Each episode of illness in a patient is described by doctors in letters or medical notes which build into a history of the person's medical life. No general practitioner summarizing case notes or hospital specialist reviewing notes can fail to be struck by their biographical aspect. This is particularly so as the entries often go beyond a factual account of illness and comment on personality and personal relationships. For example, patients have been described in medical notes as 'tall, thin, anxiety prone, introspective' and 'wily'. It is not just by chance that these comments exist because the context in which patients live is of great importance to the ways in which they react to illness. The significance of these comments as biography should not, however, be overstressed. The patient makes no direct contribution to the descriptions and the entries are a doctor's view of the patient in a situation of stress; from the patient's point of view, illness events may be of little significance in the totality of his or her life.

Anecdotes and stories, therefore, are integral to medical practice[7] and to the education of those practising it. Learning the scientific basis for understanding people is only one part of the holistic approach to which students must aspire. Downie has pointed to other types of understanding, including the narrative, historical and sympathetic modes.[5] Anecdotes and stories involve narrative and historical understanding but also contribute greatly to sympathetic understanding. However, anecdotes and stories can only achieve this if the doctor appreciates their importance and takes time to listen.

Although knowledge obtained through scientific endeavour in medicine is being vaunted as superior to knowledge obtained in other ways, learning from anecdotes and stories and being alert to their use by patients are essential to good medicine. This kind of knowledge enables doctors to deal with patients as individuals and to respect their uniqueness as persons. As George Eliot in her novel *Middlemarch* said of Dr Lydgate:

> 'He cared not only for 'cases', but for John and Elizabeth, especially Elizabeth.'[8]

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There is hope yet for the development of primary health care in deprived areas

THERE is no point in arriving too early for morning surgery because the patients will not be there: it seems that an appointment with the doctor is not enough reason to get people out of bed in this inner city practice in Liverpool.

A similar observation was made on the *Panorama* (BBC) television programme 'rich and poor' on 13 February 1995 about the behaviour of people in Drumchapel, a deprived area of Glasgow, compared with affluent Bearsden. The programme repeated what is known by anyone who has worked in a deprived area — a key problem is the lack of hope. The reality of living in a deprived area is that one is confronted on a daily basis with personal failure, violence, unemployment, fragmented communities and lost dreams. The result is that individuals, families and communities come to lack purpose and self-belief. Working as a general practitioner I see men and women in their early 20s who are resigned to a life on 'the dole' or on 'the sick', people who have no idea what they want out of life, what they believe in or with whom they identify — people who have difficulty getting out of bed in the morning.

They are not alone. The report of the Royal College of General Practitioners inner city task force[1] reminds us that primary care teams often exhibit the same features as their patients — of being overwhelmed, unable to find optimism or direction. For individuals, communities and health workers alike, two of the most pressing priorities to address are the need to locate themselves in a wider picture and to feel good about who they are.

The problem of inequity is itself of considerable importance. The Black report of 1980[2] demonstrated the profound association of deprivation and poverty with sickness and the situation has worsened since then: over the last 15 years the rich have got richer and the poor poorer and mortality and morbidity gaps have followed the same pattern.[3,4] This has resulted in the preparation of a range of books that suggest practical ways forward.[5-7]

The catch is that deprivation and poverty are not the only causes of hopelessness. The anonymity, struggle to survive and fragmented communities characteristic of deprived areas promote a loss of direction and with it a loss of hope. Jobs and housing alone will not be enough to give people a sense of identity or create a vibrant, positive culture, nor will more staff ensure that general practices in deprived areas become happier places. Interventions are needed, both in local communities and in general practices, that help people to become confident. This is the field of development.

To develop means to grow or to evolve. The word development is used in many different contexts, for example personal, service and organizational development, community development and sustainable development. All share (or should share) a common aim of moving forward.

A development approach focuses on people rather than topics. It accepts individuals and groups for what they are and helps them to change in a way that personally empowers them and also helps them to interact better with the world around them. Such a

learning process which changes people's hearts and minds takes time but it is an effective process which results in sustainable change.

A development approach is a long-term solution to long-term problems and its attraction is therefore compelling. However, development that occurs in isolation will result in wasted effort. Health concerns us all, for example lay carers, lay professionals, managers, health centres, schools and tenants associations; each makes a contribution to the whole. If each is able to develop at the same time they are likely to collaborate to enhance each other's roles in the total health care effort. This is what the wider concept of primary health care means.

The terms primary health care, primary care and primary medical care are commonly used to mean the National Health Service provision of care outside hospitals. However, the term primary health care is also used as an umbrella concept which can include everyone involved in health or care outside hospitals — health professionals and others.[8] It is a new paradigm which demands a new way of thinking, away from hierarchical structures towards a dynamic system. The goal of development is to create and maintain this dynamic system in which individuals grow in a way that is helpful for them but also enhances the whole. The tangible outcomes are many and varied, and multiple priority decisions have to be made at every level, but they must all complement each other.

Development is a relatively new field in the NHS, but there is established theory and practice to draw upon, for example in the areas of management of change and team building. Development requires the participation and collaboration of all the players and so the principles of adult learning (emphasizing participation in a learning process) and participatory research (involving all stakeholders in a research process) contribute to an understanding of how to be effective. Theory from large group interventions[9] shows how to 'get the whole system in the room', not by physically having everyone there but by using networks to give everyone the chance to participate in the effort to change.

Development aims for everyone to win and for cultural change. It is possible to use such an approach in any initiative, however big or small, as long as there is some realism as to what can be achieved in the time available. We do not have to look far to find interventions in health care that have consciously used such principles.

Five cities — Liverpool, London (Camden), Dublin, Belfast and Glasgow — have 'healthy city projects'. They are part of a network of 33 cities in Europe, and many more worldwide, all using networks with health services, community groups and local authorities to cause cultural change. Few of these initiatives, however, have involved general practice.

A development approach has been used with success in general practice in many places. Some projects have focused on the development of the practice team while others have emphasized the development of local collaboration.[10] The Camberwell primary care development project helped general practitioners and other members of practice teams to come together to reflect on their work and establish collective solutions.[11] The 'healthy eastenders project' in London, the teamcare valleys project in south Wales[12, 13] and the North Tyneside Medical Audit Advisory Group project[14] have all involved local health workers in development projects where they come to know each other better and to become clearer about what they stand for. A facilitation project in Sheffield caused change through the use of networks and coalitions of interest (*Improving quality through interpractice collaboration towards coordinated practice.* Paper presented by R Eve at the Royal Society of Medicine, London, 1993). The primary health care facilitation project in Liverpool adopted a similar approach to that of Camberwell and Sheffield.[15] These projects and others will be described in a forthcoming King's Fund publication[16] to add to a series of books on primary care development, the first of which explores the role of general practice.[17]

Follow up of such projects shows that unexpected things can happen. In Liverpool a quarter of the city was targeted with a development approach. Over a three-year period the immunization and cervical cytology rates in the targeted area rose much faster compared with the rest of the city and with another family health services authority district.[15] The intervention team did not prioritize immunization or cervical cytology — the practices did this themselves. Of course factors such as remuneration and media profile aided motivation but the message is that if you provide interventions that help people to help themselves, they do.

The Liverpool project developed the idea of local multidisciplinary facilitation teams in which local workers from different disciplines (for example, health visitors, practice managers, general practitioners and school nurses) formed teams to facilitate development in defined geographic areas. These teams develop and foster networks; they ask health care workers and others, such as teachers and social workers, what future they would like to see and what they perceive to be the immediate priorities for action. This information is amalgamated and fed back to people in order to arrive at a consensus for action in practices, across localities and in health-associated organizations, such as health authorities and voluntary organizations. Practices and individuals with similar interests are put in touch with each other and commonly perceived problems in practices are communicated to health service managers.

The facilitation teams operate a number of defined interventions,[18] which allow insights and information from a local area to be reflected upon with a view to developing shared local action. There are many examples of the development approach in action in Liverpool. For example, staff at a health centre met school children and their teacher for a discussion about health. The children painted pictures about health issues which were then mounted on the walls of the surgery waiting room. This helped the practice to feel more a part of the community and the community more a part of the practice. A research worker skilled at participatory research and unstructured interviews explored the views of practice teams about why women did not attend for cervical smears. They then produced action plans to address the issues that had been identified. Non-attenders were then interviewed and their views were presented to the practice teams at follow up. The realization that there was a mismatch between the views of practice staff and patients and that there were steps which the staff could take to tackle the mismatch galvanized the practices into action.[19]

Describing projects and models of activity cannot describe adequately the power of a development approach to cause cultural change, and the power of cultural change to cause more change. When moods and attitudes change, when it becomes common for people to talk about their work in a collaborative and enthusiastic way that indicates that they understand and value people they did not know before, and when people choose to align their efforts with others, the force for change is enormous and it develops a life of its own. Some of the comments from participants contained in the report of the Liverpool facilitation project bear witness to this.[15]

At present a development approach to change is not the norm in the NHS. However, in deprived areas throughout the country such an approach is increasingly being used as people come to recognize that it produces lasting results — and hope. It helps general practices and communities to be confident about what they stand for and where they are going, giving them the skills to be effective at change.

Direction and hope are not solely the needs of deprived areas — they are the needs of all people. You can test this yourself by reflecting on your own life: when you know what you stand for, with whom you identify and where you fit into the whole, you feel competent for the journey ahead. When you feel good about all these things you feel hopeful. When you feel hopeful, getting out of bed in the morning is not such a bad thing.

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Food for thought...

'Bereavement care is vital... Support for those who grieve will enable the grief process to proceed smoothly, albeit painfully, and help to prevent pathological grief and psychiatric sequelae. This type of care is a therapy for restoring a person to renewed function, a changed person but nevertheless a survivor.'

Charlton R, Dolman E. Bereavement: a protocol for primary care. August *Journal,* p.427.