We must start with improving GPs' education in dermatology, otherwise all attempts to provide solutions through secondary care will be swamped with inappropriate referrals. The vogue for outreach clinics was a symptom either of a specialty unable to cope with patient demand, or of a primary care service lacking appropriate training.

Dermatology should form part of the undergraduate core curriculum. It overlaps most specialties, and accounts for approximately 10% of a general practitioner's workload, yet many vocational schemes provide no formal training.[1] Appropriate training should be centred on the management of common dermatological conditions in primary care. The allocation of resources to continuing education should take account of the relative importance of each specialty to the work of the GP.

Dermatology in primary care can now provide a wide range of cost effective and acceptable treatments. Would not the proposed community based dermatology clinics benefit from being linked more closely to primary care? There has been a trend for hospital departments to discharge patients to primary care, with some loss of continuity of care. Should not the dermatological nursing expertise permeate into primary care, with practice nurses and dermatology trained nurses working together? The All Party Parliamentary Group on Skin has suggested that each practice should have a lead partner with expertise in dermatology.[2] GPs should be encouraged to increase their expertise, and study for the Diploma in Practical Dermatology. They could provide some non-core dermatological services.[3]

Primary and secondary care should explore the concept of more joint ventures, such as Dr Williams's proposed shared clinics. There should also be more sharing of knowledge and expertise between primary and secondary care. Modern technology makes this possible, yet there has been little implementation.

References

1 Tom Poyner. Dermatology education in primary care. *Dermatology in Practice* 1995;3:21–2.

2 All Party Parliamentary Group on Skin. *An investigation into the adequacy of service provision and treatments for patients with skin diseases in the UK.* London: HMSO, 1997.

3 General Medical Services Committee. *Core Services: Taking the initiative.* London: British Medical Association, 1996.

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Improving communication between doctors and patients

Editor – In response to your Editorial and the summary of the College report (May/June 1997, pages 258–9) I have the following comments to make:

- Skill and time are the two essentials for quality communication.
- Most clinicians achieve some competence in communication, but feedback usually results from failure. One remains unaware of the level of one's skill much of the time, however, student and junior members' comments on our teaching abilities can give some indication of our communication abilities.
- An assessment of aptitude for teaching and communication would therefore focus attention on such skills. Should we not have aptitude studies on medical students and junior doctors in relation to communication ability?
- Some individuals do not have the 'trait' required for good communication. In this situation, it might improve the quality of care if a fellow professional in the health care team were to take on discussions with the patient and family: another role for the nurse practitioner perhaps?
- In the health market culture, economics and quality considerations are in opposition in relation to the use of time. However, if we are to improve communication I would suggest that specialist registrar and consultant job descriptions should include one session weekly entirely devoted to discussion with patients and family.

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Professor of Nephrology
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Editor – It is encouraging that the College is trying to improve communication between doctors and patients (May/June 1997, pages 258–9) but what a pity that the working party included 13 doctors yet only a single patient representative.

DAVID GRIFFITH
Consultant physician, Care of Older People, Mayday Healthcare NHS Trust

In response

The working party included a past Director of the Patients' Association – representing a large body of patient opinion – and sought advice from five other relevant experts, three of whom are non-medical.

EDITOR

Job satisfaction and psychological morbidity in medical house officers

Editor – As the Postgraduate Dean who encouraged Dr Navneet Kapur with his dissertation for his psychiatric MMedSc, it is incumbent upon me to update readers following the publication of his article (March/April 1997, pages 162–7).

The results of Dr Kapur's questionnaire have certainly caught the headlines: in *Hospital Doctor* week ending 17th April, we read 'Juniors in despair'.