College of General Practitioners in London as a Europe-wide initiative in this field. A number of innovative activities are being piloted in this country and their outcomes evaluated. They are designed to add to primary health care services and to help older people keep well and use services more appropriately. I am aware, however, of a number of local Age Concern organizations who are anxious to explore other ways in which the services they provide and their expertise can be used to help general practices. The local organizations are having difficulties in making contact through local medical committees, faculties of the RCGP and individual practices.

I hope members of the RCGP will respond positively to advances from local Age Concern organizations or even initiate contacts themselves. They may well be surprised by the opportunities revealed.

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Summative assessment

Sir,

In the paper by Campbell and colleagues (October *Journal*, p.430) there was a reference to the large number of assessors required to carry out a simulated surgery, with the implication that this would prevent its use as an assessment technique on a wide scale. It was assumed that simulated patients require to be observed by two outside assessors, but in fact this is not necessarily the case. There is wide experience,[1] particularly in the United States of America,[2] in the use of simulators to complete marking a simulated consultation without the need for direct observation. If this technique were developed and applied in the United Kingdom it would in fact require fewer expert resources than the video based assessment proposed.

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Burnout or into battle?

Sir,

Ruth Chambers' editorial on burnout (November *Journal,* p.442) has the merit of starting from where most people are, but commitment to consensus prevents her going any further.

Burnout is not new. Like all their colleagues working in areas of greatest need, doctors in the Upper Afan Valley in south Wales were always overworked and under-resourced, working within constraints unimaginable to those responsible for defining professional success or failure. I started practising in 1961; in the following 30 years, an area averaging 8500 patients had 21 doctors, of whom one committed suicide, two were sentenced for fraud, and five had major alcohol and/or drug abuse problems, one of them acutely fatal.

The editorial offers four apparently timeless platitudes: young doctors should have realistic rather than idealistic aims, breakdown should be destigmatized, mutual support between doctors should be encouraged, and practical steps should be taken, such as not taking on too much work, or attending conferences, or starting projects. I cannot see how any of these were relevant or possible in the circumstances these casualties faced, which were typical of those in which breakdown still most frequently occurs. On the many occasions when my work depressed me, my biggest problem was not that my wife and I were exhausted, but that we had worked so hard and apparently achieved so little that was relevant to health. The solution was to think differently, and define success in our own terms.

Mankind is omnicompetent, a morally unprogrammed though social species with infinite capacities for heroism, villainy, mediocrity or any other behaviour. To cope with change imposed upon us, we must have some sufficiently robust idea of how the world works to make sense of our situation, and how we ourselves may become active agents of change, not just passive victims. Granted such imagination and understanding, human capacities to cope with difficulties far greater than anything imaginable today in this island are truly extraordinary; but without them, faced only with relatively trivial adversity, we collapse.

We stand now at the outset of a new social era throughout the world, which has already imposed huge challenges on millions of people. The most powerful social ideas presently offered for dealing with this have been those from the 19th century which we once imagined were permanently discarded as obsolete. In this new world of equally infinite opportunity and insecurity, with cooperation derided, all exits from competition blocked, and every value priced and for sale, these ideas seem to work well enough for the winners, at least at the start. But those who suffer burnout are, by definition, losers. So are many of our patients. Do we really solve their problems by suggesting that they demand even less from their mediocre and impoverished lives?

The Royal College of General Practitioners was born because it had positive ideas for the future of National Health Service general practice, as something better than a dustbin for failed specialists. In 1948 these views were heretical — not harmless platitudes but fighting talk. If anyone doubts this, they should read the Collings report[1] and ensuing correspondence in both the *Lancet* and *British Medical Journal.*

Today, at least two diametrically opposed paradigms compete for the minds of young doctors who want both to enjoy their lives and to be socially useful. A managed NHS market in which general practitioners would compete both as purchasers and providers for their patients as consumers was originally proposed by leading figures in the RCGP,[2] and vigorously adopted by government. By definition, this entails winners and losers. I proposed an alternative, area-based cooperative service giving priority to the development of patients as co-producers of health, in which 'bad' practices could be resourced rather than punished.[3] There may be other ideas. What virtually no one proposes is a return to a paternalist service in which professionals were virtually unaccountable for their work; even if we would like to go on being paid for public service without public accountability, no one any longer believes this is feasible. Yet Chambers writes as though nothing had changed, no choices had to be made, and the old ramshackle independent professional pradigm could go on making fools of all who believe in it, and martyrs of many of them.

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