Fundholding is gaining popularity and has begun to improve relations between general practice and specialists, with more shared care. More management and more incentives to make profits may lead to some economies but not necessarily to better patient care. All these new activities are a great experiment that is being observed with much interest and questioning by other countries.

How do we stand in the health league? Our health indices are not the highest. While infant mortality rate and life expectancy are among the best, our mortality rates from cardiovascular disorder, cancer and chest disease are among the worst.[4] The reasons are more to do with social and environmental differences than the quality of our medical services.

General practice is popular with young doctors: it is the first choice of almost one half.[2] In the USA family medicine is the first choice of only one in 10 of young residents, and there is a similar lack of popularity in France and Germany.[2] The UK has a free medical education system, whereas in the USA, young doctors may face debts of around £50 000 to pay off for their education.

On the whole the incomes of British general practitioners are comparable with those of colleagues in other systems.[3] When grants for expenses, retirement pensions and reimbursements are included, differentials between our general practitioners and specialists at 25–50% are much less than the 200–300% in the USA.[1]

Stepping back after visiting other countries and considering facts and data, it has to be judged that while the structure, services and processes of British general practice are sound and that it is in the forefront of new ideas and methods, there are problems.

In the aftermath of political confrontation and imposition of the new contract, there is a mood of sullen anger, frustration and low morale. The untested philosophies were enforced without sufficient preparation and demonstration of any definable benefits. There is overemphasis on value for money, managerial prowess, data collection and paperwork. There is stress because of public overexpectation stimulated by a false patient's charter and constant media sniping at the NHS.

However, now, just as in the past, we need to put the bad experiences of the recent traumatic reorganization behind us and achieve better mutual collaboration and understanding under sensitive political and professional leadership. We must allow the effects of the new contract to settle and pray for no more reorganizations over the next two generations.

The goods news is that the NHS has survived and that British general practice with its stable basis for good care is still the envy of most other health systems — we have much of which to be proud.

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Training general practitioners in minor surgery

MINOR surgery by general practitioners is here to stay, and the shifting emphasis from secondary to primary care will encourage it further. Generally it works well — it is safe, cost effective and popular.[1] But there are worries. As more general practitioners carry out more minor operations, the chance of inadequately trained doctors performing inappropriate procedures increases. Incomplete excisions of skin cancers is one area of concern;[2] doctors failing to send specimens for histological examination is another.[3]

The answer to these concerns is proper training. Many general practitioners have a great deal of experience and expertise and have been doing this work for years, but many others have not. Some doctors may have avoided doing minor operations altogether if they did not like this work. However, the new contract has put all general practitioners under pressure to provide minor surgery, especially with the added financial incentive. Therefore the profession, and the public, need to know that general practitioners who do minor surgery are being adequately trained.[4]

What is adequate training and who should be providing it? Many excellent courses already exist in the United Kingdom, but there is no consistent policy on what form this training should take. An editorial in the *Journal* raised a number of important questions — who should the trainers be, how, where and when should the training take place and how can continuing education be achieved?[5]

One major problem is that general practitioners need to know many different techniques, drawn from various disciplines. They need a foundation of basic surgical principles and stitchcraft, certainly, but just as important are joint and periarticular injections, together with a whole range of techniques from dermatology, such as cryotherapy, electrocautery and curettage. Doctors used to learn how to deal with lumps and bumps during their surgical house posts,[6] but with surgical units in large hospitals becoming more and more specialized many surgical house officers scarcely set foot in an operating theatre. And with the shift of minor surgery from hospital to general practice, fewer and fewer patients will be treated in hospital. It is therefore unrealistic to expect general practitioners' training to take place during the pre-registration year. Many doctors go on to hold casualty posts or gain other experience in surgery, and perhaps in rheumatology or dermatology, but many do not. How much training they receive is often a matter of chance.

So what should a course cover? There is no doubt, for instance, that general practitioners need a clear, safe and com-

monsense approach to skin lesions, including malignancy.[7] It is relatively easy to show general practitioners how to set up their premises for minor surgery, to keep good records and to carry out appropriate audit.[8,9] However, it is much more difficult to teach them how to do practical procedures, because ideally this should be carried out on real patients.

The best way to learn a practical procedure is to carry it out on a patient under the expert guidance of an experienced colleague. But this is not always feasible, especially with large numbers of doctors. So the next best thing is to practise on a substitute. Until very recently this meant pigs' trotters. But these do not really behave like human skin, and they certainly do not have cysts and moles. Now, however, a range of extremely sophisticated simulated tissue has become available, which makes it possible to practise a large number of different techniques. It is this variety of techniques which is so important to general practitioners. This simulated tissue is made from latex and silicone. It is entirely non-biological, yet it behaves remarkably like human tissue. Pads of skin mounted on jigs can be fitted with moles, cysts, lipomas and other lesions. There are also simulated joints for learning to give articular and periarticular injections. A green light comes on when the needle hits the right spot, so they can be used for self assessment. And there is more on the way. For example, a simulated face, ingrowing toenails and varicose veins for injection are already in production. This technological explosion has opened the way for skills training. It allows general practitioners to obtain intensive practical experience under expert supervision, giving them the competence and confidence to operate on real patients. However, although this seems a good idea, it has never been formally evaluated.

In 1992 a working party was set up by the Department of Health to re-examine the guidelines on minor surgery prepared in December 1991 by the General Medical Services Committee and the Royal College of General Practitioners in collaboration with the Royal Colleges of Surgeon of England and Edinbrugh and the Joint Committee on Postgraduate Training for General Practice. The working party has representatives from the bodies involved in preparing the guidelines together with the British Society for Dermatological Surgery and the Department of Health as well as regional advisers. Training for general practitioners is clearly an issue which the profession needs to tackle, so a subgroup of this working party has designed an intensive two day course in minor surgery to serve as a blueprint. It has a clear syllabus and can be run anywhere, drawing upon local expert speakers. Its linchpin is a series of practical sessions using simulated tissue, for small groups guided by experienced clinicians. These sessions are interspersed with short incisive lectures covering other aspects of the subject.

If the course is shown to be effective it will bear the imprimatur of the profession, and can be used as a basis for continuing training. It could also be extended beyond general practitioners to medical undergraduates, junior hospital doctors and paramedical staff. The Department of Health has funded six pilot courses to be run during 1994, some for general practitioner trainees, some for principals. The first will be held in March at the Royal College of General Practitioners, Princes Gate, London, the rest in various parts of England and one in Scotland. If these are successful, similar courses will then become available more widely.

Evaluation is a crucial part of this whole process. This will be carried out independently by the academic department of primary care at St George's Hospital, London. The department will assess not only the courses themselves, but also their outcome. Participants will audit minor operations they carry out in the year after the course, and their results will be compared with those of a group who have not attended the course.

The profession needs to show itself and the public that it takes its responsibilities for training seriously. Vocational training for general practitioners in the UK is rightly considered to be the best in the world. Practical skills training will make it better still.

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