The British Journal of General Practice

Viewpoint

Whither Co-ops and Revalidation?
What role for general practice out-of-hours co-operatives in that hottest of hot topics: revalidation?

A GP co-op is a non-profit making organization entirely and equally owned by, and mostly medically staffed by, the GP principals of the area in which it operates. Co-operatives are now the most popular way for GPs to deal with their on-call. More than 20 000 GPs now belong to one and, crucially, part own one. The average co-op consists of about 80 doctors who, while not in partnership with each other, are certainly exposed to each other's clinical practice. For most GPs, the co-operative experience brings unparalleled scrutiny of their work. Scrutiny from their peers, from their medical directors, and from the public.

Where else, until now, have 80 GPs been exposed to each other's style? Each other's talents and shortfalls? Nowhere. Co-op members, all 80 of them, peruse, potentially, each other's casenotes — more exposure than the largest of group practices. Scary! But also reassuring. Experience with MAIDDOC and other co-ops suggests that the standard of care provided by colleagues is, at the very least, adequate. Concerns of senior practitioners that neighbouring practices might not quite come up to scratch have not been justified.

The concerns of patients have too, by and large, been ameliorated. Co-ops were the first large scale NHS providers to ask routinely, by questionnaire, what patients thought of the service provided, and comment was generally favourable

These same questionnaires pass through the hands of medical managers. A body of evidence of performance thus accumulates — reassuring to colleagues, partners, patients, and medical directors ... but is it of any relevance to revalidation as presently proposed?

There are arguments for and against.

For involvement:
• co-operatives are professionally-led
• co-operatives expose practice to peer review, in a non-threatening way
• co-operatives, unlike PCGs, are with us now, and can describe co-operation as it is happening, rather than theoretically

Against involvement:
• co-operatives were not established to police good practice
• co-operatives operate out of hours, not during the normal working day, when life may be simpler, or at least different
• co-operatives may be biased in favour of members' interests to an extent where objectivity becomes improbable

Within GP co-operatives at present we make efforts to encourage good practice. Comments on performance are fed back to members in a non-judgemental way. The rude and stroppy practitioner, if habitually rude and stroppy, is occasionally tackled by medical directors. Judgement by stealth is sometimes imposed, with members quietly not put onto the rota. Medical directors may report significant concerns to the LMC or GMC. Many co-ops have a seldom-used 'wise man panel'. But a Spanish Inquisition it is not.

These actions fall far short of systematic evaluation, and therefore of revalidation. Much change would have to occur before formal involvement. The GP co-op membership would need to agree. Lay observers would have to be involved. Meaningful measurements of performance would have to be agreed, and the data collected in an accessible fashion. And the issue of non-working members would have to be addressed.

Co-ops cannot have a principal role to play in the great new game of revalidation. Their main role, quite properly, should be to look after the interests of their members. The ground rules for revalidation should be left to the GPC and the RCGP. But, as a starter for ten, co-operatives have a role in defining normal, polite and effective practice, and their expertise should be cultivated

E Mark Reynolds

The Back Pages...

If ever there was a time for doctors to be thoughtful it is now. Perhaps we can even find a way out of this mire of control-freak society that some of our sister professions could gratefully follow...

James Willis, page 330

contents

Taking Control of The Future: PCGs in Urban Deprived Areas

The publication of *The New NHS* heralded further developments in the role of general practitioners and primary care within the NHS. The development of Primary Care Groups (PCGs), and in the future, Primary Care Trusts, presents both challenge and opportunity for the provision of primary health care services, as well as the role of primary health care teams in commissioning health services. PCGs in urban deprived areas are exceptionally placed within the NHS in taking these dual agendas forward.

The RCGP is holding a conference on Thursday 20 May at the Saltaire Centre in Bradford that will address the unique challenges for general practice and primary care in urban deprived areas. It will focus particularly on how Primary Care Groups will be sustained and in the ability of both PCGs and general practice services to deliver the new agenda. The conference will facilitate the debate on the nature of health care provision, within the context of an urban deprived environment, and will provide opportunities for re-examining how health inequalities can be addressed, and accessible and available high quality care delivered to populations with complex health care needs.

Keynote speakers at the Conference will:

- establish the context of the provision of general practice services within an urban deprived environment;
- identify how this relates to the overall policy dimension for the development of primary care and PCGs, and
- explore how solutions may be identified using approaches aimed at the systems which affect the determinants of health.

Facilitated workshops will identify solutions to the challenges facing PCGs and primary care across six major areas:

- managing diversity;
- context — features of urban deprived areas
- continuing professional development;
- data — its role and usefulness;
- role of primary care; and
- small and large practices — learning from each other

The conference will also act as a catalyst to further development of a network between individuals, teams and organizations working in, or with experience and interest in, general practice and primary care in urban deprived areas. This network will provide a means of sharing good practice, ideas and innovations in service delivery and organization for general practice and primary care.

Judy Jones

RCGP Health Inequalities Task Group: Housing and Health

One of the first actions of the College's Health Inequalities Task Group when it was formed last April was to conduct a survey of College faculties, to determine priorities for the Task Group's work.

The outcome of the survey was a suggested list of topics, in which the health problems of people living in poor housing (including illnesses related to problems of damp and cold), the mental health problems arising from isolated or hostile housing situations, and the help sought from general practitioners in obtaining new housing on health grounds all featured prominently.

The Task Group is now planning to hold a conference on the subject on 29 June in Birmingham, in collaboration with the Chartered Institute of Housing (CIH), which will look at how primary care teams can work with housing agencies to address some of these social determinants of illness.

The venue in Birmingham has been donated by the local Health Authority, which is keen to work with the Health Inequalities Group which, in turn, is eager to operate outside London, at least for part of the time. The Group also wishes to adopt an international perspective on health inequalities issues, and its intention is to provide a European dimension in the first presentation of the conference. Other speakers will cover multi-disciplinary working, social exclusion and health, and the problems of particularly vulnerable groups, such as frail older people, refugees, and people with mental health problems.

The objective of the conference is a practical one — to produce policy recommendations for the College and the CIH for wide promulgation among primary care teams, housing officers, and to the Government. Workshops will allow participants, drawn from both primary care and housing agencies, to share experience of good practice and to discuss strategies for more effective co-operation.

The outcome will be to help professionals, in both health and housing, to provide more effective support to people faced with health problems related to, or caused by, their housing situations.

Sara Shaw

Ethical Considerations in Primary Care Research

With an ever-increasing focus on primary care in research, the Research Group at the College has developed a series of topical masterclasses on primary care research for health professionals. Over the past few months, these have covered topics such as qualitative research, questionnaire design, statistical concepts, and RCTs and conducting multi-centre research.

Our fifth class builds on these concepts, and looks at 'Patient Participation and Other Ethical Considerations'. This class will take place at Princes Gate on Tuesday 27 April and, like the previous classes, will involve small group work around practical issues. All delegates receive comprehensive course material, including a workbook with appropriate key readings.

Patient participation is a topical issue which affects all health professionals. This fifth masterclass aims to set the topic in the context of research and to discuss recent developments, such as confidentiality and access to patient records.[1] The class will also look at how patient participation groups may be utilized to gain input from patients in relation to research, how to disseminate research results to patients, and how this may possibly be included within the agenda of the new primary care groups. Particular attention will be given to ethical issues; for example, informed consent, patient information, or the allocation of patients to particular arms of an RCT. It will build on the notion of research as a community resource by highlighting the idea that the patient or volunteer within any project (as well as the researcher) needs protection.[2]

Speakers for the one-day class are from varied backgrounds but bring with them a wide range of experience from such organizations as Local Research Ethics Committees, The National Association for Patient Participation, and the RCGP Patient Liaison Group. This wide range of speakers will give health professionals a greater insight into ethical issues from the perspective of the patient and help them to understand the far-reaching imp-lications that research within primary care can have on individuals or groups of patients.

If you would like further information or an application form for the class on 'Patient Participation and Other Ethical Considerations', please contact the RCGP Courses and Conference Unit on 0171 823 9703, or e-mail: courses@rcgp. org.uk

Sara Shaw

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Six Doctors in Literature

Number 4: Dr Rank from *A Doll's House*, by Henrik Ibsen

Ibsen was the master analyst of the middle classes; it is therefore not surprising that he should include doctors in his work. As well as being representative of the bourgeoisie the medical profession provides a rich metaphorical avenue for this dramatist who fundamentally saw society as sick, if not terminally ill.

In *A Doll's House*, first performed 1879, Dr Rank is a close friend of Nora and Torvald Helmer. Their suffocating marriage, and Nora's eventual liberation from her domestic prison, are the focus of the play. Dr Rank visits their home frequently and is infatuated with Nora. He is the confidant of both, and much of their character development is revealed in discussion with him.

Dr Rank is terminally ill from syphilis inherited from his father. He is a physician who cannot heal himself. He represents man's helplessness before disease, at the same time as embodying a profession growing more confident through scientific advance. Rank is able to analyse and quantify his condition but is helpless to do anything to save himself:

Rank: My poor innocent spine has to suffer for my father's youthful amusements.

The doctor sums up Ibsen's view of fate:

Nora: *(to Rank)* You are quite absurd today. And I wanted you so much to be in a really good humour.

Rank: With death stalking beside me? To have to pay this penalty for another man's sin! Is there any justice in that? And in every single family, in one way or another, some such inexorable retribution is being exacted.

Rank represents the canker behind the respectable face of society. Such 'inexorable retribution' is about to break the Helmers up. The identification of moral decay with disease is made when we first meet Rank:

Mrs Linde: *(old friend of Nora)* One must live, Dr Rank.

Rank: Yes, the general opinion seems to be that it is necessary.

Nora: Look here, Dr Rank — you know you want to live.

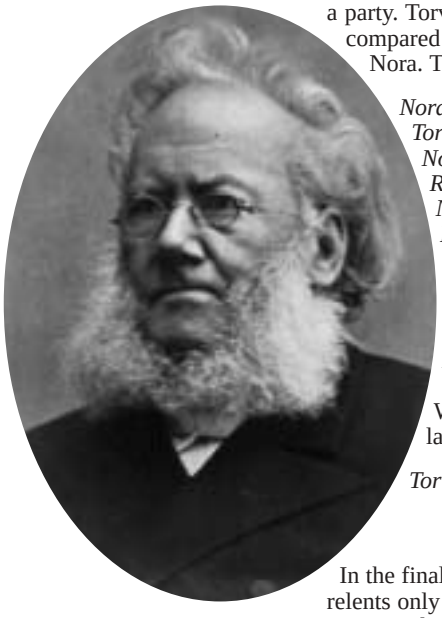
Rank: Certainly. However wretched I may feel, I want to prolong the agony as long as possible. All my patients are like that. And so are those who are morally diseased.

He goes on:

Rank: Healthy natures are left out in the cold.

Mrs Linde: Still I think the sick are those who most need taking care of.

Rank: Yes, there you are. That is the sentiment that is turning society into a sick house.



Henrik Ibsen, courtesy of *Barnaby's Picture Library*

Dr Rank is the object of Nora's most cruel teasing, but is instrumental in empowering her to leave the suffocation of her home. He attains a heroic status when he arrives at the Helmer's flat after a party. Torvald is about to rape his wife but is interrupted by the Doctor. Nora's moral growth compared with her husband is apparent as Rank reveals the certainty of his imminent death to Nora. Torvald misses the meaning of the conversation completely:

Nora: Dr Rank, you must have been occupied with some scientific investigation today.

Torvald: Just listen! Little Nora talking about scientific investigations!

Nora: And may I congratulate you on the result?

Rank: Indeed you may.

Nora: Was it favourable, then?

Rank: The best possible, for both doctor and patient — certainty.

Nora: Certainty?

Rank: Absolute certainty. So wasn't I entitled to make a merry evening of it after that?

Nora: Yes, you certainly were Dr Rank.

Torvald: I think so too, so long as you don't have to pay for it in the morning.

Rank: Oh well, one can't have anything in this life without paying for it.

When Nora explains that Dr Rank is about to die Torvald shows his shallowness and lack of insight into the family rupture that is all but on him:

Torvald: He had so grown into our lives. I can't think of him as having gone out of them. He, with his sufferings and loneliness, was like a cloudy background to our sunlit happiness.

In the final scene between the couple, Torvald berates Nora for bringing scandal upon him. He relents only when he realizes it can be concealed. Nora is no longer a child. Despite his attempt at reconciliation she leaves him in disgust. Radical surgery is the only possible treatment. At least Dr Rank has helped to cure her of 'moral disease'.

Dr Rank is a brilliant portrayal of the doctor as patient. He exemplifies the versatility of the doctor in literature. He can stand for so many things. He reminds us that we all have 'a poor innocent spine'.

Wayne Lewis

Quotes from: Henrik Ibsen (trans. Anon). *A Doll's House* (first published 1879) Dover: Thrift Editions, 1992.

Do Savings in NHS Administration Generate Real Health Gain? A Theoretical Study ...

Cuts in NHS administration will save £1bn over the lifetime of the current Parliament [1]

More nurses, more doctors, fewer administrators. A familiar cry, but is there evidence to suggest that this popular formula has any impact on the health of the nation? An important question for the first patient of my morning surgery — Mr Frank Jones. Aged 46, and recently made redundant from the Health Authority after 18 years of service. Presentation — clinical depression. From our position in general practice we may see other resource perspectives.

Year	0	1	2	3	4
Employee	0.9	0.45	0.60	0.70	0.90
Partner	0.9	0.60	0.70	0.80	0.90

Figure 1. A theoretical utility profile of employee and partner over a four-year period following loss of employment.

The principle of ***opportunity cost*** states that resources directed into one area will be at the expense of benefits lost in another, and that these costs should be judged in terms of this lost opportunity. In the simple analysis, the resources of the Health Authority released by this redundancy, for health gain in other areas, could be set against medical costs of depression and ensuing state benefit. But what is the human cost? Can health economics help estimate the real net health gain?

QALYs lost by employees	33 400 (0 – 60120)
QALYs gained by society	55 500

Figure 2. An estimate of QALY gains and losses following £1 billion of administrative savings in the NHS (possible range in brackets).

A ***cost utility*** analysis[2] relates outcomes to both quality and quantity of life and is based on theoretical choices yielding values that can be put on health states. Outcome are expressed in terms of a single 'utility base unit' that allocates a value of between 0 (death) and 1 (perfect health) to any condition and combines it with the length of time in that state to obtain a composite index of outcome — the quality adjusted life year (QALY). This approach allows broad comparisons to be made across disparate areas.

Method

First, I assume that each job loss would save £15 000 per annum over a four-year period: the life of the current Parliament. A £1 billion saving in administrators would shed 16 700 employees.

Second, as a first approximation, I assume that the utility of employee and partner are 0.9 prior to job loss. I estimate a utility profile after redundancy as shown in Figure 1, adding an arbitrary 0.5 utility loss to reflect the disturbance to the children in the family. This gives a reduction of two QALYS over four years. Depression has a utility value of 0.45, which offers a baseline.[3]

A QALY is costed as £18 000 — the amount that has been suggested as a maximum ratio to support the adoption and utilization of an intervention.[4] (Estimate inflated to 1998 prices using the Hospital and Community Health Services Pay and Prices Index).

Results

A summary of the results is shown in Figure 2. An estimate of 33 400 QALYs lost by redundant administrators and their families was derived. A sensitivity analysis allows the outcome of an analysis to be tested over a range of situations to determine its robustness against potential changes in key variables.5 For redundant employees, a range can be taken over which no loss of utility unites to a worse case analysis, when both employee and partner are depressed for over a four-year period. This gives a range of 0 to 60 120 QALYs. Using the incremental cost of a QALY as £18 000, these redundancies would purchase 55 000 QALYs, excluding the additional financial burden to the health and social services sectors as a result of a redundancy.

Discussion

A technical analysis indicates that the proposed reduction in NHS administrators generates real health gain. But QALYs know no compassion – the concept of ***opportunity cost*** involves sacrifice. And if that means a loyal servant of the Health Service for 18 years — so be it.

To the health economist, it is the societal perspective that is paramount and their rational frameworks can be seductive at a time when difficult decisions have to be made between competing resources. But decisions in health have to be taken with circumspection. Mr Jones will be too old to find employment again. And what effect will his desultory future have on the rest of his family? Short-term gain — but what is the real long-term pain? As GPs, we are often caught between the conflicting demands of patients and society; balancing the often mutually exclusive directives of economics, evidence, equity, and em-powerment.

'Next patient please'.

Mrs Thompson ... doing well with her new hip, which the Health Authority has purchased as part of their initiative to relieve the waiting list with money released from cut-backs in administration.

David Kernick

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The illustration depicts Jacques de Molay, last leader of the Knights Templar, burned at the stake for heresy in 1314, Chronicle of France or of St Denis (14th century). © *British Library, London, UK/Bridgeman Art Library, London/Paris/New York.*

On the day which happens to be the deadline for this article, I will be going with my wife to a memorial service for my trainer, Tony Danby of Lyndhurst, whose name few will recognize, but who was the best doctor I have ever known. That is my assessment. That is my validation. I could not begin to justify it, quantify it or prove it, the attempt to do so would be absurd, but it is true. No scheme of assessment on earth, however cunningly devised, would change that truth, whether it supported it or contradicted it.

That's the sort of thing he taught me, without meaning to of course. I don't know what he would have made of revalidation, this model of mine, I suspect it would have made him very sad. It certainly makes me very sad, because it means to me that we have lost the battle to uphold the special nature of professionalism which he exemplified to such a high degree. It actually makes me feel that I am not sure I want to be this new kind of doctor, and it makes me fearful for us all as patients in the future.

Which is funny, because the whole thing is supposed to be progress. But the fear is shared by almost everyone you meet. In Sainsbury's this afternoon a retired classics master wrinkled his nose — 'It's Big Brother, isn't it?' Yesterday, a civil servant said: 'It's what they've done to the teachers'. At Monday's rehearsal for our Operatic Society production, a health visitor commented: 'I used to love my job so much when we were free ... there just isn't trust any more'.

I'm supposed to be being positive about this, and God knows I've tried, but I can't make it hang together. Why was it necessary to bring it in on a pretext? I am as keen as anyone to protect the public from incompetent, dishonest, or of course murderous doctors. I believe the recent cases have highlighted a deplorable situation, and the tightening and speeding up of the ludicrously timid procedures for action in such cases is long overdue.

But that is not what is being proposed. *The Guardian* captured it succinctly on 2 February: 'Doctors who fail new checks to be struck off'. But these new checks are going to leave the glaring deficiencies which spawned them entirely untouched. [1]

So, are the 'new checks' to be a set of baseline standards? I would have no anxiety about that — a level below which nobody could be allowed to sink. I argued for such a baseline in my book,[2] and as early as 1979 in a *BMJ* Personal View on qualification for membership of the RCGP.[3] These standards would be far lower than ideal standards and we would all, in our different ways, aspire to rise above them. They would be springboards for growth, not mountain-tops we would exhaust ourselves struggling vainly to reach. In this way we could hope to preserve the vitality, initiative, and diversity which has been so characteristic of British practice. For, in practice, we know that people are best left choosing their own mountains to climb.

But unless we are entirely unlike all the other professionals who have been subjected to external regulation in recent years, that is not what we are going to get. What we are going to get is a set of target standards, set by enthusiasts (acting in good faith — I don't deny that for a moment), which are then

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raised year by year so that we can be seen to be kept under the inhuman pressure which is central to contemporary management philosophy and so that 'progress' can be demonstrated in boardrooms and debating chambers and on the morning news.

Did anyone else wake up one morning to Radio Three and learn, whether they wanted to or not, the name of the 'worst primary school in England'? Just don't try to kid me that we have nothing to fear; we live in an age that likes this sort of thing. We live in an age that believes in Utopia, attainable through technology. This is in spite of the fact that Utopianism was shown by Karl Popper half a century ago to be a logical absurdity, leading inevitably to authoritarianism.[4]

It has, of course, been tried and found wanting in Communist Europe. In practice it doesn't work. You have to give people their freedom, their individual responsibility, the widest possible room to breathe and spread their wings, and let them fly. And you have to accept that whatever level of perfection you achieve, the natural tendency will be to want to take it further.

In fact, it is worse than that, as we in general practice know very well: the safer and more effective medicine becomes, the more worried people become about the hazards that remain. This is going to go on. We must find a way of coping with that reality, which doesn't mean us all having to subscribe to a doomed quest for the Holy Grail of perfection.

I will just have to trust readers to understand that I am not arguing for complacency, or that we shouldn't always be trying to improve. What I am saying is that if you measure progress in something as vast, diffuse, and multi-faceted as general practice by single parameters such as immunization rates, or the number of books on the surgery shelf, or whether we know what ACE stands for, you will certainly improve those parameters, but at the expense of others which may be, indeed are, vastly more important.

What I am saying is that this approach is *fundamentally misguided*. That is why thoughtful doctors are worried about revalidation.

Which brings me back to Tony Danby, whose highest praise for a doctor was that he was thoughtful. If ever there was a time for doctors to be thoughtful it is now. Perhaps we can even find a way out of this mire of control-freak society that some of our sister professions could gratefully follow.

I think he would agree with me that there is no kind of medicine that we could do now which would do more good.

James Willis

Commentary

Getting To 'Yes'

The maintenance of self-regulation was fundamental to the GMC's decision to introduce revalidation. I know colleagues fear that it will be time-consuming, costly, and bureaucratic, but I can assure you it will not.

The Council is charged with maintaining the medical register. This task has always carried with it the responsibility for erasing those found guilty of serious professional misconduct. More recently, it has been possible to modify a doctor's registration because their practice has been affected by ill-health. Nowadays, poor performance is an additional factor that can be considered by the Performance Review Committee.

All these procedures suffer from the problem that they only come into play when an individual is found to be, or have been, failing. There is no proactive demonstration of adequate performance except at the point of original registration. As long as we continue to pay our registration fees and keep our address up-to date we have a ticket to practice for life.

The public rightly want further reassurance. The Government introduced NICE, CHIMP, and clinical governance in their White Paper, *The New NHS*, to satisfy this public demand. The problem is that someone or somebody has to oversee this process. It would be either the profession, in the form of the GMC, or it would have fallen to civil servants or Government appointees.

The GMC will not be introducing new hurdles for doctors to scale. There will be no examinations. The details have not yet been finalized, though the mechanism for general practice will be based on that used to (re)accredit trainers, but to a less demanding level.

Registration will not be called into question at this local level unless a doctor refuses to undergo the accreditation process. Normally, having co-operated, and been found deficient, a programme of continuing education will be agreed. On completion, there will be a reassessment. Only if the individual's standard is found still to be insufficient will the matter be reported to the GMC.

The GMC will examine the evidence and decide if the problem is sufficiently serious to warrant a formal assessment of the candidate's performance. This process takes a multi-focused approach of examining the doctor's medical records, discussing their performance with colleagues, and an MCQ test. Standards are studied across all these parameters.

If found seriously deficient at this point, a formal heating is arranged before a panel of doctors and lay people advised by a medical expert in the same field of practice as the doctor. This panel will decide if any action is warranted and, if so, whether a further period of training is sufficient or whether suspension is needed to protect the public pending review after such help.

For the vast majority of us, revalidation will involve no more than the Government has already decreed. Our registration will continue but with the additional benefit that it will denote that we are competent to practice.

As a doctor I welcome the fact that patients will be assured that I am up to the job. When I am unfortunate enough to become a patient, I am glad I shall know my physician is likewise equipped.

Simon Fradd

Ingres and Monet

Royal Academy, London
Monet in the Twentieth Century (until 18 April)
National Gallery, London
Portraits by Ingres
(until 25 April)

Two French painters, separated by surprisingly little time, will dominate the exhibition circuit in London until Jackson Pollock has opened at the Tate. Monet at the Royal Academy is a big show, of large and highly popular paintings, while Ingres at the National Gallery is rather smaller, its exhibits rather less overpowering, the painter himself rather less well-known.

The viewing conditions are also rather different. If you cannot stand well back from the final huge water lily paintings of Monet, you cannot appreciate them as an artistic whole. But when the room is scarcely less crowded than Oxford Street the weekend before Christmas, this isn't possible, and the serenity of the paintings is so at odds with the bear garden around them that the dissonance is just about intolerable.

So, if you only have time to visit one, go to Ingres. The atmosphere is much less unpleasant for a start, and the queues much shorter. You will see one truly magnificent painting, the portrait of the journalist Bertin, and a highly revealing survey of the many deeply unattractive people who administered Europe for Napoleon. You will also see some of the most beautiful portrait drawings in Western art.

Frank Minns

Handbook of Palliative Medicine
Edited by Christina Faull, Yvonne Carter, and Richard Woof
Blackwell Science, 1998
PB, £26.50, 396pp, 0 632 0477 98

Hospice Without Walls
The story of West Cumbria's remarkable hospice at home service
Andrew Bibby
1999
(Details unavailable at time of going to press)

Patients increasingly wish to die at home, but only if they have confidence in the competence and caring attitude of the medical and associated professionals involved in their care. They also want to feel secure that all their needs — physical, psychological and social — will be acknowledged and addressed.

These two books, recently published, both deal with providing the highest quality of palliative care. The World Health Organization defines palliative care as 'the act of total care of patients whose disease is not responsive to curative treatment'. This relatively young medical specialism is now being earnestly studied and embraced throughout the NHS, so both of these volumes will be of great value to those practising in this discipline.

With its beautifully illustrated cover by Michele Angelo Petroni, a sufferer of Hodgkin's Disease, the *Handbook of Palliative Care* is a must for all practice and hospital libraries.

The palliative care approach does not view patients mechanistically, but as a whole person with psychological, social, cultural, and ethical dimensions, all of which must be considered in planning management. On many occasions in several different chapters of the handbook, the problems encountered when this approach falls short are reiterated.

'There were lots of people in charge of different parts of Jack's body, but no-one was in charge of Jack.' So says John Hoyland, the author of *Thanks NHS for a rotten way to die*, reporting on the very badly managed death of his step-father. Patricia Wilkie, one of the vast array of eminent contributors to this handbook uses this apt quotation to introduce her chapter on 'The Person, the Patient and their Carers'. She demonstrates clearly that people requiring palliative care do not hold the same views, nor do they have the same needs, and they have very different expectations of care. All these variables have to be taken into consideration.

There are 22 chapters in this handbook, ranging from communication skills in palliative care to the precise details of how to organize a syringe driver. All are extensively referenced and researched and provide an excellent stepping stone for anyone considering further research.

There is an excellent section on 'Needs Assessment and Audit in Palliative Care' by Irene Higginson, in which she addresses the thorny issue of finances and looks towards providing assistance to those purchasing palliative care services. Her research demonstrates that many areas require improved care — despite many valiant efforts, all is not rosy in this discipline. She emphasizes that clinical audit, evaluation, and studies of outcome, can all improve the quality of care for patients and families.

All the essential symptomatic areas are covered thoroughly. Similarly, the authors review the management of cancer complications, and take care to mention less commonly encoutered problems, such as those associated with motor neurone disease, AIDs, and head and neck malignancy.

A chapter on 'Terminal Care and Dying' deals with the difficulty of actually recognizing this terminal phase. It is useful to realize that this a common problem for us all. We all earnestly strive to 'get it right' and ensure 'a good death', which has particular consequences for the bereaved.

Early in the *Handbook of Palliative Care*, mention is made of a relatively new concept, that of the 'Hospice at Home', and this exciting development is explored in greater detail in *Hospice Without Walls*, by Andrew Bibby. In a very detailed and movingly illustrated book, he describes a pioneering scheme in West Cumbria.

A group of disparate volunteers, led by a district nursing sister and a local GP, decided to establish a Hospice at Home scheme, covering the complete health authority of West Cumbria.

Three factors guided their strategy. First, the geography of the area did not lend itself to a central point of population on which to build a traditional hospice. Many people would therefore have had to soldier on, looking after their loved ones at home. Secondly, this was not a very prosperous area, so finances were restricted. The group wisely decided to invest their finances, not in bricks and mortar but in manpower and the provision of hospice-type services in the patient's own home. Thirdly, and most importantly, they wished to provide home-based care and allow patients to die in their place of choice among their families.

The nurses involved have been carefully interviewed, selected and comprehensively trained. They have to meet the requirements not only of the patient, but also of the carer. This vital input allows the carer to continue caring till the end. Very commendably, the scheme will accept any terminally ill patient, whatever their disease, not just cancer.

In summary, two excellent additions to the growing literature of palliative care. I commend both.

Rosalie Dunn

Doctors Talking
John Bain *et al*
Scottish Cultural Press, 1998
PB, £7.95, 128pp, 1 840 17 03 01

Doctors Talking contains edited transcripts of 11 Scottish GPs: four female and seven male. All are mid-career or later. Their beats cover a wide range socio-economically, culturally, and geographically, from urban slums to remote rural idyll. Sometimes less than idyll.

All were asked to reflect upon their work experiences and issues of professional importance. Topics included medical management, health targets and fund holding, interpersonal relationships within the new health care team, coping with personal stress, and the inability always to provide solutions to patients. One prescribes tranquillisers to the wife of an abusive alcoholic. Another poignantly notes treating isolated older Asian ladies, who take up a lot of appointments and yet have achieved the 'better life' offered in the West — probably to the envy of the folks back home.

The happiest GP — coincidentally, with the lowest patient load — regards medicine as a vocation rather than a business. He prefers the satisfaction of being part of his patients' lives in the Highlands to urban anonymity. Another notes the loss of the 'wise granny', traditionally the first line of defence in childhood illnesses, a role now often assumed by GPs. Several comment on the relationship between poverty and ill-health, reflecting a certain powerlessness. There is, as yet, no prescription on the national formulary for extra cash.

Many doctors use the words, 'depressed', 'angry', and 'frustrated' when describing their work. They seem overloaded with non-medical tasks. One asks: 'Why are expensively trained doctors offered incentives to learn how to do financial jobs which could be done better by people with an accountancy background?' Another comments: 'Minute after minute, hour after hour, day after day, it's very, very wearing, "giving" all the time; sometimes it's all too much'.

The presentation is unpretentious and simple, almost severe. There is no table of contents or other editorial graciousness, although there are black and white photographs. Perhaps the severity of the presentation unconsciously reflects the heroic struggle many of the subjects face daily.

I hope books like this will deepen the appreciation of a general public who, at times, risk taking a free service for granted.

Susan Woldenberg Butler

Diversity, culture and racism in primary health care

A training pack and video produced by RCGP member Dr Joe Kai provides educators of medical students and GP registrars with an interactive programme designed to heighten awareness of diversity.

Through images, exercises, and quizzes *Valuing Diversity* encourages trainers and students to gain a greater self awareness and thus develop a healthy and accepting understanding of difference.

Scenes of good and bad practice are enacted in the video and students are encouraged to debate what they see. In one section students are encouraged to think of stereotypes associated with their own identities. Clear guidelines are set out for each discussion and debriefing session. The looseleaf formatted pack provides trainers with handouts to photocopy and images to be shown on an overhead projector.

Racism is discussed, in the raw.

Although the pack does not profess to be a comprehensive anti-racism programme it does 'seek to dismantle assumptions and stereotypes in favour of facilitating an approach that is sensitive to the dynamic of racism and difference.'

Dr Kai spoke about *Valuing Diversity* at a conference at the RCGP in March.

So you think you are confused?

In the developing world of the New NHS, there are almost too many acronyms to keep up with. There are PCGs, PCTs, LHCs, LHCCs, NICE, and HIMPs (extra PGEA credits if you can get all six). But the College has a fine line in acronyms of its own. This is an achievement of which we should be proud, one we should celebrate.

After the initials RCGP themselves, I suspect that the rot really started with the JCPTGP. If imitation is the sincerest form of flattery (is flattery ever remotely sincere?) then we should celebrate a true epidemic. I deal on a day-to-day basis with COTPED, UKCRA, AUDGP, GPC ...

Let's return to inhouse. The first big acronym success that I was involved in was FBA. Fellowship by Assessment is our alternative route to fellowship that runs in parallel to Fellowship by Nomination. The latter was introduced in earlier days of sanity and has therefore missed the chance to be FBN — but you never know.

In April, we introduced a second route to membership to run alongside our well-established examination for MRCGP. It's called Membership by Assessment of Performance. Why not just Membership by Assessment? Well, it was the acronym, you see. MBA might make a general practitioner appear to have management skills — God forbid — so MAP it had to be.

This problem is not an English phenomenon. It was the Scots who first recognized the need for an assessment of practice teams rather than individuals. They developed the equivalent of FBA, naming it Quality Practice Award. Yes, we all call it QPA. And now we are developing a system for practice accreditation suitable for all practices on different points of the continuum. It's neatly branded as Quality Team Development or, to nerds like myself, QTD.

Following the CMO's review of CPD (the Chief Medical Officer's review of Continuing Professional Development — keep up) the College recognized that we would need to help general practitioners to show that they were, well, developing. (In New Labour jargon this is lifelong learning, which I haven't yet heard reduced to LLL.) So the College has commissioned work which will result in Accredited Professional Development, or … APD.

And the latest innovation is, of course, revalidation. We are trying to create a package that is easy for general practitioners to do — that requires minimal extra work —but which is sensitive enough to detect our colleagues who are seriously under-performing. The magnitude of this task pales in comparison to the acronym challenge: perhaps revalidation will just become 'the R-word'.

Mike Pringle

Neville Goodman

On the wonder of the phrasal verb...

A renal physician poked his head through the operating theatre door during a transplant operation. Would the surgeon pop down to the ward when he'd finished, to check up on another mutual patient? Nothing too urgent, and the bloods had already gone off. The surgeon was worried: gone off? No — the patient wasn't too bad; it was his blood samples that had gone off.

English is a wonderful language, and the phrasal verb is one of its wonders. I've already used a number: pop down (which is different from pop up), check up (not the same as check over or check in), and gone off. 'Gone off' has the added complexity of two idiomatic meanings: the literal (the blood has physically disappeared down the vacuum tube and may eventually appear in the laboratory), and the metaphorical (the patient is not going anywhere, but their condition is worsening).

Phrasal verbs are not common in other European languages. I remember from O-level German the pain of learning which preposition went with which verb, but getting the wrong preposition was just plain wrong; it didn't alter the whole meaning of the sentence. Look in a French dictionary, and 'to check up' is *vérifier*, 'to checkover' is *examiner*, and 'to check in' is *arriver*.

Pity the poor foreigner in England. Pity the foreigner who needs a doctor. How are they to know that we break out, not break down or break up, into spots? We also come out in spots, but come over all peculiar. If a drug makes a patient come over all peculiar, we tell them to come off it, if that's how it came about. We might also tell them to come off it if we think they're swinging the lead (which is just a metaphor, not a phrasal verb).

How is it that marriages and relationships break up or break down, but couples only break up, and cars that break down may eventually be broken up, but that is not the same thing? A doctor may be approached because the break-up of a marriage causes physical or mental break-down.

Phrasal verbs give their simple roots many meanings. A casualty officer might set up a drip on someone who has been set about in the street before the surgeons can set to in the operating theatre to prevent infection setting in.

Which is as good a place as any for me to sign off.

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our contributors

Susan Woldenberg Butler observes life and medicine from the exotic viewpoint of rural Tasmania

Rosalie Dunn, by popular repute, owns a lemonade company and a football club. More prosaically, she is a GP in Blantyre, Scotland, and is a palliative care facilitator with Lanarkshire Health Board

Liam Farrell writes for the *Lancet* and can therefore say what he wants ...

Simon Fradd is a distinguished member of GPC. Since the exfoliation of an unfortunate beard, he has become a member of the General Medical Council

David Kernick bombards most general medical journals with copy. He is a GP in Exeter

Frank Minns's main ambition in life is to be the British naval attaché in Rome. He is an authority on anti-submarine warfare and the best Tuscan restaurants in Marylebone

Professor **Mike Pringle** chairs UK Council of the RCGP. He combines a brilliant academic reputation with incisive chairmanship and immaculate hair control

Mark Reynolds is a GP in Maidstone, Kent. He chairs the the National Association of GP Co-operatives. Dogged efforts for some time now have earned him an MBE

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James Willis was described in a March issue of the *Lancet* as a 'renowned communicator', which rather makes him sound like a brand of mobile phone

All our contributors can be contacted via the Journal office

Liam Farrell

They are special

All specialties must endure the slings and arrows of outrageous fortune, but some have suffered more than others.

Witness the current parlous state of the general surgeon: they used to be the top men, seeking the bubble reputation, even in the cannon's mouth, with an attitude so square and prickly that, if you sat on it, you'd bleed to death. God be with the old days when we had surgeons like my friend Tetley: he was called that because he used to perforate everything, but at least he was getting stuck in there. Now, it's just a few varicose veins and hernias each week, if he's lucky, as the sub-specialties gobble up the big stuff. That's why general surgeons love being on night duty, as interesting things like road traffic accidents with major intra-abdominal trauma may come in — the surgical equivalent of a white-knuckle ride — while the sub-specialties are asleep in bed.

Some specialties are tootling along as ever before, as constant as the Northern Star. If specialties were cars, ENT would still be a Lada. Neurologists continue to spend most of their time cleverly diagnosing some dreadful progressive illness that they can do nothing about anyway, and psychiatrists continue to prescribe antidepressants and sedatives and counselling that GPs can do just as indiscriminately. Anyway, they never ask about people's feelings.

But what goes around comes around, and the ship has certainly come in for public health. When I was a lad, public health doctors were, to a man, offensive old women pottering around doing vaccination clinics and school medicals as a kind of something to do when the bridge club was in recess, with as much street cred as Tommy aftershave or Garth Brooks's music. Then the Thatcherite review of the health service began and everything became value for money and management and mission statements and MBAs, and now the consultants in public health are the biggest shots of all — the twin virtues of being called 'doctor' plus being able to spell 'statistics', making them irresistible candidates for big, shiny cars and personal parking spaces.

But of all the specialties that have seen their sun come up and begin to brightly shine, surely the genitourinary specialist must feel the most favoured. It was formerly a rather smutty, furtive, half-amateur discipline, located unpleasantly around the Congo of the body. Then the AIDS epidemic began and confirmed that every cloud does indeed have a silver lining. Suddenly every region needed a GU specialist; they became media darlings, able to talk fluently about things like condoms and antibodies, sometimes in the same sentence; and they were role models; winners of countless People of the Year awards; Mother Teresas with a frisson of sexual excitement; the cutting edge of science blended to an intoxicating cocktail with trendy, liberal values. The winter of their discontent had become a most glorious summer.

So whither general practice in the maelstrom of these changing times? The media is uncertain of our position: 'Casualty' portrays us as idiots, 'Peak Practice' as heroes (yet still idiots), and