performed under the NHS. Cosmetic surgery therefore remains the only branch of surgery in which surgeons will start to undertake procedures on the basis of having assisted at such procedures but for which they have no hands-on training. Training programmes must include hands-on supervised training in the private sector, organised at low cost for informed patients.

The main area of controversy in the United Kingdom is about who shall be regarded as qualified to carry out cosmetic operations. Traditionally, almost all cosmetic surgery was performed by plastic surgeons, although specialists in otorhinolaryngology, oromaxillofacial surgery, oculoplastic surgery, and dermatology now teach and include cosmetic procedures in their training syllabus.

These specialties are currently working together in a joint working party of the Royal College of Surgeons of England to provide coordinated advice on training; there is no provision for a separate specialist advisory committee in cosmetic surgery, which could otherwise have provided an ideal solution. Unfortunately the royal colleges do not have a mechanism to assess the standards of unaccredited cosmetic surgeons who are currently practising.

The advice of the profession to the department of health is unanimous—that training and continuing medical education are as important in aesthetic surgery as in other branches of surgery and that doctors qualified to carry out cosmetic surgery must be accredited in the appropriate specialty, have equivalence of training, or have an equivalent European qualification. Many surgeons working in private practice and in cosmetic clinics would not meet these criteria. A two year moratorium was therefore proposed to enable the clinics to organise appropriate training for their surgeons. The suggestion that surgeons already practising cosmetic surgery should be allowed to continue was strongly opposed by the profession as it would permit surgeons who are unqualified to remain in practice possibly for decades. Despite these representations the Department of Health has now brought forward muted proposals, which demand only that surgeons be medically qualified and have attended some postgraduate courses.

The national commission monitoring standards of care intends to control the worst excesses of the cosmetic clinics and to ensure that there is an even standard of care across the private sector, whether treatment is provided by consultant surgeons or in clinics. Surgeons whose operations regularly result in dissatisfied patients complaints, and complications will hopefully be excluded from practice. With the proposed regulations, however, this will probably not happen until considerable harm will have been done to too many patients. The public would be better protected if people consulted their general practitioners first, but it is likely that the number of self referrals will increase rather than decrease. Public education through the professional bodies is important, but in the face of increased public demand, glossy advertising, and inadequate regulation only the most sanguine optimist can believe that the situation has been controlled adequately.

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Using telephones in primary care

A significant proportion of consultations might take place by phone

NHS Direct, the United Kingdom's open access telephone advice system, which is staffed by nurses supported by computer decision software, has been the subject of a long and often bitter debate. Is it value for money; is this system the most effective; how should it relate to other services; and what is its effect on them? But this concentration on one particular initiative ignores wider questions about telephone consultation in primary care. What is its role? Who should do it? What background and training do its providers need?

The telephone has been around for more than a century, but the literature on these questions is scanty. A recent Medline search on telephone consultation found only 77 references on its use in primary care over 35 years. Most of these references were reviews, commentaries, or case studies, with only a handful of controlled trials.

Just as the recent debate has centred on NHS Direct, so the literature focuses on use of the telephone out of hours (33 of the 77 papers dealt with calls made out of hours, which account for 1-2% of primary care contacts) and to triage urgent problems, although there are many other types of encounter in primary care. In the United States and elsewhere, up to a quarter of primary care contacts are by telephone.[1 2] I recently reviewed consultation patterns in an east London practice that had encouraged the use of the telephone by setting up a daily telephone surgery. The surgery's rate of phone contacts was also around a quarter, although the norm in the United Kingdom is far lower. Only half the encounters were for new problems; others were requests for information on treatment options, side effects of drugs, queries on the organisation of care, and follow up of acute and of chronic problems. We need to know far more about the telephone's potential as a mode of delivering routine primary care.

Reading the literature, it often feels as if the main purpose of the telephone is to keep patients at arm's

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length, its use assessed by its impact on medical workload rather than by improved access and convenience for them.[3] For more than a decade enthusiasts have encouraged consulting over the telephone and documented their experience, yet their findings have had little impact on general practice as a whole.[4–6] Despite its support for NHS Direct, the government shows little interest in other aspects of telephone access, and the General Medical Council's guidance on the subject makes telephone consulting feel like a slightly shady activity, best avoided by respectable and prudent practitioners.[7]

These negative attitudes are curious. If, as is often stated, 80% of diagnoses are made from the history, and since not all encounters entail diagnosis, one might expect that an appreciable proportion of consultations could take place by telephone. This could help patients, who save travel time and costs and do not need to arrange childcare or work cover, even if it does not save time for health professionals. We need to measure both the benefits and the limits of telephone medicine compared with face to face consultation, and how best to organise it, so that both doctors and patients can use it as effectively as possible.

The telephone is clearly a communications tool with several restrictions, including an absence of visual clues and non-verbal communication (although this may change in the future).

Despite this there has been little study of telephone consulting skills and little critical thinking about how best to work on its limitations and what background and training (which is scant) users need.[1 2] The relative merits of intuitive clinical expertise versus systematic enquiry guided by computer algorithms; of nursing and medical backgrounds and education, with their different emphases on systematic management and diagnostic judgment; and of telephone and face to face encounter are separate issues, yet they are often confounded. Interprofessional rivalries between nurses and doctors and the financial implications of their different pay scales may influence policy and add to the confusion.

Other questions remain unanswered. What impact does prior acquaintance with a patient, access to personal medical records, and continuity of care have on making telephone consultation more effective, safer, and increasing its potential? How good is telephone contact for patient education and monitoring of chronic diseases? The literature suggests hypotheses, but we need systematic and controlled data. Commercial organisations like banks have put considerable effort into telephone advice systems (with varying success) and telephone helplines such as that run by the Samaritans are an important feature of the voluntary sector. What lessons can we learn from these?

Most of all we need to understand why the telephone, after being part of our lives for so long, has met with so much suspicion and so many irrational assumptions, and why there is so little evidence on how best to use this simple piece of communication technology.

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Health care for older people

Scottish report has international relevance

In response to serious concerns about the health care provided to older people in Scotland the Scottish expert group on healthcare of older people, led by the chief medical officer, Dr E M Armstrong, has released an insightful report entitled *Adding Life to Years*.[1] The charge of the group was to describe the major health problems that older people confront, explain their journey through the healthcare system, investigate potential ageism, and promote good practices. The articulate and comprehensive report identifies a series of themes. Four of these are outlined below. Specifically, the report promotes individual responsibility for health, advocates for primary care, identifies the benefits of multidisciplinary teams in the care of elderly people, and discourages ageism. As indicated by the supporting literature, these themes have international relevance.

Health care is a shared responsibility

An older adult consulted for the report said: "A doctor can do only so much. We oldies must realise we are responsible for our own health." *Adding Life to Years* is to be commended for promoting individual responsibility in health care. Encouraging older adults to be physically and mentally active and to reduce poor health habits is an important theme of the report. For example, when an older adult presents with pain due to arthritis, the "pill for every ill" approach should be avoided and non-pharmacological options explored.[2] Weight loss and exercise may have an important role in minimising symptoms without placing the patient at risk for adverse events.[1] Exercise has been documented to improve muscle strength (thereby reducing frailty, functional decline, and injuries) even in frail residents in nursing homes.[3] Similarly, older adults should be encouraged to stop smoking. As stated in the report, "It is never too late to give up." Stopping smoking reduces the risk of cardiovascular disease, cancer, and respiratory complications. A quarter of older adults (65-74 years of age) in Scotland were identified as smokers.[1] Lower rates of smoking

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