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Our recent General Practice issue (7 July 2003) has been accused of presenting a “black armband” view of the discipline. Despite this, we are pleased that the issue has evoked strong reactions.

General practice is not in crisis

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TO THE EDITOR: The recent issue on general practice (7 July 2003) contained many statements that were inaccurate and unfair to a profession that has existed before most specialties and will exist beyond their passing. It is unfortunate that the issue represents an opportunity missed.

Notwithstanding the funding issues, general practice is not “in crisis”, as many of your authors would attest.¹ It is vibrant and leading the way in health-care reform in this country, and much of its loss of appeal to new doctors has to do with the attitudes of many of the authors, who talk it down rather than up.

The quoted comment from Donald Berwick — “we are carrying the nineteenth-century clinical office into the twenty-first-century world”² — is surely the most inaccurate statement. Modern general practices bear no relationship to even their mid-20th-century counterparts, whereas the average specialist office still looks the same and functions in a similar way. General practice is over 80% computerised,³ unlike the practices of our specialist colleagues. General practice has been responding to the challenges of a community-centred approach, while specialists still respond to a disease-centred model. Indeed, many members of the profession correctly talk about research as a means of raising the profile of general practice — in this regard, the specialties have been hiding behind the power and influence of research institutes.

Until funding bodies such as the National Health and Medical Research Council give general practice research priority over such esoteric areas as “Major porcine antigens for the generation and modulation of immune responses to neovascularised pig tissue xenografts” (\$480,000)⁴ in allocating research grants, things will not change.

Further, many of your articles still reflect a degree of discomfort with general practice as a distinct discipline — reflected in the confusion over “general practice” versus “primary care”. These are two separate areas, and, while general practice is well defined, primary care is not.

Several authors^{5,6} in the recent general practice issue speak of Divisions of General Practice and of the opportunities for collaborative research therein. Unfortunately, academia has failed to engage with Divisions. Although the Board of the Royal Australian College of General Practitioners has several professors, the Board of the Australian Divisions of General Practice sports a couple of part-time senior lecturers. Divisions report that academics often have a paternalistic attitude towards general practice, without understanding the true potential of partnerships with GPs.

General practice remains the most important, popular, and utilised part of the healthcare system, both in Australia and overseas. It is embracing change and responding to demands, often in innovative ways. We should be celebrating its achievements, rather than talking about imagined “crises”.

1. Del Mar CB, Freeman GK, van Weel C. “Only a GP?”: is the solution to the general practice crisis intellectual? *Med J Aust* 2003; 179: 26-29.
2. Van Der Weyden MB. Australian general practice: time for renewed purpose. *Med J Aust* 2003; 179: 6-7.
3. Western M, Dwan K, Makkai T, et al. Measuring IT use in general practice. Brisbane: University of Queensland, 2001: 152.
4. National Health and Medical Research Council. Outcome of 2003 Project Grant Funding Round. Available at: www.nhmrc.gov.au/funding/outcom02.htm (accessed Jul 2003).
5. Mudge PR. Australian academic general practice: looking back, looking forward. *Med J Aust* 2003; 179: 8-9.
6. Beilby JJ, Furler JS. General practice research. *Med J Aust* 2003; 179: 55-56. □

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IN REPLY: I would be heartened to believe that all is well in Australian general practice, that it is indeed “vibrant and leading the way in health-care reform in this country”. But the reality appears to be otherwise. Surveys

attest that doctors are unhappy, and Australian general practitioners have not escaped the mood of discontent and disillusionment.^{1,2}

That more than 80% of our general practices are computerised is laudable. But is this technology being used in a patient-centred way? Are visits coordinated so that waiting times are minimal and queues a thing of the past? Do practices use their computers in a way that efficiently integrates office processes, patient care, patient records, prescribing, pathology, referrals and health outcomes over time? In short, is this technology being used as a vibrant tool for practice efficiency and quality patient care? It appears that there is still some way to go, as a recent survey of GPs revealed that less than 50% use their computers for prescribing and less than 30% for managing appointments and clinical records.³

Whether specialists hide behind the façades of research institutes is uncertain. But what is certain is that research output in the field of general practice in Australia lags far behind that of medicine, surgery or public health.⁴ Furthermore, the National Health and Medical Research Council awards research grants on merit, not on a subjective assessment of what each sector “deserves”.

I am disturbed to learn that all is not well between some Divisions of General Practice and general-practice academia. A recent review of the Divisions’ role⁵ makes no mention of this divide, but submissions to the review did outline the need for stronger relationships between Divisions and academia. It takes two to tango and the solution lies with both parties.

Finally, I am encouraged that, despite the alleged “crisis” theme of the Journal’s recent issue on general practice, there are those who believe that “general practice remains the most important, popular and utilised part of the healthcare system”. However, on the issue of whether there is a “crisis”, participants in the recent Australian Health Care Summit would beg to differ: the general opinion was that not

only is general practice “in crisis”, but so too is the whole healthcare system.⁶

- Schatner PL, Coman GJ. The stress of metropolitan general practice. *Med J Aust* 1998; 169: 133-137.
- Chew M, Williams A. Australian general practitioners: desperately seeking satisfaction [editorial]. *Med J Aust* 2001; 175: 85-86.
- Weule G. IT uptake lower than expected. *Medical Observer* 2003 Aug 22: 24.
- Askew DA, Glasziou PP, Del Mar CB. Research output of Australian general practice: a comparison with medicine, surgery and public health. *Med J Aust* 2001; 175: 77-80.
- Australian Department of Health and Ageing. Review of the role of Divisions of General Practice. July 2003. Available at: www.health.gov.au/hsdd/gp/divisions/divfuture.htm (accessed Aug 2003).
- Van Der Weyden MB. Australian healthcare reform: in need of political courage and champions [editorial] [published correction appears in *Med J Aust* 2003; 179: 339-340]. *Med J Aust* 2003; 179: 280-281. □

“Only a GP?": is the solution to the general practice crisis intellectual?

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TO THE EDITOR: As much as we agree with the general sentiments of Del Mar and colleagues' views about the malaise of general practice,¹ we feel they simply listed some of the well known symptoms without elaborating on the underlying pathology or analysing the failure to provide appropriate treatment.

Their conceptualisation of general practice focused on clinical performance within a disease-centred model of medical care, which includes the issues of published and cited papers, critical appraisal and evidence-based medicine. Their analysis did not address systems issues, including the funding of general practice/practitioners, organisational change (such as amalgamation and corporatisation), and the establishment of Divisions of General Practice that have largely failed the community as well as the discipline.

We would argue that redressing the problems in general practice requires a fresh start in thinking. We need a much broader conceptualisation of general practice and its role within the healthcare system. Firstly, the *specialty* of general practice is *patient-focused generalism* — that is, a focus on patients' biopsychosocial healthcare needs and

understanding of their illness experience. Secondly, we need to recognise the important place of general practice in healthcare delivery and population health. After all, an average 217 patients per 1000 seek medical care each month, of which only nine will be hospitalised and one will require tertiary care.²

A broader conceptualisation of general practice must embrace the discipline's patient-centred approach to patient care and an explicit understanding of systems approaches within the context of the populations served by the discipline.

This can only be achieved if we embrace different research models and understand modes of healthcare system organisation, both of which are based on dynamic, non-linear models. Such an approach implies that we continually revise our models of clinical practice around patient and community needs. In fact, the greatest strength and the greatest opportunity of our discipline is our grassroots involvement — our ability, based on our individual experience, to advocate on behalf of our patients for a system based on their care needs and our ability to deliver such care.

We don't underestimate the challenges inherent in reorienting our discipline away from the mechanistic disease model of the 20th century towards a dynamic, patient-focused model relevant to the 21st century.

- Del Mar CB, Freeman GK, van Weel C. "Only a GP?": is the solution to the general practice crisis intellectual? *Med J Aust* 2003; 179: 26-29.
- Green LA, Fryer GE, Yawn BP, et al. The ecology of medical care revisited. *N Engl J Med* 2001; 344: 2021-2025. □

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IN REPLY: We agree wholeheartedly with Sturmberg and Martin that it is often hard to separate cause from effect. Are the symptoms actually the cause? The old villains — amalgamation and corporatisation — are only two of the main culprits. After all, they have had influence on specialist practice too.

The point we tried to make is simply that the intellectual deficiencies in the discipline of general practice, which attracted a public flaying¹ after an international conference on general practice research this year in Canada,² are too often ignored. Addressing them in the context of biomedical research, rather than embracing a different paradigm, may be one solution.

The approach advocated by Sturmberg and Martin (ie, emphasising healthcare system organisation and using novel research methods) is fine — we need innovation in healthcare systems and new ways of improving them. Nor do we trivialise patient-focused healthcare, in which huge advances have been made based on general practice research. Patient-focused healthcare was one of the themes of the recent research conference.²

But, if general practice enquiry remains limited to health services research, and if specialists do research on disease without involving general practitioners (however old-fashioned and “mechanistic” that might appear), we will always have difficulty clawing our way out from an intellectually inferior position. A recent example to illustrate the importance of clinical research in general practice is the latest hormone replacement therapy (HRT) uproar. For many years, the benefits of HRT have been simply projected on and promoted in the general population. Now that breast cancer risks have become clearer,^{3,4} it is obvious that earlier research could have prevented this negative fall-out.⁵

As Sturmberg and Martin so rightly point out, many illnesses are principally managed in primary care. Should we not become experts (through research and teaching) in their management too?

- Is primary-care research a lost cause? *Lancet* 2003; 361: 977.
- Wonca Kingston Research Conference Issues Preliminary Report. 2003. Available at: www.globalfamilydoctor.com/publications/news/april_2003/feature1.htm (accessed Sep 2003).
- Risks and benefits of estrogen plus progestin in healthy postmenopausal women: principal results from the Women's Health Initiative randomized controlled trial. *JAMA* 2002; 288: 321-333.
- Million Women Study Collaborators. Breast cancer and hormone-replacement therapy in the Million Women Study. *Lancet* 2003; 362: 419-427.
- Lagro-Janssen T, Rosser WW, van Weel C. Breast cancer and hormone replacement therapy: up to general practice to pick up the pieces. *Lancet* 2003; 362: 414-415. □

Is general practice vocational training at risk?

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TO THE EDITOR: It is fitting for the Journal to recognise the crisis facing Australian general practice (7 July 2003).

Every thinking person in the profession knows general practice needs to alter course if it is to survive. They are not lulled by the widely touted sophistry of practice accreditation, vocational registration, “cookbook” talk of disease management and other distractions.

However, nothing in the contributions gave me hope for the future of general practice and the community it serves. To paraphrase, Australian general practice is really a specialty, requires postgraduate training as long as that of rocket scientists and needs to be even more dependent on government involvement. It had also better look more like a specialty by doing some research.

General practice training may suit the training industry and government, but does not look like producing better *doctors*. The product looks like a medically qualified hybrid between a social worker and a case manager, something that may titillate government but does not appear to impress the rest of the profession.

General practice training relegates to the past the absolute necessity of acquiring the sharpest clinical skills as a diagnostician, and fosters instead the mantra of “better communication skills” and, worse, a disdain for core knowledge.

The political nature of this training does not appear to fool potential entrants, who are shunning general practice, nor does its professional façade fool some of our more astute medical leaders.¹

But the plight of general practice is posing a hidden danger to the whole profession. The move away from core knowledge in general practice has inspired a “dumbing down” of the profession that is now influencing undergraduate medical education. Under the guise of “problem-oriented learning”,

core knowledge is being seriously neglected, such that physiotherapists and nurses will soon be better trained than medical graduates.

I believe grassroots general practitioners (not their myriad representatives) need to rebel against government involvement in their professional training (ie, the Royal Australian College of General Practitioners) and reaffirm their “medicalness”. We can not be professionals and have governments determine our future, as suggested by Kidd of the RACGP.²

Australian general practice should look now to the august independence and academic robustness of the Royal Australasian College of Physicians to give us a new flag — not one of specialty, as we are not specialists, but one of independent professional standards and allegiance.

1. Phelan P. The medical colleges: issues at the turn of the century [editorial]. *Med J Aust* 2002; 176: 360-361.
2. Kidd M. Is general practice vocational training at risk [editorial]? *Med J Aust* 2003; 179: 16-17. □

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IN REPLY: Boffa appears to have overlooked the key messages in my editorial, which clearly outlined the risks inherent in government involvement in vocational training for general practice.

These risks include a lack of long-term funding commitments, reliance on professional support for success, and the current challenge posed by the poor image of general practice and training requirements among potential registrars. My editorial also clearly stated the need to distinguish medicopolitical objectives from the requirement for high standards of education and training.

Boffa’s presumably tongue-in-cheek suggestion about general practitioners joining the Royal Australasian College of Physicians overlooks the success of the Royal Australian College of General Practitioners (RACGP) in setting and maintaining standards for high quality clinical practice, education and training, and research in Australian general practice for nearly 50 years.

The RACGP is independent of government. Our core activities are funded by our members. The RACGP remains the largest medical college in Australasia, with over 10 000 GPs as financial members and over 18 000 GPs as members of our Continuing Professional Development program. □

Back to the future

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TO THE EDITOR: The Journal’s recent, extremely interesting issue on general practice (7 July 2003) has prompted me to look back at a symposium held at Sydney Hospital on 1 April 1966 (April Fools Day!). The subject was “The future of medicine”. The three speakers were Sir Charles McDonald, Chancellor of the University of Sydney; Mr Harry Jago, NSW Minister for Health; and myself, on behalf of the Australian Medical Association (NSW). My contribution on that day concluded as follows:¹

From the facts, figures and trends which I have given you, I would forecast as follows (and again, this must be subject to no radical changes in the international, political or economic framework of the country).

There will be a relative decrease in the numbers of doctors available to the community, and the greatest fall will be in the group most needed, the general practitioners. On the other hand, I expect a greater demand by the population for medical services. The average age of the patients will slowly increase, and geriatric problems will make up the bulk of day-to-day medical problems. It is likely that universities will have different types of medical training for those who plan to undertake general practice and those who intend to specialise.

The State and other third parties will provide the main channel by which medical practitioners are remunerated, and I hope (but by no means feel certain) that most will be remunerated on a fee-for-service basis.

Small country towns will have even less resident medical attention than they command at present, but better transportation and communications

will enable them to be serviced from the large towns with base hospitals.

In the hospitals, increasing use will be made of full-time and part-time paid specialists, and in addition new hospitals will arise in the form of geriatric hospitals and hospitals staffed by general practitioners.

Finally, the social, financial and professional status of the medical practitioner will ultimately depend on professional unity and wise leadership. Loss of status will inevitably occur with breakdown of either of these conditions.

Perhaps I should have been a fortune teller!

1. Jones KS. Medicine of the future. *Med J Aust* 1966; II Suppl 2: 21-24. □

Badmouthing GPs

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TO THE EDITOR: Let me congratulate the Editor and his team for their provocative issue on general practice in Australia (7 July 2003). Some of the major challenges are clearly delineated — particularly that of providing care to a chronically ill and ageing population.

While general practice in particular may be suffering from decreasing interest among young doctors, medicine in general is not seen by school leavers of today as the profession it was 30 years ago. Many bright school leavers are pursuing the “corporate world” in economics, law and business, but we can promote the overall satisfaction and variability of medicine in general and general practice in particular. The critical issues are outlined in the editorial.¹

Taking a leaf from our “economically” driven society, we need to present to governments and the public the evidence that healthcare systems focusing on primary care are associated with higher patient satisfaction, lower overall health expenditure, better population health indicators and lower per capita rates of drug prescribing.² Surely, governments (and, more importantly, treasuries) will listen to these arguments.

We also need to adopt a “whole-of-profession” approach. I am concerned that specialists (particularly in the hospital environment) continue to portray a negative image of general practitioners, particularly to young doctors.³ We can all remember, in our “resident” days, hearing negative comments from consultants: “If only the GP had done this or that or referred the patient earlier”.

Part of the problem is that there is still not enough vertical integration between undergraduate and graduate medical school education, postgraduate years 1, 2 and 3 and specialist training. A particular problem is that, after having had increasing exposure to general practice as a student, medical graduates then spend 2–3 years in a hospital environment where they have little or no contact with general practice. During this time they are influenced by hospital specialists who encourage them to pursue the “illth agenda” in hospital medicine and perpetuate negative stereotypes of general practice. Trainee doctors need exposure to positive general practice experiences in these immediate postgraduate years, including general practice terms (especially in rural general practice) along with hospital attachments. This would require significant dialogue between the federal and state health departments but would go some way towards renewing interest in general practice and continuing to provide Australians with one of the best health-care systems in the world in terms of equity, access, cost and outcomes.

1. Van Der Weyden MB. Australian general practice: time for renewed purpose [editorial]. *Med J Aust* 2003; 179: 6-7.
2. Starfield B. Is primary care essential? *Lancet* 1994; 334: 1129-1133.
3. McLean B. Specialists turn students off GPs. *Australian Doctor* 2003; June 20: 13. □

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TO THE EDITOR: Like Julian White, I was deeply moved to read the final chapter in the fable of the white-tail spider.¹ White comments that “The lack of strong evidence to support [the association of white-tail spider bites with necrotic ulcers] seemed to be a triviality to be ignored”.

However, I wish to take issue with the attitude to GPs reflected in his statement “General practitioners regularly and confidently diagnosed skin lesions as ‘white-tail spider bite’.” What is the evidence for this statement, or does White view it as too trivial to deserve scrutiny?

As a GP, I rarely come across a case of spider bite in which a confident diagnosis can be made. However, I am frequently asked questions such as “Could this be a white-tail spider bite?”, and frequently witness patients latching onto one of a list of possibilities, or unwilling to be dissuaded from the diagnosis they have arrived at independently of any medical advice.

Furthermore, it is only after the publication of Isbister and Gray’s evidence² that I am able to define clearly for my patients the effects of white-tail spider bites, rather than leaving room for doubt. It is a cheap shot for a specialist in such a narrow field to malign GPs on the basis of their failure to critically appraise the evidence relating to aetiology of a rare problem for which there was said to be no treatment.

It has become common to read derogatory statements about GPs by specialists unsupported by evidence. Interestingly, such comments are not aimed at emergency department nurses, resident medical officers, physiotherapists or other specialists. I would argue that this may be of some importance. Denigration of the value of medical training and skills may contribute to negative attitudes towards GPs in the community. This may translate into adverse behaviours such as unwillingness to seek medical advice, reluctance to have children vaccinated, inadequate use of antenatal care services, degradation of communication between medical practitioners, and demoralisation of the medical workforce. It may also make it difficult for people to accept advice about white-tail spider bites.

Perhaps White could afford GPs the respect that he does the white-tail spider, rather than taking a random opportunity to malign the competence of GPs.

1. White J. Debunking spider bite myths [editorial]. *Med J Aust* 2003; 179: 180-181.
2. Isbister GK, Gray MR. White-tail spider bite: a prospective study of 130 definite bites by *Lampona* species. *Med J Aust* 2003; 179: 199-202. □

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COMMENT: Chaffey and Brooks draw attention to the negative effects of specialists badmouthing general practitioners: undermining GPs' self-image and community status, and discouraging medical students and young doctors from pursuing a career in general practice. Hays has made similar observations about problem-based learning exercises, written by specialists, wherein the mismanaged rural patient is "rescued by clinicians in the nearest large teaching hospital".¹

Medical badmouthing has been defined as "unwarranted, negative and denigratory comments made by doctors about other doctors in different branches of medicine".² It is most visible when uttered by specialists in teaching hospitals, but is almost equally as common from GPs criticising some real or imagined lack of common sense in the treatment received by one of their patients in a teaching hospital.²

The underlying psychological mechanism of badmouthing stems from a common human need for self-aggrandisement and defining of group membership by aggressively putting down people outside the "in-group".³

So, while badmouthing is maladaptive behaviour for the medical profession as a whole, it does have some adaptive features for different subgroups.

Specialists in private practice usually have good working relationships with GPs — indeed, their practice would suffer if they didn't. But, in my (non-evidence-based) experience (I haven't done a study on the topic), nearly all specialists see themselves as part of a medical elite who have achieved their status through having the ambition, energy and fortitude to complete a rigorous postgraduate training and examination process beyond that required of GPs.

And we GPs are appropriately grateful for their skills, especially when one of our patients is faced with a life-threatening emergency. Also, most continuing medical education is given by specialists "teaching" GPs. Reciprocal opportunity for constructive GP feedback about patients' hospital outcomes is rarely given or gratefully received.

Specialists and their junior staff are frequently inconvenienced by overloaded outpatient clinics and by emergency patients, referred by GPs, who arrive at 6 pm instead of 9 am. And on rare occasions they see a patient with a necrotic ulcer due to a basal cell carcinoma, referred by a GP who agreed with a patient's diagnosis of "spider bite". What the specialist doesn't see is the other 100 patients bitten by an uncaptured white-tail spider who are managed solely, logically and effectively by GPs. Extrapolating from one or two cases to the whole of general practice is bad epidemiology and evidence of sloppy scientific thinking.

Badmouthing is an ingrained feature of human nature and a historically unattractive part of medical culture. It will continue until all doctors realise that they are on the same team, fighting the same war against the many facets of disease and disability. GPs and specialists need to understand and respect each other's role and task. This requires mechanisms to enable already time-poor doctors to interact regularly with each other.

In one survey, about 10% of students admitted that negative comments by specialists about GPs had influenced their decision to reject a career in general practice.² This was part of the rationale for setting up a medical school counterculture through rural student clubs.⁴

But even more harmful than badmouthing is the perception by students and young doctors that general practice is an unattractive branch of medicine, beset with governmental red tape, a divided leadership, and, after failure of the Relative Value Study initiatives,⁵ a guaranteed continuation of poor remuneration for heavy responsibility taken and long hours worked.

1. Hays R. Problems with problems in problem-based curricula [letter]. *Med Educ* 2002; 36: 790.

2. Kamien BA, Bassiri M, Kamien M. Doctors badmouthing each other. Does it affect medical students' career choices? *Aust Fam Physician* 1999; 28: 576-579.

3. Peach HG. Badmouthing between disciplines. *Aust Fam Physician* 1999; 28: 581.

4. Kamien M. Rural student clubs and the social responsibility of medical schools. *Aust J Rural Health* 1996; 4: 237-241.

5. Royal Australian College of General Practitioners. Relative values. What is the RVS? Available at: www.racgp.org.au/document.asp?id=512 (accessed Oct 2003). □