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

knowledge that is to be generated. Knowledge that is not technical or rational cannot always be studied or generated through positivist scientific methods and other methods may need to be used. These kinds of knowledge can be generated by researchers[3] and practitioners.[2]

Qualitative data may be collected using a variety of research strategies, such as action research.[4] Here, the researcher or practitioner may act as a participant observer to gather data about the participants' behaviour, actions and conversations (ethnography), and use in-depth interviews to gain an understanding of the participants' perceptions and feelings, meanings and interpretations (phenomenology). These qualitative data may be complemented by quantitative data.

While positivist science is essential to the generation of technical-rational medical knowledge, workers intending to embark on a piece of research should first assess the value and appropriateness of the available research strategies, according to the sort of knowledge they wish to generate. They may find that approaches other than the double-blind, randomized controlled trial (or other approaches based on the positivist philosophical position) may suit their purposes better. Likewise, educators should match their teaching and learning strategies and philosophies to the kinds of knowledge they are making accessible to students.[5]

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Spirituality, healing and medicine

Sir,

Dr Aldridge's review article (October *Journal,* p.425) raises several important points but does little to allay the confusion surrounding the subject.

Complementary medicine, if it is to be taken seriously, must be subjected to proper clinical trials. Some spiritual healing treats the restoration of wholeness as the primary task, rather than the treatment of illness or symptoms. Restoration of this balance may or may not then eliminate illness or disease. I understand 'spiritual' to refer to that area of being that is dealt with and sustained by religion. The personal functions of religion are primarily to reinforce the identity of the individual and to give him or her a sense of belonging.

Spiritual healing, therefore, should strengthen identity and increase a feeling of belonging. These aims, which are not contradictory, are those of truly holistic medicine and, I contend, those of many general practitioners.

Dr Aldridge describes two forms of spiritual healing, through touching and through more distant influence. Both involve exerting influence on a passive patient. However, I prefer a different division: one form is the exercise of healing gifts, whereby some people are able to influence others in the direction of healing in a way reminiscent of hypnosis or telepathy. This can be in a religious context but is often not, and the context is peripheral to the exercise. The other form of spiritual healing is more closely related to prayer and is carried out in a religious context. It may contain elements of contact and influence but this is peripheral. The effect is more directly to confirm the identity of the person and increase the sense of belonging, and it is here that religion, particularly in my view christianity, has so much to offer.

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Sir,

The review article by David Aldridge is a timely reminder of the change in health care, which attempts to bring a whole-person approach to understanding both the causation and the therapy needed in medicine, within a world view which acknowledges that man is a spiritual being.

In the past, western medicine has rightly moved away from what appeared to be myth and magic, and has concentrated on natural cause and effect. This has produced great benefits and many helpful advances in medical care. However, natural science has denied or ignored the metaphysical or spiritual domain. Now is an appropriate time to attempt to bring together the two domains, as the majority of people believe that man is more than just a physical creature, and whether or not we believe this ourselves, this belief in people must play a major role in both the causation and treatment of illness behaviour.

While many would agree that it is important to explore the spiritual aspect of health and illness, caution should be exercised. First, there needs to be a distinction made between christian healers and other spiritualist healers; most christians would not associate themselves with the Confederation of Healing Organizations, most of whose members do not practise christian healing.

Secondly, we should not underestimate the problems associated with adding the metaphysical dimension to our routine medical work, as there is very little known about how the two domains interact.

Thirdly, it will be exceedingly difficult to undertake research programmes in this area. Although there have been studies which have attempted to measure the effects of prayer on disease processes,[1] I believe that the results should be treated with some caution. The research methodologies available to us have been designed and perfected for a naturalistic model of health and illness, and they are probably not suitable for investigation in a mixed domain model where the supernatural and the natural are interacting.

Finally, I would like to stress the importance of clearly understanding what spiritual forces are being called upon in any spiritual healing process. Is it an inner force of a positive attitude (perhaps like a placebo response), is it calling on the christian God through the power of Jesus Christ, or is it some other spiritual power which to the christian would be dangerous and unacceptable?

Let us continue to explore the area of spirituality in health with caution and humility. We may believe that there are more things in heaven and earth than our present philosophy considers, but we should recognize and affirm the progress made by western medicine while being prepared to admit its deficiencies and seek for a more holistic approach to benefit our patients.

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