organisations who wish to support the project. Please note that the PO Box quoted at the end of Burdon's article is no longer valid; the correct address is that given below.

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- 1 Burdon J. Another deadly Zairian disease. *BMJ* 1996;313:58.
- 2 Raab RS. An emergency insulin distribution programme: taking a lead role in the international insulin supply crisis. *International Diabetes Federation Bulletin* 1995;4:40-1.

Stress in general practice

Stressed doctors should take time to recover before deciding on their future

EDITOR,—I hope that the anonymous general practitioner who writes about the stress he or she is suffering while in practice has been helped by the counselling service that the BMA has set up and is receiving professional guidance.¹ I had an almost identical breakdown a couple of years ago, when it was not acceptable to be seen to be weak. From my own experience I would urge the author to accept help and not feel guilty. It sounds as though the author has always been a caring and sympathetic doctor and, when well again, will be a wiser and even more valuable member of the profession.

I would urge people in the author's position to take time away to recover and not to retire or move sideways until they are able to do so with absolute confidence. We can make rash decisions when ill. They should not feel that they must rush to get back to support colleagues. If they do leave work then they should not feel unhappy about claiming their augmented pension and should return to NHS work when ready; this will not affect their pension provided they opt out of the NHS scheme offered with the new job. They should be warned that they will suffer a period of "bereavement" if they leave work, which needs to be talked through.

I would be interested to know whether the BMA has any advice to offer those of us who are relatively young, living on pensions, who feel that there must be something we could usefully do to prevent the mixture of loss of worth and tedium that we experience from time to time.

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- 1 The stress: is it our fault? *BMJ* 1996;313:120. (13 July.)

General practitioners must educate patients in the appropriate use of services

EDITOR,—I get concerned about the picture painted of morale in general practice, particularly distressing examples such as that given in the recent anonymous personal view.¹ I believe that, of all the areas of clinical medicine in which I have worked, general practice provides the greatest opportunity for clinicians to practise unfettered medicine. Some general practitioners may disagree with this view and will point to the 1990 contract for general practitioners as heavy handed interference by the government.

Morale is often mentioned to me as a major problem. Reasons given include an increased workload, more demanding patients, a lack of general practitioners, list sizes, a lack of adequate funding, inappropriate discharge from hospital, and care in the community. The end result is

overworked, stressed doctors who believe that they are not valued either by the government or by some patients.

The economist's view can be put simply. Jean Baptiste Say, an 18th century political economist, said that supply creates its own demand. This "law" is often proved true in practices that employ a partner to ease the workload. Once established, the partner generates a demand for care (not necessarily appropriate) that may previously have been unmet. Similarly, some practices, albeit only a few, tempered their acceptance of the financial inducements in the 1990 contract and have developed only those services that they wished to develop. This meant that they had to decide on the work and personal lifestyle that they wished to lead and not the other way round. Curtailing supply appropriately has been a common tactic in the hospital sector, but few general practitioners actively consider it in their own setting.

Deming wrote that "Customers (patients) are not in a good position to judge what will serve them in the future. The producer (doctor) is in a far better position," adding that a key dimension to this is "training the customer how to use the product."² Education of patients is commonly viewed with scepticism, although over the years a number of practices have conditioned their patients to use services appropriately.

The main difficulty in implementing these approaches is attitude and confidence. It requires a combined partnership effort to work effectively, with mutual support and understanding. The introduction of cooperatives for out of hours work throughout Britain should have restored some confidence in general practitioners' ability to manage the demands of patients and to educate patients in the appropriate use of services. The big question is whether this knowledge and experience can be translated to daytime practice.

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- 1 The stress: is it our fault? *BMJ* 1996;313:120. (13 July.)
- 2 Deming WE. *Out of the crisis*. Cambridge: Cambridge University Press, 1982.

American guidelines on managed care are not the answer

EDITOR,—If, in their editorial on clinical guidelines in the independent sector, Gillian Fairfield and Rhys Williams are suggesting that the guidelines used by American managed care organisations to authorise care are evidence based then they are misguided.¹ In a national poll Group Health in Seattle was recently acknowledged to be "one of the best [managed care companies] at monitoring health, risk behaviors and disease outcomes."² Group Health has clinical guidelines that are strongly based on the effectiveness literature. They total just 13. Some health maintenance organisations offer incentives for limiting referrals and certain procedures through reviews of use. These "referral guidelines" have existed for a long time and are seldom evidence based; their intent is cost containment rather than cost effectiveness. If it is these to which the authors are referring then it would be a retrograde step for the NHS to adopt such a practice.

The authors correctly predict that private patients in Britain would not accept rationing by their insurers. Enrolment is dwindling in traditional health maintenance organisations with their own staff, which are renowned for

their gatekeeping function. The insurers are busy developing alternatives that are more patient friendly and have names such as "options" or "alliant plus"; these even allow the choice of physicians paid on a fee for service basis—whose costs, ironically, managed care was set up to control.

Private insurers have no advantage over the NHS in the provision of useful data on outcomes. The independent health company BUPA only recently entered the primary care market, where the bulk of high cost and high volume long term care will occur in a primary care led NHS. Group Health has been host to many patient outcome research teams; despite the existence of data back to 1977 the lack of an appropriate coding system that links processes with outcomes is the barrier to more sophisticated research into outcomes. Read codes, which the Somerset morbidity project used,³ or new diagnosis codes may help.⁴

Surely the only place to experiment with evidence based guidelines is in the NHS. It is there that the real clinical controversies exist as doctors struggle with whether treatment A will be cost effective given patient B's age, sex, and socioeconomic and disease status, rather than in the private sector, where the concern is mainly elective surgery in people of higher socioeconomic status. Techniques of adjusting for case mix are increasingly being used to aid this complex process.⁵ Perhaps the private insurers' funds could best be used to support such an effort in the NHS if the interest is truly in collaboration.

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- 1 Fairfield G, Williams R. Clinical guidelines in the independent health care sector. *BMJ* 1996;312:1554-5. (22 June.)
- 2 America's best HMOs: rating the top managed care companies. *Newsweek* 1996 Jun 24.
- 3 Pearson N, O'Brien J, Thomas H, Ewings P, Gallier L, Bussey A. Collecting morbidity data in general practice: the Somerset morbidity project. *BMJ* 1996;312:1517-21. (15 June.)
- 4 Mayfield JA, Strand T, Toya AR. A call for specific codes for diabetes foot and eye care. *Diabetes Care* 1995;18:418-21.
- 5 Davenport R, Dennis M, Warlow C. Effect of correcting outcome data for case mix: an example from stroke medicine. *BMJ* 1996;312:1503-5. (15 June.)

Statistics should reflect existence of two Indias

EDITOR,—I wish to comment on Ganapati Mudur's news item, which refers to the poor health conditions of Indian women.¹ Unfortunately, the article does not reflect the better conditions that exist in the southern and western states of India—namely, Kerala, Andhra Pradesh, Tamil Nadu, Karnataka, Maharashtra, and Punjab—because the statistics for these states are combined with those for the backward states. Such news items are a great discouragement to the efforts of the local states and the voluntary organisations that are striving hard to improve women's health in India.

I hope that in future the *BMJ* will try to differentiate between the two Indias. That there are two Indias is sad but a fact.

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- 1 Mudur G. India's women get poor deal on health care, says World Bank. *BMJ* 1996;312:1627-8. (29 June.)