dation is not in place. Without outside pressure, it is difficult for any group to submit its members voluntarily to ongoing scrutiny that could lead to loss of their livelihoods.

The articles in this series bring forward several good ideas for ensuring that revalidation gives patients a voice and responds to their needs, and that there is genuine effort to deal with the obstacles raised by Cain, Benjamin, and Thompson.[8] Walshe and Benson recommend harmonising the regulation of all the health professions,[6] Lakhani cites the importance of using lay people in the revalidation process,[5] and Dauphinee stresses the importance of substantive skill and independence.[7]

Good as they are, however, these ideas alone will not deter the increasing involvement of governments, payers, and patients in the regulation of doctors. The medical profession has to resist the temptation to deflect the pressure to reform. Doctors should take control of the situation through institutions such as the General Medical Council, and move forward urgently with a robust programme of revalidation. Doctors and patients have no other good alternative.

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Health research policy in the European Union

Drastic revision is needed

"Health" is the number one theme in the first outline proposal of the European Union's seventh framework programme of research (FP7) for 2007-13.[1] Translating this indication into actual "research for the health of Europeans" will require a drastic policy revision with relation to the current (FP6, 2002-6) research programme, which is severely lacking in a population dimension[2] and champions "the traditional mix of basic science and biomedicine" that is deemed wholly inadequate to support health systems by the World Health Organization's ministerial summit on health research.[3]

This revision requires four main changes: in conception, content, procedures, and resources. The programme's conception must incorporate a simple but crucial idea: "From the population to the population." Research prompted by health problems in a population must provide results that are relevant and applicable in that population. This goes against the common misconception—transparent in the sixth research framework—that a solution to a biological or clinical problem found at, say, the molecular level can be equated to "the" solution of the problem for a population. Ignoring population oriented research is not only naive but delays effective actions to improve health or to avert harm to health, as epitomised by the stories of the adverse effects of hormone replacement therapy[4] and of cyclo-oxygenase 2 inhibitors.[5]

The content must be guided by an epidemiological approach to health and disease, developing population based investigations on genetic, environmental, social, and economic determinants through the many different coordination mechanisms between countries that are envisaged in the "European research area."[6] This multiplicity should help to implement a clear, coherent research strategy for all citizens' health rather than be the sum of studies plugged into projects conceived primarily in biological or biotechnological terms, often with industrial production development as the key objective (a motive resurfacing in some national commentaries to the first outline of the seventh research framework[7]). The strategy should be centred on generating knowledge in forms that can be used to improve the performance of European health systems, globally and in all components, from measures to prevent diseases or treat those that are not yet preventable to key societal determinants of health. Evaluation of all types of health related interventions is essential, including large randomised trials of preventive measures on diet, exercise, or other lifestyle changes (that do not attract investments by the pharmaceutical industry) for which the positive innovation of "large" projects introduced by the sixth framework should be adapted specifically.

The procedures need to be improved substantially. Currently they tend to favour applicants who are resourceful in writing project proposals that are cumbersome in form but airy in substance, with diffuse talk about collaboration, management, and "European added value," rather than giving precise and achievable scientific objectives. This is profoundly anti-educational for younger researchers as it penalises the ability to compete on scientific grounds through rigorous professional peer review and encourages fund-

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raisers who can "talk the talk" but not necessarily "walk the walk." Procedures should in an orderly fashion connect the distinct roles of the political, scientific, and administrative elements in the programme's formulation and implementation. Once political decisions are fixed on the recently proposed general themes of the seventh research framework,[1] the key responsibility should be transferred to active, fully competent researchers from all relevant biomedical, epidemiological, and social areas. They should formulate the call for proposals' topics within the health theme(s) and evaluate the merit of submitted projects with the administrative and technical support of EU staff. Topics should not be specified too narrowly, to allow selecting the best quality projects through competition. In health systems research, high quality studies require as much imagination and rigour as in any other kind of research: limiting the proposed European Research Council[8]—a welcome instrument to improve the scientific governance of EU funded research—to the basic sciences reflects an obsolete hierarchy of first and second class sciences that also demands urgent revision.

At the level of resources, four requirements stand out. Firstly, adequate funding—say, at least 20% of the total life sciences allocation—should be assigned to a well identified "health systems research" section of the programme. Secondly, appropriate provisions should be made for large and complex megastudies as well as for smaller, agile investigations exploring new hypotheses in which only some of the 25 EU countries participate. Thirdly, the programme should embody mechanisms to allow adequate time—conditional to positive periodical evaluations on a competitive basis—to do population based studies, usually longer than experimental or clinical studies: mechanisms such as the European Strategy Forum on Research Infrastructure[9] may be appropriate, in particular for "life course"[10] investigations of disease development. Fourthly, substantial investments in education and training, formal and on the job, should be targeted specifically to strengthen competence in all population health sciences.

Hopefully these proposals will find a way into the new EU programmes: short of this, the EU research "for health" will miss its target and remain by and large a well intentioned misnomer.

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The future of singlehanded general practices

Recent developments put their future in doubt

See News p 1467

Do singlehanded general practices have a future in the United Kingdom's NHS? Singlehanded practices—those that have only one principal doctor with a contract with their primary care trust—have been dwindling in number for many years, and this decline has now become much more rapid. Between 1994 and 2003, the number of singlehanded general practitioners fell from 2959 to 2578 (from 10.8% to 8.5% of all general practitioners) in England.[1] Between 2003 and 2004, the number fell by a further 660 to 1918 (now comprising 6.1%), a larger fall over one year than in the preceding nine years. Yet singlehanded doctors make up a much larger proportion of the primary care workforce in many other developed countries. For example, in the United States in 1998, 46% of family practitioners and 34% of general internists were practising alone.[2]

Ever since the foundation of the NHS, singlehanded general practitioners have made an important contribution in the UK, particularly in inner city and rural areas where recruiting general practitioners has proved difficult. These areas often have deprived populations and, in inner city areas, a high proportion of patients from minority ethnic groups. Singlehanded general practitioners have been an integral part of these communities for several decades, providing both NHS and pastoral services to their local population. In 2004, 22% of all general practices in England were still run by doctors practising solo. Why then is the future of singlehanded general practitioners now in doubt?

Over the past 50 years in the UK, general practices have gradually expanded, with both the mean number of doctors and the mean number of patients per practice increasing.[3] Some of the decline therefore represents a desire for doctors to work in larger practices—in particular, those who want part time clinical work because of family or other clinical and managerial commitments. For such doctors, larger practices can offer more flexible working arrangements. Doctors may also find larger practices more attractive to work in because they reduce

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