The problem of an individual contract that specifies a 24 hour, 365 day per year availability to patients would be negated by the devolvement of such responsibility to the general practice consortium as a whole. However, a useful degree of continuity of patient care would be retained, owing to the commitment of members of the consortium to their patient 'list'. Patient choice will be ensured by the control which family health services authorities will have over placing contracts, thus fostering the variety and diversity of general practice, so necessary to a nationally directed system that retains responsiveness to local needs.

Current discussion about reaccreditation will have been resolved by a system of continual reaccreditation by audit, adequate time and resources having been given for family health services authorities to monitor the performance of consortia based on health outcome, and for general practice consortia to monitor, advise and direct postgraduate education for their principals by unobtrusive, computer-based, information-gathering technology.

Educational development is the forte of modern general practice in the UK and by the year 2000 the education of medical students will be primarily general practice based, opening up opportunities for the study of disease and its impact, physical, psychological and social, on individuals and the community at large. Postgraduate education will have been improved by making general practice experience a mandatory requirement for the general professional training phase for all hospital-based specialties. For accredited general practitioners, postgraduate education will have become more flexible, based on the active participation of all principals in local standard setting and the development of local disease management protocols, involving close interaction with hospital-based specialists.

These changes, having been evolved in consultation with the profession by successive governments, will ensure a less stressed practitioner and less stressful working environment. These are the rewards of a worthwhile job well done, with adequate resources to do that job, increasing the motivation and efficiency of general practitioners.

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Care of long-term mentally ill people

Sir,

Dr Elizabeth Horder's editorial (October *Journal,* p.399) has highlighted an area which concerns all general practitioners: the problem of providing good primary medical care for people with long-term mental illness in the community.

It is difficult to estimate the total number of long-term mentally ill people outside hospital who are socially disabled by the sorts of illnesses which Dr Horder describes. A conservative estimate is about 180 000 (0.5% of the 36 million adult population of England),[1,2] of whom only a proportion are former long-stay patients.

Dr Horder addresses the primary medical care needs of those housed in hostels. This group have at least been identified and provided with special care. The main challenge general practitioners face is how to provide primary medical care to the majority, that is, those living independently, with families, or in lodging houses.

Many people with long-term mental illnesses, such as schizophrenia, are withdrawn and inactive and do not make demands on their doctors, so that their mental and physical problems may be neglected until they build up to a crisis. General practitioners may be unaware of the problems of their long-term mentally ill patients, or even of their existence. Even when the patient sees the doctor there may be considerable barriers to communication including hallucinations, delusions, and lack of insight. Most general practitioners and their staff lack training in dealing with these patients, and this must contribute to negative attitudes towards taking on their care. Research carried out from St George's Hospital Medical School has shown that such patients pose many problems in practice and that they are often seen by general practitioners only when crises develop. Very few general practitioners have specific policies for the care of the long-term mentally ill.[2]

There is, therefore, a need to improve the provision of primary medical care to all long-term mentally ill people. With the help of the Mental Health Foundation we are testing the feasibility and impact of setting up practice-based call–recall registers of these patients, and training general practitioners in the use of a structured assessment of such patients at regular intervals.

Long-term mentally ill people should be encouraged to live outside residential care and be treated as normally as possible. They are an at-risk group which needs a special proactive approach, but they are no different in principle to other groups such as under five year olds and over 75 year olds. By organizing ourselves to seek out long-term mentally ill patients at regular intervals, we general practitioners might avoid seeing such patients only at times of crisis, or even worse, neglecting them altogether.

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Double-blind, randomized controlled trial

Sir,

We were interested to read Dr Charlton's editorial (September *Journal,* p.355).

There are different kinds of knowledge; different philosophical bases for knowing. One of these is 'technical-rational' knowledge, derived through positivist science, such as the double-blind control study. Another kind of knowledge, as Charlton recognizes, is 'craft knowledge' which professionals acquire through experience.

Craft knowledge may be tacit and unarticulated,[1] as suggested by Charlton in his description of the brilliant doctor who cannot explain why she/he achieves better results than others. Schon argues that the practitioners can generate theory or craft knowledge from their own practice when they meet an unusual situation.[2] This leads to 're-framing' the problem, or 'on the spot' experimentation, and is part of craft knowledge.

The philosophical base for generating knowledge must match the sort of