to a large non-UK born population, and not less so as is implied?

General practice is varied, partly because the needs of communities are varied. We should be asking, 'What are the best ways to meet the needs of London's various communities?' rather than convincing ourselves that there is only one type of 'good quality' general practice.

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## Budget holding

Sir,
It was with interest that I read Dr Higson's response (September *Journal,* p.392) to my letter (April *Journal,* p.170) in which I was critical of budget holding. With remarkable eloquence he paraphrases the philosophy of *Working for patients,*[1] outlining the theoretical, but as yet, unproven advantages of the new National Health Service management structures. I am not convinced that his reasoning lends logical support to budget holding. For example, he rightly stresses the importance of future planning. However, it seems somewhat illogical that a budget holding practice has to project its costs for the forthcoming year when family practitioner committees cannot predict what their funding allocation will be one year hence. A practice's use of resources may vary enormously from month to month and year to year. How can one effectively predict expenditure with such fluctuations in demand for resources?

While I am the first to admit that there should be change in the NHS, I believe that any change should be gradually phased in and based on soundly researched facts and evidence, not on political theories emanating from think tanks. With this in mind, could Dr Higson answer the following questions?

— What factual evidence is there that general practitioners are not at present using existing resources efficiently and cost-effectively, accepting that the wide variation in the use of resources does not equate with efficiency or otherwise?

— Which successful working budget holding schemes or models, either here or abroad has the government studied and critically appraised?

— Which hospitals have the spare capacity to provide a quicker, more efficient service to those patients referred from budget holders?

— What guarantee is there that the 'ratchet' effect will not be applied to general practitioners' budgets, as it has in the case of the hospital service in the overall 'downward pressure' on expenditure?

— With such high financial and political risks involved, why were no pilot studies performed?

Budget or fund holding is clearly a system of cash limitation. The advantages sound both plausible and seductive, but to date, are only theoretical. Nevertheless, a number of practices have applied for the privilege. In my view they fall into four categories:

- Those who are against budget holding in principle, but who reluctantly apply because the local hospital services are so poor. These doctors may feel that they have nothing to lose in such circumstances. Perhaps budget holding will give them more influence in the provision of services. Perhaps not.
- Those practices who regard the concept of budget holding as something of an intellectual challenge — something akin to climbing a difficult mountain 'because it is there'.
- Those who genuinely believe that it is in the interests of their patients, not questioning the true motives of the government or suspecting any hidden agenda.
- Those who think they will gain financially.

In these difficult times when the profession is reeling from the tidal wave of change we must not accept that budget holding for all is inevitable. The concept must be constantly questioned and reappraised. Joining the vanguard of budget holders during the so-called experimental period will do more to lend credibility to a scheme which the majority of general practitioners regard as badly flawed, than scientifically testing a doubtful hypothesis.

In the end it comes down to adequate funding of the whole of the NHS. Arthritic patients, waiting for their hip replacement for too many years, seeing orthopaedic wards closed down to make their local hospitals' books balance, will not care about budget holding. I think they would regard the 'doughnut' theories of management with even greater contempt.

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**Reference**

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## Orchitis in chicken pox

Sir,
A two year old boy presented to me with chicken pox rash which had been present for one day. He was treated with paracetamol and calamine lotion. He also had green nasal discharge and a cough and was given pivampicillin suspension. He saw my partner four days later with a swollen left testicle. This was not painful and there were no signs of torsion so he was not admitted to hospital. He had stopped taking pivampicillin by that time and was given cotrimoxazole paediatric suspension. When I saw him again four days later the testicle had started to improve but it was still enlarged by 50% and was pink and tender. The chicken pox rash was beginning to heal. One week later the boy's left testicle was completely normal.

Orchitis is not given as a complication of chicken pox in my textbooks, but our local paediatrician told me that it can occur with any virus. I am interested to know whether orchitis in chicken pox is common and whether any effect on fertility can be expected.

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