The new commitments will make a strong practice team essential. Practice nurses will be far more effective at health education than doctors. Doctors who invest in good staff, good premises, and good relations with the health authority will be able to meet realistic targets for health promotion.

The General Medical Services Committee must ensure that targets are realistic, and 80% for cervical cytology screening would be a strong incentive for us to give up our screening programme. More importantly the committee must ensure that the government will fund, and continue to fund, the staff and premises necessary to run a preventive service. This is a new and additional service. Initially it may be funded by redistribution among general practitioners, but ultimately new money must be forthcoming as more practices meet their targets.

The new contract is, on the whole, good for patients and good for doctors. We should support it and negotiate the small print.

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1 Department of Health and Welsh Office. *General practice in the National Health Service: a new contract*. London: DoH, 1989.

SIR,—Ms Patricia Day and Professor Rudolf Klein state that Alain Enthoven advocated budgets for general practitioners (for hospital care) as part of the internal market.¹ This is the opposite of the case. Enthoven saw general practitioner budgets as damaging to rational decision making by district managers; it is the managers who would trade with each other (hence the internal market). Enthoven made this clear when I worked with him at the Nuffield Trust in 1984 and 1985 and has recently reiterated the point forcefully in a letter to me. I think it is important to point this out, given the political momentum behind general practitioner budgets in the wake of the white paper.

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1 Day P, Klein R. NHS review: the broad picture. *Br Med J* 1989;298:339-40. (11 February.)

SIR,—Mr Kenneth Clarke has suggested that individual general practitioners should express their views on the new government contract for general practice. I think it is vital that we do so now.

The stated aim of the new proposals is that they should make general practice more responsive to the needs of the consumer. I hope we can assume that this means the patient. Studies of what patients want from their general practitioners consistently find that they want a doctor who listens, who understands, who takes trouble, and who explains. In other words they want an unhurried, competent, personal doctor whom they can trust when they are sick. Anything that militates against that most basic and legitimate need is against their true interest.

Our existing contract has some serious defects in this respect but the one now proposed seems to be a great deal worse. By encouraging competition linked with cost containment it must increase the pressure for shorter and "cruder" consultations. By introducing arbitrary financial incentives for such activities as well person clinics, whose value in the form proposed is unproved, it will further erode the doctor's time for traditional consultations. The central dominance given to cost control will introduce a new factor into the doctor-patient relationship for which both patients and

their general practitioners are unprepared. I fear that it will endanger the quality of that relationship.

Patients commonly take for granted that their doctor is competent. The need to ensure that that trust is justified should be the most important element in any good contract for general practice. The proposed new contract will seek to do this by forms of external control. This cannot be effective except in preventing the crudest level of incompetence. The effective way to improve quality of care in general practice is by performance review conducted by a practice on its own work, leading to agreed decisions and actions. Such activity needs to become an integral element in the working lives of general practitioners. If this is to become a reality it must in some way have "protected time." Instead of recognising this the new contract will make this type of professional learning compete for practice time with other activities which will carry persuasive financial rewards. I fear that formative self assessment based on shared review of clinical work will be the loser—together with the patients of course.

The need for selective rewards for good work and for quality control are not in question. They are both essential to encourage good general practice. The current proposals, however, achieve neither of these things. They come to us as an arbitrary package of crude bribes to undertake activities whose value, in some cases, has never been properly tested. They have been presented with an arrogant and, in my view, mistaken belief that their originators know what is best for patients and for general practice.

In their present form the proposed new contract is unacceptable.

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SIR,—We are led to believe that £1m has been devoted to informing us of the hotchpotch of ideas that have been put together as a white paper to reform the National Health Service. It is clear that the authors of the paper took pains to remain uninformed about matters of health care, and the result is that they have prepared a disastrous plan that is being "sold" very effectively.¹

It is tempting to take the pragmatic view that the present government is so impregnable and so determined to put its vision into practice that the best course is to accept the inevitable and try to obtain the best interpretation of the broad themes that have been promulgated in the interests of our patients, practice, hospital, or whatever.

This is likely to prove a dangerous and damaging course in the longer term, for if a firm and accurate assessment (and rejection) of these ill conceived initiatives is not provided by the profession they are in effect given credence by acceptance.

We have a responsibility to redress the balance. May I suggest that the BMA in conjunction with other responsible professional bodies, perhaps aided by sponsorship, seeks to provide an educational programme to inform the public of the wrong headedness of the government's new approach and spend a similar amount on this vital project to that which has been devoted to spreading the alternative gospel.

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1 Black D. Kind of health care we do not want. *Guardian* 1989 Feb 6:20 (col 2).

*The secretary writes: "Our primary concern has been to ensure that the profession is fully informed on the government's proposals. A BMA video highlighting the key proposals has been sent to every division, a special newspaper was produced, and slides have been made for speakers to use at meetings of doctors. The public and MPs have

been informed of our initial views through a major media campaign and extensive parliamentary lobbying. A special briefing conference for interested organisations is being planned. Additional channels of communication with the public, MPs, and other organisations will be used as the profession's views are formulated."—ED, *BMJ*.

SIR,—We note the comment in Dr Stephen Lock's editorial that the Conference of Medical Royal Colleges and Faculties in the UK has not responded separately to the white paper on the NHS.¹ The Joint Consultants Committee agreed that a unified response from its two constituent bodies—the conference and the Central Committee for Hospital Medical Services—would properly reflect the opinions of all hospital doctors. The views of the conference have been incorporated in the submission of the Joint Consultants Committee to the social services committee of the House of Commons. In due course the conference may need to respond to specific points in greater detail.

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1 Lock S. Steaming through the NHS. *Br Med J* 1989;298:619-20. (11 March.)

Budgets for general practitioners

SIR,—When I was young many doctors seemed to drive expensive cars. I and some others tried to economise by driving small cars. These reduced expenses were reported in our tax returns, and the government reflected them in reducing that part of our gross income that related to our cars.

A similar (and perhaps more serious) mechanism applied to the expenses of our surgeries: today's economies became the standard by which future allowances were based. I believe that the government is offering us another treadmill that looks very attractive but shares this problem. We can have budgets. If we economise we can spend the savings on our surgeries. But what evidence have we got that if we make economies the size of our budgets will not then be reduced?

The result of these treadmills for the profession is not progress from our running but angina.

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Ethics committees: local and national

SIR,—Dr K Korlipara¹ supports Baroness Warnock's appeal for a national ethics committee.² The case is well made, but why should it be as a replacement for "the myriad local ethical committees"? Baroness Warnock, in fact, did not make this explicit. She merely referred to hospital ethics committees as being insufficiently detached from the particular hospitals with which they are concerned.

It is a pity that Dr Korlipara should have such a poor view of his colleagues' impartiality and fear their political prejudice. The reasons adduced for replacing local ethical committees are the same ones that I would propose as establishing their necessity.

Several years' experience of chairing an ethical committee serving a health authority with a population of about 500 000 has convinced me of the necessity of some such local structure. Whereas Baroness Warnock's national ethics committee