troduced to a healer who had recently moved into the area. I invited him to sit in on one of my surgeries and this was such an interesting experience that we decided to repeat it on a regular basis once a week. We have now been holding this joint surgery for two years.

I work full time in a busy six-partner National Health Service general practice. The joint surgeries with the healer are held in the morning, and patients are informed and asked to give consent to a healer being present. Most do not seem to mind, and a sizeable minority are positively interested. At first neither of us was sure what we were trying to do or even learn, but it became clear that every consultation has a spiritual dimension and a spiritual diagnosis can be made. This is usually quite simple and commonplace, for example loneliness, fear of ill health, lack of purpose in life or low energy.

The surgery is run as any busy morning surgery, aiming to give patients 10 minutes per consultation, and running for over two and a half hours. We start with a brief meditation for several minutes before calling the first patient. The previous week we will have chosen a quality as a focus for the day, for example compassion, forgiveness or cooperation, and will try and use that quality throughout the surgery. The patients present their problems in the normal way, and I make a diagnosis from the history, examination and investigations. Like any good doctor I will try to place this illness in the context of their life, and encourage them to explore the reasons why this illness may be happening to them now. The possible therapies are then discussed with the patient. The healer may be involved with this process if it seems appropriate, but most patients are wary of the healer at first so he tends to keep an attentive silence. After the patient has left we discuss the consultation. The healer will give his intuitive impressions, and how he assesses the patient's imbalance in terms of intuitive diagnosis, energy blocks, aura fields, and the spiritual problem. We then try to make a spiritual diagnosis, and review future approaches.

It is a challenge to fit all this into a 10 minute appointment system. These surgeries are always exciting and interesting. I am learning all the time, and also rediscovering a whole area of wisdom and knowledge that I had not given adequate recognition to.

Only in the last 20 years have we fully recognized the part that our mind plays in illness, and perhaps in the next 20 years we will begin to recognize the part that the spirit plays in ill health. We will then begin to talk not only of psychosomatic illness, but spiritualsomatic or even psychospiritual illness. One day we may be able to make psychospiritualsomatic diagnoses — perhaps it is easier to say holistic. Healing of the spirit can occur in any consultation, and indeed it can happen in any human contact, when we are alone, and when we are asleep and dreaming.

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Quality assessment or quality control?

Sir,

I enjoyed reading the editorial 'Quality assessment or quality control?' (August *Journal,* 309). Having worked in the field of quality assessment in Sweden,[1] I would like to stress some of the issues raised from a Nordic point of view.

It is difficult to evaluate changes within a health care system on a general level that will be understood by readers of international journals, without losing the fundamental cultural and social conditions framing the work. It is, however, quite possible to combine theoretical work with descriptions of practical methods of quality assessment.[2-4]

The distinction between quality assessment and quality control helps to separate different aspects of medical audit. It is especially valid in the Scandinavian countries where the government and health authorities make a major impact on the delivery of care by allocating resources to different levels of care.

The enhancement of quality assessment by family physicians themselves allows the essence of our discipline to be made visible to and understood by patients and the politicians regulating our work.

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Physician in palliative medicine

Dr Charlton's response (August *Journal,* p.347) to the editorial by Dr Ilora Finlay (January *Journal,* p.2), highlights a number of points that are pertinent to the development of palliative care services in the community.

The Dorothy House Foundation was set up in 1977 as a home care nursing service for the terminally ill, later adding back-up beds and daycare, and ensuring the general practitioner's control of medical intervention. The Macmillan nurses offered advice, support and information for the general practitioners and district nurses working with the patient and family.

The recent appointment of myself as a physician in palliative medicine, from a background of general practice, while seeming to accept the specialty as separate, was in fact designed to do just the opposite. The physician in palliative medicine's role is dependent on the general practitioner retaining control and this complements his efforts to enable patients to be at home with their families, if that is what they wish. This acknowledgement of the role of the general practitioner is crucial to the development of the physician in palliative medicine's role. The Foundation envisaged this to be a facilitator, who can advise, support and educate in a similar way to the Macmillan nurses. That physician will be available for consultation at the request of the general practitioner and, through his or her training in both family and palliative medicine, should be in a position to offer appropriate advice or support when needed. The role is proactive in education, and will be research based.

The Foundation would agree with Dr Charlton that the development of the specialty should no longer concentrate on an increase in the number of inpatient units but on providing specialist physicians who can enable health care teams to improve the care of the dying in the most appropriate setting.

We believe it is an essential component of the work of the physician in palliative medicine to develop educational programmes and to research ways in which the specialty can be integrated into current health care systems. The Macmillan Education Centre of the Dorothy House Foundation has developed courses and workshops for many disciplines and will continue to provide appropriate teaching for all people involved in palliative care, employing a multidisciplinary approach.

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