of the past, nothing stands still. A general practitioner can no longer be seen as the lone friend and confidant of the patient, fighting his or her corner regardless of responsibilities to society. It is unreasonable to view the patient in isolation, with expense being regarded as of no importance and the needs of others irrelevant. We do not need to see ourselves in a mystical, priestly role, interceding on behalf of the patient from the surgery confessional. Rather, we should work with our primary health care teams, hospital colleagues, and health authorities. Together we can mould a service for patients that is both affordable and equitable.

There has always been rationing in the NHS. To date it has been managed by waiting lists. Fundholding has empowered general practitioners to apportion priority, with clinical input from specialists. This is an uncomfortable role, but general practitioners are best placed to make these decisions.

As fundholders we have forged links with our local hospitals and health authorities that never previously existed. We have persuaded hospitals to provide new services for all general practitioners in our area and have successfully defended threatened services in community nursing and community psychiatric nursing. Our consultant colleagues perhaps listen to us more closely.

If fundholding is dismantled general practitioners will be disempowered and patients will be disadvantaged. Locality purchasing commissions will be mere talking shops where we will be politely listened to but essentially ignored. A general practitioner with a chequebook is considerably more powerful than one without.

As care devolves to the primary sector we need as much influence as possible. Fugelli and Heath are surely mistaken in believing that the traditional model of general practice will always be valid. The new team model is the democratic option: less paternalist; less authoritarian; realistic; and, hopefully, affordable. We should abandon the blinkered central intercessional role and become pivotal team members. General practitioners will feel undervalued only if they fail to adapt to change.

All Luddites end the same way—irrelevant. We must not oppose change but see it as an opportunity, embrace it, and mould the future to our vision in close liaison with all other health care professionals—clinicians, nurses, and managers alike.

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1 Fugelli P, Heath I. The nature of general practice. *BMJ* 1996;312:456-7. (24 February.)

Favouring a mythological traditional orthodoxy is absurd

EDITOR,—As chairman of Warwickshire general practice commissioning group, a course organiser for a vocational training scheme, and a fundholding general practitioner, I wish to respond to Per Fugelli and Iona Heath's editorial on the nature of general practice.[1]

General practice is evolving rapidly; nearly half of all British practices are fundholding, and over a quarter are part of commissioning structures. Consequently, many general practitioners have gained new skills to improve the care of their patients and their populations. For many these are acceptable and pragmatic methods of advocacy. To suggest that all of these skills should be abandoned in favour of some largely mythological traditional orthodoxy is absurd.

General practice must deliver care to all patients. Every consultation and every episode of care must be part of an overall structure of accountability. They cannot simply be islands unto themselves.

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General practitioners are not as beleaguered as they were

EDITOR,—In their editorial on the nature of general practice Per Fugelli and Iona Heath describe the values that they believe should inform the way in which general practitioners work.[1] They are correct to draw attention to the central importance of family doctors' long term knowledge of their patients and their role as gatekeepers, but their assertion that general practitioners can walk away from the implications of managerial change in the NHS is questionable.

Fugelli and Heath perpetuate the myth that fundholding general practitioners are concerned primarily with their own power and ambition. They go on to say that the emphasis of gatekeeping has shifted from the interests of individual patients to those of the general population and, by implication, those of taxpayers. Nowhere do they cite any evidence to support these propositions. Finite resources have to be allocated to meet ever increasing demands and needs. The purpose of fundholding is to gain a place at the table where the decisions are made about the service our patients receive.

The problem for general practitioners is the gulf that exists between the expectations placed on us and our ability to meet those expectations. The collapse in recruitment is at least partly due to the perception of general practitioners as beleaguered and overworked. Yet it doesn't have to be that way. Considerable progress has been made on the out of hours issue, paperwork, and the handling of complaints. This success has been achieved by general practitioners working with managers, patients, and politicians to develop a shared language and common agreement on the objectives we are trying to meet.

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Service is abused because it is perceived as being free

EDITOR,—I agree with many of the points that Per Fugelli and Iona Heath make about the nature of general practice.[1] I believe that general practice should lead the shift from an authoritarian to a democratic model of decision making. This model, however, must emphasise the joint responsibility of the doctor and patient in the careful and judicious use of scarce resources.

I prioritise the future in a different way from that of Fugelli and Heath. The problem with being the humanist of the NHS and practising in a holistic fashion is the amount of time it takes. General practitioners' time is already superscarce. The article speaks of ideals. I believe that we must define the current nature of general practice accurately before we can move on.

Firstly, our terms of service are so undefined that they make us the dumping ground for any work—medical, social, or administrative—that no one else wants or "owns." We must agree on a core job description for our principal role as primary health doctors. This does not mean that we have to accept being social workers, counsellors, or managers.

Secondly, it is naive to ignore the financial costs that occur throughout primary care. Rather, we must begin to incorporate financial management more closely into some aspects of primary care. It is anachronistic that we are perceived to be a free service. Is there any other service that is free nowadays?

The culture of consumerism so rules the world that people—both managers and patients—abuse us because our time is not costed. If our time were costed then people would think far more about things such as the transfer of care from secondary care, inappropriate requests for home visits, and consultations out of hours. Changes in dentistry and eye checks are recent examples that have resulted in increased work for general practitioners because we are the free alternative. General practitioners must do hours of social services work each year because we are free.

We already know that a major crisis is developing in the recruitment and retention of general practitioners. Morale is rock bottom and good will exhausted. Society seems to want a 24 hour service without the costs. I believe that we must debate these areas now and act soon to protect the nature of general practice.

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Nostalgia doesn't help recruitment

EDITOR,—Per Fugelli and Iona Heath describe a utopian model of general practice that I find it difficult to identify with.[1] The vision of a paternalistic doctor who shields his patients from the dangers of modern medicine and steers them through various life crises single handedly seems to ignore reality.

Patients in the late 20th century are sophisticated: they demand the latest in technology to diagnose their symptoms, and if it is available why shouldn't they? There are enough missed diagnoses to make us all feel humble at times. And isn't it more appropriate for a nurse to perform a cervical smear test and a health visitor to check a child's development? It is certainly appropriate for administrators to deal with paperwork, fund managers to deal with contracts, and young people on youth training schemes to make coffee. It is arrogant of doctors to think they can do it all themselves.

My relationship with my patients is stronger if I can not only refer them for special treatment but reassure them about how and when it will be done. My responsibility does not end with a referral letter but extends to their secondary care. And it makes more sense to arrange that care in an annual round of discussions for all my patients than to have to telephone every time someone has to wait too long for treatment. I can explain to a patient why she cannot expect funding for removal of a tattoo because I know the opportunity costs, instead of commiserating with her about the rationing imposed by the health authority.

Most general practitioners have views about the health service beyond their individual practices, and they should exercise their power to