enabled local people to negotiate for a better bus service.¹¹ In other areas needs assessment has stimulated local people to find their own solutions to problems, through self help groups, befriending schemes, or activities such as food cooperatives and children's breakfast clubs.^{11 12}

Building links with the community takes time, and the early stages of any initiative may be frustrating as people learn to work together and trust each other. Many practices, recognising the difficulties of doing this alone, now employ a patient liaison officer¹⁵ or link worker, whose job is to seek patients' views, forge links with other local agencies, and help set up health promoting activities based on patients' concerns. Other practices work closely with community development workers,^{11 12} who, because of their training, can stand back from the "medical model" and see health, as most patients do, in much broader terms. Because these workers are separate from the practice, patients are often more willing to share their feelings with them, and they in turn are better placed to accept and pass on criticism than someone in the team.¹¹

Health authorities, in their role as purchasers, are looking at ways of carrying out needs assessment, and many have identified the general practice as the logical local unit with which to work. But to gain a sound knowledge of their local area general practitioners need to be prepared to fight the inevitable pressure to achieve rapid and measurable health gains overnight and to argue for the necessary extra resources, protected time, and access to skills. Only then will they be able to build a more complete picture of the community and achieve health gains, which may be both unexpected and difficult to measure.

Many general practitioners may find it difficult to see past the ever increasing demands of patients and the new contract. The current emphasis on patient's charters and consumer rights exacerbates this. Yet a clear view emerging from those

general practitioners who have cultivated links with the community is that working like this can greatly improve job satisfaction.⁹ When the community participates in discussions about the realities of health care patients' expectations often become more realistic. Equally, doctors, by learning about resources available within the community, are better able to address the wider issues affecting people's health and to suggest more appropriate solutions to their patients' needs.¹² At a time of low morale among general practitioners these findings are surely relevant.

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Career choices for generation X

Young doctors want flexible career paths, not long term commitments

Young doctors are not choosing to train or settle in general practice as they did a decade ago, which has serious implications for training schemes and practices recruiting new partners. Changes in the NHS may partly explain this. Baker *et al* found that the four commonest reasons given by qualified general practitioners for not practising as principals were the commitment out of hours, difficulty combining work with family commitments, requirements of the general practice contract, and increasing demands from patients.¹

A broader shift in values and expectations of work may also be occurring, and we need to understand the social context in which young graduates have grown up. The old certainties of work and family life have been crumbling.² Time honoured values such as security, authority, tradition, and a rigid moral code have gone. In the 1980s the outward directed values of status, image, and consumption replaced them. In the 1990s these were replaced by the inward directed values of empathy, connectedness, emotion, autonomy, and ease.

But the '90s also has a darker underside, explored by Stuart Coupland in his novel *Generation X*.³ He charts the extended adolescence experienced by "twentysomethings" in America and their inability to make long term commitments or imagine a future. Underemployed, overeducated, and unpredictable, they settle for "McJobs": low paid work in service industries with poor prospects. Slacker is another word associated with

this disenfranchised group.⁴ Slackers leave even the McJobs to some other poor sucker and settle for doing very little.

Cannon describes the new work ethic, in which a decline in trust and loyalty to organisations together with a mortal fear of boredom leads young people to view employment in transactional terms: What's the deal? Why get saddled with a difficult job? Work and jobs are being redefined: new working practices include planning for career long self development, being able to switch focus rapidly from one task to another, working with people with very different training and mindsets, and working in situations in which the group is the responsible party.

General practice lends itself splendidly to this description of a new working environment. Doctors are by self selection unslack, but Generation X has arrived at medical school⁷ and won't be yearning for the good old days because they don't have any good old days to remember. Despite the relentless negative press since the general practice contract ("Disasters in the inner city," "Trainee crisis deepens," "Doctors are more miserable than ever," etc) I am surrounded by colleagues who love their work, relish the variety that their patch offers, and enjoy a highly supportive professional network with many career opportunities. How can the job be redefined to engage a new sense of vocation while retaining elements of the work that continue to be satisfying? Our challenge is to find

opportunities that appeal to these younger doctors.

Talking to recently qualified general practitioners in London, I have found that they expect increasing flexibility in their lives. Some of the traditional strengths of general practice, such as long term commitment to partnerships, are viewed with increasing suspicion. Allen has pointed out that the medical career structure is rigid and outdated.⁸ It has also failed to adapt to the changing NHS and to the fact that half of those entering the profession are women, of whom more than half intend to work less than full time for at least part of their careers. Women have always fitted their work into their lives, and an increasing number of men are attracted to this option.

The challenge is clear. We must respond to the demand for increasingly flexible career paths for general practitioners. This has wide ranging implications for undergraduate

teaching, vocational training, and lifelong personal and professional development.

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Minoxidil lotion over the counter

Hair today and hair tomorrow—but at the price of continuous treatment

On the advice of the Committee on the Safety of Medicines, the Medicines Control Agency removed the prescription only label from 2% minoxidil lotion and made it available over the counter from pharmacies in January 1995. But it is still not available on prescription from the NHS.

Once Upjohn has prepared its product for marketing direct to the public, patients will no longer need to badger their general practitioner for private prescriptions. How many hours our general practitioners will save and how much income they will lose are unknown, but those plagued by patients for this drug for male and female baldness will no doubt be relieved.

The discovery that oral minoxidil induces widespread hirsutism was entirely serendipitous. The mechanism is still obscure, but the logic of seeking a local effect soon followed. Publications in the late 1980s reported regrowth of non-vellus hair in half the subjects of both sexes with androgenetic alopecia¹; in only 8% was it reported as dense. "Fastidious compliance with twice daily application" seven days a week is essential. A result is apparent only after four months or more, and, sadly, any new hair falls out two months after treatment is stopped.² The same review states that "minoxidil has a significant stabilising effect on the retention of hair in most men with male baldness," and in women "minoxidil seems to stabilise loss consistently."

Curiously, at least one study has reported an unexplained improvement in growth of non-vellus hair—over half of that noted in test subjects—in subjects using just the vehicle.³ Was massage acting as a remedy? The drug is dissolved in an aqueous alcohol solution with added propylene glycol to enhance absorption. This makes it irritant and almost drinkable, though at £30 for 60 ml—a month's treatment—it is rather expensive for use even in a cocktail. Because about 1.4% of the dose is absorbed systemically there were fears of hypotension or interference with concomitant antihypertensive treatment. But the risk has proved so small that the committee was presumably prepared to ignore it. Is that wise?

The original studies of side effects were carried out in normotensive subjects. Apart from irritant and allergic reactions to the topical preparation, cardiovascular side effects, such as oedema and hypotensive symptoms, were as common in the study group as in subjects given a placebo. Nevertheless, those of us who tried the preparation on our patients in its early days have anecdotal evidence of

hypotensive episodes. This may have been because we warned the patients that this might happen. Lawyers expect doctors to tell every patient of all the possible side effects of a drug; so patients will eventually report every one of them, however bizarre.

What happens when the drug is used by hypertensive patients, those with angina, or those taking hypotensive drugs? Although the leaflet accompanying the bottle will give all the warnings and precautions, how certain can we be that users will read them and then heed them? What uses other than as a hair restorer are likely? One recent paper reports the drug's (unsuccessful) use in male erectile dysfunction.⁴

Over the counter status means that manufacturers can now market their product direct to the public, with no need to press the scientific case on general practitioners and dermatologists. Previously, Britain's Advertising Standards Authority seems to have turned almost a blind eye to the cosmetic industry's extravagant and emotive claims for topical remedies for dry skin, greasy skin, aging skin, wrinkles, dry hair, greasy hair, mottled skin, and even "cellulite." The industry's promises that products will preserve and restore users' bodies so that they look like the perfect nudes in the advertisements frequently astonish critical dermatologists. It would be disturbing if a similar onslaught was launched on the millions with falling hair.

Should the emphasis be on regrowth, "customers" will have to spend at least £120 before realising the lotion's benefit because improvement takes four months or more to become apparent. Users are advised to give up if no benefit is obtained after a year, after having spent £360. Those convinced by the lotion's efficacy will need to continue its use for life. On the other hand, if its value as a stabiliser preventing further hair loss is emphasised, who would be churlish enough to deny their scalp the benefit? The drug could net its manufacturers many millions.

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