There is a clear need for a multicentre, randomised trial to assess the risks and benefits—both to mother and fetus—of single versus repeated doses of antenatal corticosteroids. Several such studies, such as the TEAMS (trial of early and multiple steroids) project in the UK, are planned or in progress in several countries, including Australia, New Zealand, Canada, and the United States. Until the results of these studies are available we suggest that only a single course of antenatal corticosteroids should be given to all women at risk of preterm birth at 24-36 weeks' gestation.

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The specialist of the discipline of general practice

Semantics and politics mustn't impede the progress of general practice

Over the past 50 years general practice has established itself not only as an academic discipline with its own curriculum, research base, and peer reviewed journals but also as the cornerstone of most national healthcare systems in Europe. In so doing, general practitioners have shown that the intellectual framework within which they operate is different from, complementary to, but no less demanding than that of specialists. General practitioners must achieve a working diagnostic and therapeutic knowledge across the reach of biomedical science and must be able to forge effective and continuing relationships with an enormous range of individual patients. They need to understand the processes by which illness is socially constructed within the patient's life, and they must mediate between the patient's subjective experience of illness and the scientific explanation.

The breadth and comprehensiveness of its endeavour has made general practice notoriously difficult to define.[1] On p 354 Olesen et al attempt a new definition that emphasises the frontline nature of the care offered and the need to incorporate psychological and sociological perspectives alongside biomedical ones.[2] Immediately, in using the term "specialist," they have become ensnared at the boundary between semantics and politics.

The English language uses "generalist" and "specialist" as opposites. Other languages may be more obliging, but in the *BMJ* we are stuck with English and must find a way of using it that does not obstruct our purposes. In many European countries general practitioners have needed to claim specialist status to achieve recognition as a separate discipline. In the United Kingdom, however, this recognition has been accomplished through exploiting the notion of opposites and showing that the expertise of the generalist is complementary to that of the specialist and that the two are profoundly interdependent. Having achieved this, many British general practitioners will find it difficult to accept a definition that includes the word specialist. Yet much rides on the use of this word.

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The notion of opposites, with its consequences for optimal (cost) effective health care,[3] in fact implicitly underlines the specific virtues of general practice. General practice is special—a specialty—not so much in terms of in depth expertise in the complexity of a defined biomedical area but in the complexity of medical care in the patients' context.[4] Its focus is on integration and the ability to switch between different perspectives (biomedical, humanities) around patients' health problems.[5] This relates to a specific set of concepts, rules, and criteria[6] that appear in the definition of Olesen et al.[2] Yet the main database for biomedical research, *Index Medicus*, does not accept general practice as a specialty heading and provides an incomplete listing of general practice research journals. This severely impedes academic progress in general practice and is just one, but probably the most important, example of how recognition as a specialty might greatly strengthen the position of general practice.

The situation is further complicated by the complexities of European legislation, which seem to imply that general practitioners must claim specialist status if they are not to be disadvantaged in relation to specialist colleagues. The division between specialist and generalist is enshrined in the European Union Medical Directives, which have separate sections dealing with postgraduate education and training for specialists (title 3) and for general practice/family medicine (title 4). The requirements under title 4 are

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minimal and are exceeded in several countries throughout the union. Over the past five years general practice bodies in Europe and the Advisory Committee on Medical Training have made considerable efforts to improve the standards for postgraduate training for general practice. So far, these have been to no avail because of an apparent lack of will on the part of national governments and the European Commission—despite the importance of improving the quality of frontline care provided to patients. Frustrated by this lack of political will, the profession in some countries is suggesting that general practice should abandon title 4 and claim specialty status to argue its case more effectively for high standards for postgraduate training.

Given this semantic and political muddle it might be important to refer to general practice in terms that reflect its intellectual potential. In Dutch "huisarts" (home doctor) refers to medical care in the patients' context. "Family physician" also pays tribute to care in the patients' context, though family should refer to "a group of intimates with a common history and future," not just to the conventional nuclear family.[6]

Semantics and politics must not continue to impede the progress of general practice. Ways must be found to ensure that the interdependence of specialist and generalist roles is reflected in mutual respect and equivalent status—professionally, in remuneration, and academically. On this basis, the terms specialist and generalist might still be used but with a different emphasis, having lost their divisive and politically harmful connotations.

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On target for health?

Health targets may be valuable, but context is all important

Twenty years ago asking a health minister what he or she wanted to achieve would probably have elicited a response based on inputs, such as the number of new hospital beds opened or the amount spent on health care. Although some ministers might still give such a response, the focus is shifting to outcomes rather than inputs.

One feature of this shift is the development of health targets. In 1984 the World Health Organisation's office for Europe launched its 38 targets for "Health for All by the year 2000."[1] These stimulated European countries to reassess their health strategies and, in many cases, to set their own targets for health improvement. The WHO has recently revisited its earlier targets and created a new package with targets, "21 … for the 21st century."[2]

This new policy will probably stimulate countries to reassess their health policies. But 15 years on, what are the lessons? Are health targets a useful component of health policy? What determines whether they succeed or fail? These were the questions asked by participants at a recent conference in Paris.

A recent review of health targets in Europe identified three levels of implementation[3]: intentions are articulated at the political level; a plan is developed at the political level; and the plan is implemented at the practical level. The development of a programme at the political level requires both recognition of the need for action and political will to implement it. Some countries recognise the need for action more than others. In Denmark, for example, Health for All was thought appropriate only for developing countries. Only once it became clear that Danish life expectancy was lagging behind that of its neighbours did the political will to address the issue follow.[4]

A key issue is the question of the appropriate political level. Some countries, such as Finland or the Netherlands, have succeeded in developing national policies, but in others the regions have made the running, such as North Rhine-Westphalia in Germany and Catalonia in Spain. Either model may work, but there must be clarity about who is responsible. Targets are less successful when introduced at the wrong level, such as federally in Germany, or where regional and central governments are clarifying their relationships, as in Italy.

Even if political agreement about the need for action and direction of change can be reached, a plan may remain elusive. Several lessons emerged. Firstly, a broad consensus needs to be developed among stakeholders. North Rhine-Westphalia, for example, has created a state health conference, bringing together a wide range of interests, which is mirrored by similar bodies in towns and cities. Secondly, targets need to be limited to a manageable number. The WHO's original 38 is widely agreed to be too many, but so is 21 in the new programme. Most national and regional programmes have focused on five to ten. Thirdly, any plan should be based on evidence of effectiveness. Although health promotion is supported by more evidence of effectiveness than is often thought,[5] much remains poorly evaluated and is often highly dependent on context. Finally, targets need to be linked to resources. The English *Health of the*

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