the *Independent*, telephones the author when a letter says something unexpected or surprising, and he was unlucky that this policy did not detect the letter purporting to be from Professor Honderich. The *Guardian* asks for a telephone number but does not actually ring to verify authorship. Jeanette Page, letters editor at the *Guardian* for seven years, is not aware of any fraudulent letters having been published. She simply discards letters that do not ring true.

The *Lancet*, like the *BMJ* and many other scientific journals, has no policy on verification. At the *New England Journal of Medicine* all authors of accepted letters have to sign a copyright release form, and *JAMA* requires a signed financial disclosure. If the *BMJ* had followed either of these policies we would have rooted out the elusive Dr Bird. However, they would not stop a more determined pseudonymist, such as Paul Blackman, writing from his own address.

There are new challenges ahead. Although the journal now receives only a handful of letters every week by electronic mail, we expect that most submissions will be sent this way within the next few years. Checking the authenticity of emailed letters can be difficult because they are not signed. Steve Kennedy of Demon Internet, one of Britain's Internet providers, says that standard electronic mail can be faked just as easily as letters and there is little that can be done about it. Nevertheless, software exists that allows messages to be encrypted, though these systems are not yet widely used.

Until better safety mechanisms are in place, letters will remain vulnerable to fraud, and many such frauds may lie undetected. In future the *BMJ* will write to all authors of accepted letters to ask them to sign a conflict of interest statement and for an electronic copy of their letter. In the meantime, Dr Bird's letter should be considered of little value—"strictly for the birds."[12]

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Working with the community

General practitioners could gain much from greater involvement

When viewed from hospitals or the Department of Health, general practitioners may seem embedded in their local communities, ideally placed to act as "the patients' advocate."[1] But the view from an underprivileged housing estate may be that the local practice is just as remote as the local teaching hospital. Although the *Health of the Nation* asserts that many of the solutions to long term health problems are outside the remit of traditional heath services,[2] general practitioners still regard health mainly in terms of the medical needs of individual patients and families. If general practitioners and the primary health care team are fully to represent their patients' wider health needs they will need to find ways of relating to their communities that go beyond merely understanding the epidemiological data.

"Community" implies a shared interest or geographical locality.[3] If the primary health care team is to work more closely with local people it will have to consider what communities exist within its practice population. If it is going to ask people their views it will need to value the replies and be prepared to look for ways of responding to them. It will have to recognise how people become motivated to learn about health and the value of peer group support in this process.[4] In future, health professionals may need to see their skills as one part of a wider partnership in which the contribution of patients to their own health has equal value.

Existing methods of hearing patients' views focus on the surgery, tend to be one off events, and are rarely central to planning. Surveys of patients' satisfaction tend to ask the questions important to the primary health care team and may miss the issues of real concern to patients[5]: often all they do is "endorse the status quo."[6] Patient participation groups can extend the possibilities of dialogue but tend to follow a practice based agenda, and critics highlight the fact that their members are rarely representative of the practice population.[7]

What is required, as *Local Voices* suggests, is "a radically different approach to that used in the past." The primary health care team will have to link with a wide range of community groups and informal networks to reach those most at risk of ill health, who are often those least able to voice their concerns. The team will need to use methods, often qualitative in nature, that will enable patients to express their views freely. This will require a new way of working for most health professionals, who must be prepared to develop or seek out the new skills required.[8] They may learn from other agencies —for example, schools have developed mechanisms, such as parent-teacher associations, school councils, and parent governors to listen to the views of parents and children.

Several general practices have published accounts of their attempts to seek out their patients' views.[9-12] Their methods have included suggestion boxes, surveys and interviews, focus groups with patients or existing community groups,[13] and collaboration with other local agencies and groups.

Practices seem to be most successful when they use a variety of methods and are committed to involvement with the community as a continuing process. In one study practices reported that the information that they gathered contributed to their ability to provide services in more equitable and acceptable ways for local people.[9] In time they hoped that the need for medical intervention might also be reduced. Far from making huge and unreasonable demands, patients often make practical and achievable suggestions —such as changes to appointment times or to the message on the answering machine. Instead of running conventional health promotion clinics for a few worried well patients, practices may, for example, be invited by a women's group to run a stop smoking class in the local community centre. As this responds to a felt need rather than an imposed need it is more likely to succeed.[14] Social problems are often identified, such as damp housing or the lack of "things to do" in the area. While not strictly medical, these nonetheless affect people's health. Raising awareness of the problem can often help to solve it— in south London, for example, the results of a practice survey

enabled local people to negotiate for a better bus service.[11] In other areas needs assessment has stimulated local people to find their own solutions to problems, through self help groups, befriending schemes, or activities such as food cooperatives and children's breakfast clubs.[11,12]

Building links with the community takes time, and the early stages of any initiative may be frustrating as people learn to work together and trust each other. Many practices, recognising the difficulties of doing this alone, now employ a patient liaison officer[15] or link worker, whose job is to seek patients' views, forge links with other local agencies, and help set up health promoting activities based on patients' concerns. Other practices work closely with community development workers,[11,12] who, because of their training, can stand back from the "medical model" and see health, as most patients do, in much broader terms. Because these workers are separate from the practice, patients are often more willing to share their feelings with them, and they in turn are better placed to accept and pass on criticism than someone in the team.[11]

Health authorities, in their role as purchasers, are looking at ways of carrying out needs assessment, and many have identified the general practice as the logical local unit with which to work. But to gain a sound knowledge of their local area general practitioners need to be prepared to fight the inevitable pressure to achieve rapid and measurable health gains overnight and to argue for the necessary extra resources, protected time, and access to skills. Only then will they be able to build a more complete picture of the community and achieve health gains, which may be both unexpected and difficult to measure.

Many general practitioners may find it difficult to see past the ever increasing demands of patients and the new contract. The current emphasis on patient's charters and consumer rights exacerbates this. Yet a clear view emerging from those general practitioners who have cultivated links with the community is that working like this can greatly improve job satisfaction.[9] When the community participates in discussions about the realities of health care patients' expectations often become more realistic. Equally, doctors, by learning about resources available within the community, are better able to address the wider issues affecting people's health and to suggest more appropriate solutions to their patients' needs.[12] At a time of low morale among general practitioners these findings are surely relevant.

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Career choices for generation X

Young doctors want flexible career paths, not long term commitments

Young doctors are not choosing to train or settle in general practice as they did a decade ago, which has serious implications for training schemes and practices recruiting new partners. Changes in the NHS may partly explain this. Baker *et al* found that the four commonest reasons given by qualified general practitioners for not practising as principals were the commitment out of hours, difficulty combining work with family commitments, requirements of the general practice contract, and increasing demands from patients.[1]

A broader shift in values and expectations of work may also be occurring, and we need to understand the social context in which young graduates have grown up. The old certainties of work and family life have been crumbling.[2] Time honoured values such as security, authority, tradition, and a rigid moral code have gone. In the 1980s the outward directed values of status, image, and consumption replaced them. In the 1990s these were replaced by the inward directed values of empathy, connectedness, emotion, autonomy, and ease.

But the '90s also has a darker underside, explored by Stuart Coupland in his novel *Generation X*.[3] He charts the extended adolescence experienced by "twentysomethings" in America and their inability to make long term commitments or imagine a future. Underemployed, overeducated, and unpredictable, they settle for "McJobs": low paid work in service industries with poor prospects. Slacker is another word associated with this disenfranchised group.[4] Slackers leave even the McJobs to some other poor sucker and settle for doing very little.

Cannon describes the new work ethic, in which a decline in trust and loyalty to organisations together with a mortal fear of boredom leads young people to view employment in transactional terms: What's the deal?[5] Why get saddled with a difficult job? Work and jobs are being redefined[6]: new working practices include planning for career long self development, being able to switch focus rapidly from one task to another, working with people with very different training and mindsets, and working in situations in which the group is the responsible party.

General practice lends itself splendidly to this description of a new working environment. Doctors are by self selection unslack, but Generation X has arrived at medical school[7] and won't be yearning for the good old days because they don't have any good old days to remember. Despite the relentless negative press since the general practice contract ("Disasters in the inner city," "Trainee crisis deepens," "Doctors are more miserable than ever," etc) I am surrounded by colleagues who love their work, relish the variety that their patch offers, and enjoy a highly supportive professional network with many career opportunities. How can the job be redefined to engage a new sense of vocation while retaining elements of the work that continue to be satisfying? Our challenge is to find