and of how fortunate that we are to be working in the UK. That aside, the WONCA conference allowed the junior delegates to share their experiences.

As a result of this conference, I am sure that some models of training that we take for granted at home will be proposed to the training bodies of other countries by their delegates, and the UK delegates will propose to our College, ideas that we have gleaned from other countries to assist our trainees. One such idea is to establish a national trainee network that provides support and information for trainees — an idea that works extremely well in the Netherlands and Ireland.

We attended the pre-conference and exchanged ideas and information about how we practice in our respective countries with other junior GPs and trainees. The small group workshop structure worked well despite a total of 19 nationalities being represented. We were able to generate common issues facing young GPs, and surprisingly reached close consensus as to how matters may be improved. One example of this is the status of GPs is so variable across Europe, from being the most trusted and valued professional in the UK, to being a 'reject' doctor in a large number of other countries — lobbying governments and universities, and leading by high quality practice, were common solutions to this predicament.

Waqaar Shah

Mike Fitzpatrick

The future of general practice

Sometime around last Christmas, the patient editor of the *British Medical Journal*, had a dream, indeed a vision, of how the health of the nation would improve over the decade ahead.

> *'As people began to realise that preventing themselves from becoming unwell was infinitely preferable to having avoidable illnesses treated, they started to listen more carefully to the government's health promotion messages: eating more healthily, drinking more sensibly, taking more exercise, and avoiding unnecessary exposure to the sun. Generally, the media helped move the process along. In particular, they played a major part in making drug misuse completely unfashionable.'*[1]

My first thought was that this was some sort of spoof. But no, it was published on the day after the Epiphany, not on 1 April. As this editorial begins with some references to Dougal and Zebedee of the *Magic Roundabout*, I then suspected an acid flashback, or perhaps too much Ecstasy over the festive season.

But as the author proceeded to attribute the transition to Elysium to the introduction of 'wellbeing centres' staffed by dietitians, fitness advisors and nurses, and 'new age clinics', providing 'alternative and complementary' therapies, a much darker realisation dawned. This pipe dream was being offered as a serious contribution to the discussion of the future of primary health care.

I believe that the future of general practice depends on its capacity to establish clear boundaries between doctors' surgeries and 'wellbeing' and 'new age' approaches. We need to maintain the distinction between medical science and quackery, instead of 'putting quack doctors out of business' — by taking up quackery ourselves. We also need to distinguish between the diagnosis and treatment of illness, on the one hand, and the medicalisation of life in the (generally misconceived) quest for disease prevention, on the other.

The principle of prevention has become a bloated monster in contemporary health care, corrupting medicine, coercing patients and damaging relationships between doctors and patients. Everybody now knows that smoking is bad for you — whether or not they choose to stop: the contribution of every other lifestyle factor to health is of marginal importance. Health promotion — most notably in the sphere of diet — has moved far beyond what can be justified scientifically, and has become increasingly moralistic and intrusive. Screening tests — smears, mammograms, PSA levels — generate anxiety out of all proportion to health benefit.

My modest proposal is that GPs should abandon the authoritarian roles they have assumed in the spheres of prevention and public health (in particular the ambition of some GP entrepreneurs to tackle social inequality, social exclusion, domestic violence, child abuse, teenage pregnancy, or whatever cause some government thinktank defines as fashionable). The work currently carried out in primary care in the spheres of health promotion and screening is an ideal candidate for privatisation — much of this sort of recreational health care is already carried out at gyms and health clubs. Removing all these activities from our surgeries would not only relieve GPs, it would provide some respite from bullying health promotion for the more vulnerable and deprived sections of the community.

The only preventive activity of incontrovertible value currently carried out in primary health care is the childhood immunisation programme. But if the government is moving ahead to remove our health visitors and nurses to new 'children's centres' then it would make sense to provide immunisations in these centres. This would certainly provide a more useful role than patronising parents with fatuous advice about how to bring up their children.

If doctors gave up social and moral engineering — tasks for which they have neither expertise nor training — they could concentrate on the diagnosis and management of acute and chronic illness, for which they are well equipped by the achievements of medical science over the past century. They could also focus on some of the real challenges of medical practice in the new millennium: how to help patients who present with symptoms, which may be diverse, persistent and disabling, but in whom no disease can be diagnosed, how to relieve the suffering of long-term invalidity and terminal illness, how to help people with mental illness. If we gave up trying to be politicians or priests we might be able do a better job of being doctors.

REFERENCE

1. Lapsley P. The magic roundabout. *BMJ* 2006; **332:** 43–44.