that clinical setting; a commitment to the recognition of the huge efforts made by GPs and other primary care researchers; and a concern that excessive bureaucracy, underfunding, and lack of support by practice colleagues could damage the increasingly impressive profile of internationally successful GP research in the UK. Our main concern was to broaden awareness of how much the RCGP already does to support individual researchers, practice-based research, and the strategy and delivery of the national research agenda. Both the Seamarks and Tudor Hart acknowledge the need for GPs to group up to deliver: 'Multicentre studies on and with participating patients, conducted peripherally by primary care staff with personal knowledge of and responsibility for those patients, and coordinated centrally by groups including both fully trained researchers and experienced primary care staff, provide the only possible sites for research on patients as they actually are, where they actually live, which we must have for guidelines to become optimally effective aids to clinical decisions.'[1] The individual GP researcher is not extinct — they are just working with others across the UK, backed by the RCGP, and advocating for the highest quality research we can deliver at all levels.

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REFERENCE

1. Tudor Hart J. Clinical research by GPs in their own practices. *Br J Gen Pract* 2009; **59(560):** 214–215.

10.3399/bjgp09X454179

Re: Practice-based research

This correspondence is now closed — Ed.

Future of general practice

The marked contrast between the personal view 'A final g'day to English general practice'[1] and 'Practice, politics, and possibilities'[2] was striking.

Much of Adrian Elliot-Smith's observations about the changes in general practice may ring true, but his defeatist and world weary acceptance of the demise of urban general practice in this country is far from the mark and surely needs challenging.

Martin Marshall makes an excellent case for concentrating on the core values of general practice (commitment to excellent medical generalism, whole patient care, and the advocacy role of GPs on behalf of their patients and communities) and the need for social marketing to get the message across of the benefits of good local general practice.

We need to recognise that collectively and by working collaboratively we can influence the debate about the future of general practice. We need to get out of our silos. The government and society want autonomous and self-responsible clinicians.[3] The government can only set the direction, ensure minimum standards, and help to break barriers that prevent development of good services. As professionals we need to promote creativity and ambition, raise skills, be flexible, pursue excellence, promote excellent leadership and management, and set our own challenging standards of excellence. Our accountability to society will be strengthened by empowering patients and by demonstrating transparency of performance and our commitment to addressing health inequalities.

Perhaps we have being too long cultivating our own garden. It is time to look beyond its hedges and fences because the world will continue to intrude. Unfortunately, Voltaire never told us how to cultivate it successfully.

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By way of biography I work as lead GP for a community enterprise organisation. The practice has been established for a year in a deprived and previously under-doctored area.

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3. Cabinet Office. *New professionalism.* Strategy Unit, Cabinet Office, 25th February 2009. http://www.cabinetoffice.gov.uk/strategy/publications/excellence_and_fairness/report/html/new_professionalism.aspx (accessed 11 Aug 2009).

10.3399/bjgp09X454188

Politics and primary care

The August *BJGP* contained articles that run straight to the heart of 21st century UK health care and what must be done to secure the future for the patients. Kath Checkland, Adrian Elliot-Smith, and Martin Marshall are to be thanked for their contributions, that viewed together, frame the scene perfectly.

The commercialisation, atomisation, proletarianisation, managerialism, and contractualism that infests so much of contemporary national life and the health service in particular ought not to go unanswered. Together we can respond effectively, but who will join the fight?

In order to prevail we must be fully and directly engaged politically — that means we must get elected in some numbers. I have committed myself to standing as an Independent as far back as 2006[1] and retired prematurely from general practice in 2008 for that purpose. In the last couple of days Dr Wollaston from Totnes has become a candidate with substantial chances of success — arguably because she is not a typical party politician.

It is my view and I suspect the view of many, that primary health care is best delivered by multidisciplinary, autonomous, coherent teams dealing with defined populations — this is no golden-age idyll, merely the objective reality. Likewise, coherence and collaboration between all sections of the healthcare delivery system