practitioners are in a position to plan because they have survived many changes, and to fail to reappoint them on the basis of a local health policy "whim" conflicts with individual patients' rights in choosing their own general practitioner.

If managers were better informed of practice activity before 1990 and spent time equipping general practitioners instead of attacking them, they would learn from the general practitioner how to maintain quality of care. This aspect is being addressed very successfully by the Medical Audit Advisory Groups.

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1 Butland G. Commissioning for quality. *BMJ* 1993;306:251-2. (23 January.)
2 Gray DP. *Planning primary care.* London: Royal College of General Practitioners, 1992.

EDITOR,—Graham Butland describes with good intention and formidable lack of insight the procedures that will destroy general practice.[1] This new generation of NHS manager is, it seems, here to stay and brings with it a quality meter to measure our healthcare and a sledgehammer to dismantle the old order. Many products can have their quality measured in simple terms. How are we to measure the quality of primary care?

Consumer sensitive businesses work well when the product is something being purchased by a consumer with a wide choice of suppliers. When the product is the supplier it is naive to suppose that the same rules apply. When the consumer does not directly pay for the product the entire basis of the business model is unsound.

Repeated surveys have shown a high degree of patient satisfaction with general practice. There is always room for improvement—few would argue that recent incentives (immunisation targets, for example) have not helped to produce better health for our patients.

But to take Butland's theories to their probable conclusion would produce large, impersonal, primary care centres where indeed the measurable parameters of quality will be readily demonstrable. They will be staffed by teams of doctors and other professionals working in shifts in much the same way as hospitals are run. A triage worker will assess the problem ("Hi—I'm Tim your triage worker, how can I help you?") and direct the customer to whichever doctor, therapist, or care provider seems appropriate. Why does this "seamless care" merely seem careless?

I was taught that a consultation in general practice can last many years. When Butland measures the "skills and talents" of general practice he does not appreciate that they rely on stability and knowledge of the patient. Doctors on fixed term contracts will never reach the pinnacle of understanding that can sometimes bring true but unmeasurable quality to a consultation.

Perhaps we should not be too surprised when we find ourselves in the new world of quality primary care. When a successful grocer was asked by a grocer's daughter how to run the health service, what could we have expected if not a supermarket chain enterprise—open all hours.

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1 Butland G. Commissioning for quality. *BMJ* 1993;306:251-4. (23 January.)

EDITOR,—The chief executive of a family health services authority wishes to impose greater control over general practitioners. He suggests that family health services authorities appoint and, where advisable, sack primary care workers; define services to be provided in local contracts; set standards for the structure and process of general practice; provide practices with expertise in management; and be involved in reaccreditation of general practitioners.[1]

Audit of general practitioner services is generally regarded as desirable, but funding is scarce. Reaccreditation is acceptable to many general practitioners. Better tuning of capitation and item of service payments to reflect the work involved in earning them might also improve the performance of primary care. But imposition of direct management by local family health services authority executives will demotivate those many general practitioners for whom responsibility directly to patients is a major source of vocational pride. General practitioners may need viable alternatives to Graham Butland's proposals to avoid losing responsibility for their practices.

Am I alone in feeling threatened at the thought that audit is supervised by direct employees of the family health services authority? Medical audit advisory groups do not tell us their procedures to prevent gossip and simplistic interpretation of raw statistics weighing on the minds of family health services authority managers with discretionary powers. Interim guidelines state that confidentiality of patients and clinicians is an important aspect of audit.[2] Doctors should insist on suitable procedures for medical audit as a precondition for collaboration.

Audit and standard setting of measures common to all or most practices may best be designed and supported by a central body with nationwide aegis. This will avoid invidious comparisons between standards and procedures of different family health services authorities and permit interdistrict comparisons of results. Such a body may also be more consistent in applying discretionary funds for research and innovative practice. It could be charged with the task of determining priorities for primary care funding. By having direct links with national policy makers and avoiding duplication of research effort it would be more cost effective than channelling research funds through local bodies.

Reaccreditation could be handled most convincingly by a body drawn from the caring and scientific professions, with additional publicly elected or appointed representatives. As with audit a nationwide body is needed for nationwide consistency.

Some health workers may benefit from education, examination, and resources for wise management. Providing these will result in stronger management than having authority imposed by workers without a clinical background.

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1 Butland G. Commissioning for quality. *BMJ* 1993;306:251-2. (23 January.)
2 Conference of Medical Royal Colleges and their Faculties. Interim guidelines on confidentiality and medical audit. *BMJ* 1991;303:1525.

EDITOR,—I have grave concerns about the underlying message in the paper by Graham Butland, in which he implies that management of general practice by family health services authorities will provide better quality service than peer review.[1] While his aims for promoting and facilitating the process of standard setting are admirable, there still remains the conflict between general practitioners wishing to provide a high standard of clinical care and the family health services authorities' agenda for managing the structure and process of the provision of care with inadequate funding.

Provision of asthma care in the community is one example of the problems we face. While the 350 strong General Practitioners in Asthma Group felt that the advent of asthma clinics in general practice was a positive step, we have concerns about the variety of provision of care in these clinics.

In anticipation of the forthcoming changes in the provision of care for patients with chronic disease in general practice, the group surveyed all family health services authorities and health boards throughout the United Kingdom. This survey aimed to provide some baseline information regarding their current procedures for ensuring quality of care in general practice asthma clinics.

We received 97/117 (83%) completed questionnaires (four refusals). Most respondents (76%) relied on their own medical adviser to agree the protocols for purposes of payment, but only 49% of the people making these decisions had any expertise in asthma care; 15% relied on individuals who were not trained in medicine or nursing. Only 52% required a qualification or further training in asthma management, while 86% accepted that the nurse's role included adjustment of therapy according to practice protocols. The commitments of family health services authorities or health boards to reimburse the costs of initial and continuing training for nurses were low.

What hope is there for asthma care in the future if the family health services authorities and health boards continue to rely on staff not trained in medicine or nursing to make "quality of care" decisions? While the new proposed arrangements[2] for provision of care for asthmatic patients in general practice are admirable, the proposed remuneration of £400 per general practitioner per year is inadequate to implement the new scheme. It is not 35% of general practitioners who will lose out[3]—our patients will be the ultimate losers.

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1 Butland G. Commissioning for quality. *BMJ* 1993;306:251-2. (23 January.)
2 General Medical Services Committee. *Guidance on the new health promotion package.* London: GMSC, 1993.
3 Beecham L. GPs agree health promotion package. *BMJ* 1992;305:1314.

Mozart's scatological disorder

EDITOR,—I share Oliver Sacks's doubts about Benjamin Simkin's twice previously proposed hypothesis that Mozart suffered with Tourette's syndrome.[1-4] Not only has Simkin been unable to produce evidence of a family history of this genetic developmental disorder but he has also failed to satisfy the essential diagnostic criteria.[5]

Simkin's case rests on his proposed association of coprolalia, palilalia, and echolalia with alleged examples of facial and bodily motor tics, which occurred during Mozart's adult life. However, with the solitary exception of Sophie Haibel's mention of "extraordinary grimaces with his mouth," which might qualify for a complex motor tic, Simkin then proceeds to deflate his argument by begging the question when he assigns inappropriately several examples of Mozart's humorous hyperactivity to the category of motor "Touretisms."

It must be emphasised that tics, the essential feature of Tourette's syndrome, are "involuntary, sudden, rapid, recurrent, nonrhythmic, stereotyped, motor movements or vocalizations" which, though experienced as irresistible, can be suppressed for varying lengths of time.[5] Neither the variability of Mozart's facial expression, which portrayed his frequent alterations of mood, nor his compulsion to beat out, with repetitive movements of his hands and feet, the rhythm of the harmonies which continually filled his head, comply with the above definition of motor tics. Nor are the decisive, deliberate, well coordinated movements of leaping over tables and chairs, or miaowing like a cat while turning somersaults on the floor, in the category of tics.

Surely there is nothing "Tourettish" about Mozart stamping his feet and shouting "Damn!"