The British Journal of General Practice

An introduction to the Back Pages

From this issue the *British Journal of General Practice* acquires a new section — the Back Pages. We have scope for the first time to publish high quality, peer-reviewed original material, but unconstrained by the formal layout of academic papers. We need not follow slavishly that much-loved pattern of Introduction, Methods, Results, and Discussion. There is more to general practice than rigorous analytical science, and the new section will reflect this. We hope that we can be more eclectic in our material. There is scope for passion, polemic and the picaresque.

Broadly speaking the Back Pages will carry reportage and analysis, such as the essay on changes to the MRCGP in this issue, and an extended book review section — Digest. In this issue Malcolm Rigler writes on the role of the arts in general practice and we carry a wide range of book reviews.

We invite readers of the *BJGP* to submit material for our new section...
Essays should not normally exceed 1200–1400 words. Material will be peer-reviewed. A short list of *Further Reading* or *Sources* is preferable to exhaustive formalized references. **Shorter articles** should be of 200–400 words. We welcome news of developments in general practice from around the world. We shall continue to review books relevant to general practice, but also welcome discussion of general medical and non-medical texts of potential interest to our readers. Reviews of CD ROMs, videos, broadcasting, film, the performing and visual arts can also be submitted. **Columnists** — we have space for two or three columns per issue, unashamedly following the precedent of *Soundings* in the *BMJ*. Subject matter can be as varied as general practice itself. We invite sample columns, of 500 words, typed, double-spaced, backed up on disc (TXT), with skeletons for two more. Submissions should reach the Journal Office by 1 December. **Graphics and illustrations** are especially welcome. We are also keen to include **photography** for its own sake... *General Practice in Camera*. Please submit transparencies. Reproduction will initially be in black and white though we hope that colour reproduction will be possible in due course. And finally **Shorts**... anecdotage and reminiscence, and poetry, are all welcome.

Limited space dictates that submissions should always be as concise as possible. Material should be submitted to the Journal Office in London, addressed to the Deputy Editor. Material should be typed, double spaced, and whenever possible on disk, formatted TXT. Handwritten scrawls are acceptable in emergencies.

The changes in the *BJGP* in this issue represent but the first stage in an evolution of the Journal. Highly cited international medical journals need not be dull. General practice isn't.

Alec Logan

contents

The Back Pages....

Sport and exercise medicine, and general practice

The phones are hopping, the waiting room is crowded and the surgery is running late. Not another sports injury! Self-inflicted, because they ran too far, used too big a racket, or crashed into another player on the football pitch. And these consultations are never short because athletes always want to have been cured yesterday, to examine all the options and be fit and playing again tomorrow. It is strange, however, that we should rate chronic bronchitis in a smoker, dyspepsia from alcohol abuse and counselling the addict as more important. Much of our workload is due to self-inflicted illness but sports injury occurs when people are actually trying to improve their health and well-being. Rather than relegating them to the back of the queue, perhaps we should be encouraging them, making sure that we are skilled in treatment, perhaps even prioritizing them. We already target resources on coronary heart disease screening and smoking cessation, which have moderate outcomes even in the most successful programmes. I wonder if sports participants get the attention they deserve.

Musculo-skeletal injures make up a major part of our workload and the skills needed in treating the elite athlete are the same as those needed for treating the weekend sports participant. Indeed, the skills attained in treating sports injuries are applicable to the management of soft tissue injury in any one of our patients. There are, in addition, many other aspects of sports medicine of particular relevance to primary care; we are called upon to help in many sports events, advise people about exercise, provide first aid at the local sports, help the football teams and even cover the school ski trip. We are asked to examine people before they start to exercise, tell them about their exercise-induced asthma, and almost every leaflet you pick up suggests that your patients ask their GP's advice before they exercise. Whether we like it or not, sports medicine is an integral part of our daily work — a "core service" to use the latest buzz-word.

So you wish to learn more about sports medicine! Most of us would look to our university medical school or postgraduate departments of general practice first, perhaps even contact the College. But sports medicine rarely features on the undergraduate curriculum, there are only a handful of university departments of sports medicine in the UK, and the College has not yet addressed this field of practice. Most everyday sports medicine is carried out in the community by general practitioners but there is little teaching, training or research carried out in general practice. If we look to university departments of general practice for leadership we will be disappointed to find just a few enthusiastic individuals. Yet, general practice is a natural home for sports medicine and the precedent of combined university departments has already been set in the USA. There is an educational gap which is poorly served within our discipline.

General practitioners are a very resourceful lot however and many have sought teaching elsewhere. There is an excellent distance learning course at the University of Bath. It is directed by a GP who has developed a programme aimed primarily at GPs. There are part time MSc courses in Glasgow and Nottingham, although these are most suitable for those living nearby. GPs have also attended full time courses in London and Dublin, but this is a major financial commitment. Others have constructed their own curricula, attending the week-long courses organized by the British Association of Sport and Medicine or the Scottish Postgraduate Board together with the evening or one-day meetings run by various bodies throughout the country. Indeed, general practitioners now make up the majority of candidates in the Diploma in Sports Medicine examinations of the combined Royal College of Physicians and Surgeons in Glasgow and Edinburgh and the Society of Apothecaries in London. Surely it is an indictment of our discipline that we must look outside in order to meet our educational needs. There are

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...we need leadership, and encouragement to establish sports medicine in our university departments of general practice

three key clinical university departments of sports medicine in Glasgow, Nottingham and London. Two of these are allied to orthopaedics and one to cardiology. There must be a place for a department of general practice.

Scotland leads the way. The Diploma of the Scottish Royal Colleges is an excellent, practical, clinically focused professional qualification. One of the most outstanding initiatives in these islands is the network of sports injury clinics in Scotland. Most of these are manned by interested general practitioners who give their time generously to provide a service. These achievements are recorded in a report which brings great credit to the doctors involved.

There are many changes occurring in sports medicine at present and it would be unfair not to recognize that our College is part of these discussions. Our representatives need our encouragement in their negotiations. It is likely that the Academy of medical Royal Colleges will give some formal recognition to the specialist training required for sports medicine. If there is specialty recognition, there will be many GPs in the queue and, when these negotiations are complete, there will be a great expansion of sports medicine as a clinical discipline with associated developments in teaching, training and research. General practice teachers, both undergraduate and postgraduate, must anticipate these changes and play a major role. We need leadership and encouragement to establish sports medicine in our university departments of general practice. General practitioners in the field can also play their part. Medical education is consumer driven and we can change the system by directing the CME curriculum. We can help teach students about sports medicine in our practices and we can influence the provision of clinical services through fundholding or commissioning. The College could play a further part by creating fellowships to support sports medicine similar to those in stress and prescribing, develop a strategy for sport and exercise medicine in primary care, publish an occasional paper, and continue to support joint meetings. Already there are some hopeful signs of partnerships with other bodies, such as the British Association of Sport and Medicine (BASM); there will be a joint meeting organised by BASM South West and the RCGP at the 1998 Spring meeting in Exeter.

After all, most sports medicine is in primary care and almost all sports injuries are first treated by general practitioners.

Domhnall Mac Auley

Further reading

Journals

British Journal of Sports Medicine
BMA House, Tavistock Square, London WC1H 9BR

The Physician and Sports Medicine
PO Box 462, Hightstown NJ 08520-9205, USA

Medicine Science Sports and Exercise
American College of Sports Medicine, 401 West Michigan Street, Indianapolis, IN 46202-3233, USA

Textbooks

Oxford Textbook of Sports Medicine
Harries M, Williams C, Stanish WD, Michell LJ
OUP 1996 (0 19 262010 X)

Sports Medicine for Primary Care
Richmond JC, Shahady EJ
Blackwell Science 1996 (0 86542 348 2)

The Olympic Book of Sports Medicine
Dirix A, Knuttgen HG, Tittel K
Blackwell Scientific, 1988 (0 632 01963 8)

Useful Addresses

The British Association of Sport and Medicine, The Anatomy Building, St Bartholomew's Medical College, Charterhouse Square, London EC1M 6BO

The Institute of Sports Medicine, Charles Bell House, 67-73 Riding House Street, London W1P 7LD

The National Sports Medicine Institute, ... same as Br Assoc of Sport and Medicine

The following universities have some involvement in sports medicine - University of Birmingham Medical School, Manchester Metropolitan University, University of London Hospital Medical College, and the universities of Aberdeen, Bath, Glasgow, Nottingham, Sheffield and Strathclyde.

1997 Annual General Meeting

The **AGM** will be held at the Royal Geographical Society, Exhibition Road, London SW7, on Friday 21 November 1997. The meeting opens at 14.00 with the presentation of College Awards and Fellowships. There will be about 140 members elected to Fellowship of the College and amongst the Awards will be the first presentation of the Bill Styles Memorial Award which is a project grant presented to a doctor aged 35 or under. For the first time, a booklet will be distributed at the meeting which will give details of the main Awards and Award winners.

The **James Mackenzie Lecture** will be delivered by Dr Ben Sweeney MA FRCGP, who will talk on the theme of *Literature and Medicine*. Dr Sweeney, a Glasgow GP, is a former Vice-Chairman of Council and currently Chairman of the College's Committee on Medical Ethics. The meeting will also include a presentation on *A Job for Life? The Future of General Practice* - one of the themes of the 1998 Spring Symposium being hosted by the Tamar Faculty.

The business part of the meeting will include a report of College activities in the past year from John Toby, Chairman of Council, and the presentation of the annual accounts by Tony Mathie, Honorary Treasurer.

Dr Lotte Newman will be chairing her third and final Annual General Meeting as President of the College. At the conclusion of the meeting, she will hand over to her successor, Professor Denis Pereira Gray OBE MA FRCGP.

The Annual General Meeting is not just the transaction of College business. It also gives members the opportunity to come to the College, meet other members and College officers and get a first-hand account of what the College is doing in a number of areas of general practice.

devolution

The problem with devolution is not what to do with Scotland, Wales or indeed Northern Ireland. The problem is what to do with England.

What's new? We Scots have been saying that from at least as far back as the Battle of Bannockburn.

The definitive vote on September 11 has given a clear mandate to the government to proceed with the Scottish parliament. The White Paper, *Scotland's Parliament*, made clear that this would be a significantly different body from that proposed for Wales. A parliament with tax-raising powers, with total control of the NHS in Scotland.

What is the likely impact for the Scottish Health Service? (This term already exists, having been changed by Michael Forsyth in his last months of office, perhaps in a vain attempt to gain votes north of the border, from the NHS in Scotland.) What is the likely impact for the College?

There are already significant differences in the governing of Scotland resulting from its historic position as an independent nation. These include a different established church (a magnet for Royal second marriages), a separate and distinct legal system and a different education system. The health service in Scotland has traditionally had its own policy unit, but policy has largely followed the lead of the Department of Health in London. Regulation change, including trusts and fundholding and, most recently, *Choice and Opportunity*, have applied north and south of the border, usually with some cosmetic change in Scotland to 'tartanize' the publication.

Health accounts for more than 30% of the current Scottish Office allocation. Together with education and social services, it will be a regular and significant topic for debate in a Scottish Parliament. Some predict that as much as one day per week could be devoted to health. This will inevitably result in much closer scrutiny of the health service at a strategic and local level. It is entirely possible, some would say likely, that the Scottish Health Service of the early millennium will look quite different from its English counterpart. The White Paper makes explicit the role of the new parliament in negotiating the GP contract in Scotland. SGMSC (the Scottish sub-committe of GMSC) will assume a negotiating role. The position regarding the Joint Committee is less clear. The GMC will remain a UK institution.

The College has, over recent years, strengthened its links with Westminster. In Scotland, although links are established with the Management Executive of the Health Service in Scotland, these could be much strengthened. If the RCGP is to influence debate, it will be important for us to link directly with the Scottish Parliament and its members, in addition to the Scottish Office.

We are fortunate in that, compared with the other UK Colleges in Scotland, the RCGP has a well-established, functioning Council with excellent support staff. The recent appointment of the Scottish Development Manager will clearly benefit the rapid developmental change which will be required to address some of the issues highlighted. We will require to replicate several of the aspects of Princes Gate in our Scottish Headquarters. We might even require a building. There is much thought and debate to be had, but Scottish Council was quite clear during the first debate that we did not want a Scottish College, but wished to develop the RCGP in Scotland as part of the existing UK College.

Scottish Council are well placed to accelerate development and meet the challenge. That still leaves us with the question — what to do with England? Answers on a postcard to the Chairman of Scottish Council!

Colin M Hunter

tempting pre-registration house officers...

There have been three significant events in 1997 that will influence the content of pre-registration house officer (PRHO) posts: the General Medical Council has published its expectations of PRHO posts in the *New Doctor*[1], postgraduate deans in England now manage 100% of the salaries of PRHOs and the Medical Act has been changed so that PRHO experience is no longer confined to NHS-owned property. Although there have always been a few opportunities for PRHOs to work in general practice[2,3], this should now become much more common.

Many regions are getting ready to take small cohorts of PRHOs in general practice in 1998; a few have some pilots that started in August. This gives us a little time to review how general practice might contribute to the values, skills and knowledge to be gained during the year. It also allows us to consider how we can make sure that these young doctors feel secure in our environment that is full of uncertainty.

The pre-registration year should enable young graduates to put into practice the skills and knowledge they have gained during their undergraduate years. It should also be a time during which they demonstrate that they uphold the values of our profession which are set out in *The Duties of a Doctor*[4]. General practice has many positive aspects: we have a long history of teaching communication skills, our practice teams are usually well developed and our patients are continually available should young doctors wish to review their progress. Our training practices are already expected to provide the opportunities necessary to meet the aims of the general clinical training.

Most undergraduates will already be thinking where they might be placed for their pre-registration year, and general practice may not appear such an attractive option. Most undergraduates will have experienced general practice; they will have observed the rapid stream of patients booked every ten minutes (or worse still every five) and wonder how they will cope on their own. Many would have seen the GP registrar covering calls through the night and wonder if they will be expected to do the same. Most will prefer the familiarity of the hospital environment, with all its problems, to the uncertainty of general practice.

The Directors of Postgraduate General Practice Education have already set out the opportunities for PHROs in general practice, and many are actively recruiting practices that are interested in providing general clinical training. General practice needs to be much clearer how the time should be spent and how we will ensure graded clinical responsibility. We need to work closely with the medical schools and postgraduate deans so that the year is rounded. General practice should aim to complement time spent in hospital posts not compete against it.

Jacky Hayden

1. General Medical Council. *The New Doctor.* London: GMC. 1997.
2. Harris CM., Dudley HAF., Jarman B *et al.* Preregistration rotation including general practice at St. Mary's Hospital Medical School. *BMJ* 1985; **290:** 1811-1813.
3. Wilton J. Preregistration house officers in general practice. *BMJ* 1995; **310:** 369-372.
4. General Medical Council. *Duties of a Doctor.* London: GMC 1995

International travel scholarships

Applications are invited for international travel scholarships, awarded by the College. These are designed to enable general practitioners from the UK to travel overseas to study aspects of health care relevant to this country's needs, to assist doctors from overseas who wish to visit the UK to study an aspect of primary care relevant to their own country's needs, or to help countries develop their own systems of primary care. A total of 13 of these scholarships were awarded in 1996 and six were awarded in January 1997.

The **Katharina Von Kuenssberg Award** is awarded each year for the most outstanding international travel scholarship application submitted. The **John J Ferguson International Travel Scholarship** is awarded each year for the outstanding scholarship application from a doctor undertaking study in relation to the Middle or Far East.

The **value** of each scholarship will range from £100 to £1,000.

Closing Dates
International Travel Scholarships
Friday 16 January 1998
(for projects from 1 March 1998-1 March 1999)
Friday 14 August 1998
(for projects from 1 October 1998 - 1 October 1999)
Katharina Von Kuenssberg Award
Friday 16 January 1998
(for projects from 1 March 1998 - 1 March 1999)
John J Ferguson International Travel Scholarship
Friday 14 August 1998
(for projects from 1 October 1998-1 October 1999)

If you would like further details or an application form please contact
Mrs Mayuri Patel,
Assistant Committee Clerk to the International Committee RCGP
14 Princes Gate, Hyde Park,
London, SW7 1PU
Tel: + 44 171 581 3232 Ext 233
Fax: + 44 171 589 3145
http://www.rcgp.org.uk/
or Email: **mpatel@rcgp.org.uk**

Why have an RCGP International Family Medicine

Interest in primary medical care has grown beyond all expectation in the past decade. The pivotal role of family medicine in aiming for comprehensive health care for all with limited resources seems to have been globally accepted. So is it any surprise that the call from overseas on College expertise has risen correspondingly?

More funding and increased flexibility for such activities, both nationally and internationally, have given the College a springboard. An exciting challenge for the College over past years has been how to respond to the demand for health care reorientation programmes, in order to deliver benefits to our overseas and UK members and partners, and international general practice as a whole.

Why the College?

The College has an understanding of the organization and delivery of primary health care services, has an expertise in education and training, good national and international relations, and an international reputation. As a result, the College's expertise and knowledge are sought after by potential overseas partners.

A programme to 2000

A recent feasibility report, which launches a three-year *RCGP International Family Medicine Development Programme* to the year 2000, underlines the need for well-honed systems for high-quality project management, focusing on partnership, deliverable outcomes and value for money. A great emphasis is put on building strong, long-term relationships with other agencies including international coordinating, government and non-governmental bodies, and potential partnership organizations.

Not surprisingly, resource management has had to be a focal point; both external charitable and government funding has been and will continue to be secured for projects that have rendered the programme self-financing in the past two years. Equally, evaluation of coordination and monitoring systems for maximizing live and potential projects with limited resources is constant.

What exactly is an International Development Project?

An International Development Project is a project or phased programme involving the Royal College of General Practitioners in partnership with a recipient country to assess and develop primary care to meet the needs of the partner health care system and population within jointly agreed, pre-defined parameters in terms of aims, objectives, inputs and outcomes; it is primarily funded by that country or an appropriate third party.

Policy has been defined in key statements such as *The Essential Features of International Development Projects*, *Contact with Repressive Regimes* and *Overseas Work Experience*.

We believe that development projects should encompass partnership. We look for skills transfer projects working with local people, underpinned by strong relationships with overseas partners who take the lead on development. This ensures outcomes that remain sustainable when projects end. A variety of models and ideas are used as reference points in developing primary care systems, drawing on experiences of UK development and international knowledge and relations. Our work must be appropriate to the culture, health needs and resources of partner countries.

The projects so far

International PHC projects started in 1985, with the RCGP/Kuwait Fellowship. Since then 19 projects have been completed, with a further 16 planned or current (Table). The list is truly international.

Partners want sustainable development through skills transfer. We believe that it is possible to provide assistance across a wide range of family medicine inputs based on overseas needs and requests. Currently on offer are advice in education, training, both in their development and delivery (from basic skills courses to

Development Programme?

undergraduate, postgraduate or CME curricula, exchanges, intensive training), assessment, examination and quality assurance; courses/study tours on PHC organization to teacher training. Our Ukraine Adviser has just published his text book on general practice written in Ukrainian (the first ever in Ukraine) and this month we shall assess the potential for minor surgery courses in Singapore.

College members: an invaluable resource

There is no international development without College members. Members with experience or interest in education and training and international development who can spend up to 4-8 weeks a year overseas can become *International Development Advisers* to assess potential projects and deliver them.

Not aid, but exchange

The value of international exchange, dialogue and reputation is unquantifiable and cannot be underestimated. The College is committed to the value of overseas experience in the professional development of doctors working in the UK. These projects provide opportunities for our membership to work internationally and gain valuable experience. Equally, international work brings numerous benefits to the reputation and influence of the College as a whole, adding value to national campaigns or projects, and broadening its portfolio of activities.

New opportunities for the future: are you interested?

We are constantly seeking GPs in active general practice or recent retirement who are interested in international development to become involved in our projects. This is your chance to receive information on future work opportunities, by completing the adjacent reply slip.

With the present Government's pledge to support sustainable development programmes overseas that focus on skills transfer, there could be no better time to work to mutual benefit for fellow GPs overseas.

Philip Evans, Sarah Young

Table 1

RCGP International Development Work 1985-Present

KUWAIT 1985-present: Primary care development programme
MALTA 1989-90: Re-establishment of Malta College of General Practitioners
ROMANIA 1990: Collaboration with WHO in GP training programme
CZECH REPUBLIC 1991: Advising WHO on GP development
HUNGARY 1992: Advising WHO on GP training and education
TURKEY 1992-3: General practice training pilot (World Bank funding)
RUSSIA 1992: St Petersburg Exchange Fellowship
SAUDI ARABIA 1992-94: Family medicine training programme
SLOVAKIA 1994-6: GP Development programme (PHARE)
PORTUGAL 1994-7: GP trainers exchange programme
HUNGARY 1994-7: GP training programme, PHARE
UKRAINE 1994-8: General practice development (ODA Contract)
KEMEROVO, Russia 1995: GP study tour (ODA Contract)
PHILIPPINES 1995-7: GP exchange programme (Brit. Council)
GAZA, Palestine 1995-7: Pilot project, GP training
PAKISTAN 1997-: Assessment and support of university GP postgraduate education and training, Karachi
IRAN 1997: Assessment of family medicine on behalf of WHO
LEBANON 1997-1999: Postgraduate doctor in-service training
KARELIA1997: Advising NHSOE on GP training and education
SINGAPORE 1997: Minor surgery course development
MAURITIUS 1997: Assessment of general practice training
WEST BANK, Palestine 1997: Assessment of GP training
MALTA 1997-98: Assistance with GP training programme
BANGLADESH 1997-: Assistance with East London/Bangladesh GP exchange programme
NEPAL 1997-: Development of an education and training programme
INDONESIA 1997-: Development of a GP education and training programme

RCGP Family Medicine Development Programme

We are constantly seeking GPs in active general practice or recently retired with experience in education and family medicine delivery who are interested in international development to become involved in our projects.

We also want to communicate with members with a broad interest in international activity. If you are interested in either/both, please cut out/photocopy, complete and return this form to the address below.

Name:

Membership No:

Please answer either questions 1 or 2 and questions 3 to 6:-

1. I would like to receive details of ***all*** future work opportunities (if you answer yes to this question, your name will be put on all vacancy mailings - do not answer ques 2): Yes ☐
2. (Answer yes to no more than two of the following options, otherwise tick yes to ques 1 only): I would like to receive details of all future work opportunities in:-

   Eastern Europe and FSU: Yes ☐
   Western Europe: Yes ☐
   The Middle East: Yes ☐
   The Far East/Asia/Pacific: Yes ☐
   Africa: Yes ☐
   The Americas: Yes ☐
3. I would like to receive more information about the International Family Medicine Development Programme: Yes ☐
4. I would like to receive the International Newsletter: Yes ☐
5. I would like to receive details of international conferences: Yes ☐
6. I would like to receive details of international awards: Yes ☐

Return to: Membership Dept., RCGP, 14 Princes Gate, Hyde Park, London, SW7 1PU, Fax: +0171 225 3047. Also from http://www.rcgp.org.uk (International Section)

The modular MRCGP — an end or a beginn

As the man said (and I don't think it was Kenneth Clarke), "If it ain't broke, don't fix it". However, at least as far as the MRCGP is concerned, the converse should not be inferred, that because the exam has been fixed it must have been broke. The new modular configuration explained by David Haslam in his editorial[1] should be seen as managed evolution, designed to sustain the vigour and efficiency of College Membership as the educational and professional environments in which it operates themselves evolve. Not to adapt would have been the extinction option.

People's attention is understandably focused on the detail of the new format[2], which has been generally welcomed as robust and sensible. Nevertheless, it is as well to remember that any and every test procedure is underpinned by some fundamental questions and assumptions. Some of the questions are a bit risky to ask out loud, and some assumptions could be very unsettling to the queasy candidate on the Clapham omnibus.

"What's the exam for?" for example. Easy, surely. The MRCGP tells whether a doctor is competent enough to join the College. Next question.

"But what is 'competence'? How competent is 'competent enough'? And how can you be sure?" And with the posing of these three questions the ice beneath our feet begins to creak. (Let me make it clear, I'm talking about tests of competence in general, not just the College's one; the same uncertainties apply to them all.)

"Not everything that counts can be counted, and not everything that can be counted counts."

It won't do, for example, to assert that because a test purports to be a test of competence, then competence is whatever it turns out to be testing. A working definition of competence, such as the MRCGP's published blueprint, needs to be nailed to the mast before test methods are chosen and items written. And it won't do to say that 'competent enough' is whatever mark is set as the pass mark. Any pass mark, be it 50% or the mean minus one standard deviation, is simply a numerical expression of the consensus of whoever is allowed influence over the test's outcome. It is as much determined by politics and pragmatism as by performance statistics, and reflects attitudinal factors such as whether we want to be tough or generous to borderline candidates. Finally, "Because the test has impressive statistical indices of internal consistency" is not a sufficient answer to the question "How can you be sure of the result?" High reliability could be achieved, for example, by having a thousand-item Multiple Choice Question and nothing else, but, with a multifarious subject like general practice, validity would be lost. Einstein, it is rumoured, kept permanently chalked on the board in his Princeton laboratory, "Not everything that counts can be counted, and not everything that can be counted counts."

Far more of the important parameters in examination procedures and standards are matters of opinion and policy and compromise than might be generally appreciated. It is widely believed — naively and erroneously — that the progressive refinement of an assessment package represents an ever-closer approximation to some elusive yet attainable ideal. Someone somewhere (probably an academic married to a statistician: one fears for the sanity of the children), ought to be able to come up with 'the answer'. If we only work long enough and hard enough, we assume, the 'right' definition of competence can be discovered, the 'best' test procedures devised, and complete decontamination from bias and bad luck achieved. All such assumptions are false.

Take competence: it is debatable whether a doctor can be said to possess a unitary quality such as competence, existing independently of context and analogous to whatever the Intelligence Quotient is a measure of. Most experts consider the notion of 'competence' (minimal or otherwise) to be an over-simplification. What doctors have is a clustered array of separate competencies, each of which is case-specific to the clinical context. More precisely, doctors encounter (and can be tested on) an assortment of clinical and

ing?

professional challenges to which they may make more or less effective responses. Moreover, the type of competence ranges from the reflective self-analytic 'I can describe each step as I laboriously take it' kind of competence shown by good GP registrars to the 'I can't explain but I've met this so often I just know what to do' sort of competence professed by the seasoned principal. The former's ability to build practical skill from its theoretical components needs to be tested, while the latter's ingrained habits have to be measured against, and justifiable in the light of, contemporary knowledge and expectations.

A popular model of the acquisition of competence sees it as a sequential and hierarchical process. From a basis of factual knowledge the doctor-in-training is believed to synthesize a repertoire of low-order, then high-order, skills which coalesce into a potential competence which, on a good day gets expressed in workaday performance from which actual patients derive actual benefit. Research suggests, unfortunately, that real people progress from novice to expert in a much more jerky and case-specific way.

Abstractions such as 'decision-making skills' or 'professional values' are just that — abstractions, which do not necessarily generalize from one context to another. To those charged with administering appropriate test procedures, the lesson is a stark one: sample widely, and don't assume that a candidate who understands the long-term management of epilepsy is equally good with diabetes. We must not kid ourselves that we can ever arrive at the best package for assessing so slippery and multifaceted a thing as a doctor's competence.

The question *"How competent is competent enough?"* is of crucial importance to the individual candidate in high-stakes tests such as Summative Assessment or (especially when College policy prevails and MRCGP becomes the norm for principals) our own examination. Standard-setting cannot even in principle be left to statisticians and psychometricians. What constitutes 'minimally competent' or 'Membership-level' general practice has to be a compromise decision reflecting the interests of all the stake-holders: candidates, teachers, examiners, committees, paymasters, and above all patients. In order for any assessment to command credibility and respect, the standard-setting process that defines who shall pass and who fail needs to be eclectic and transparent.

There could easily develop a potentially acrimonious but wholly unnecessary conflict of vested interest between the purveyors of Summative Assessment test methods and the MRCGP. I believe there is no sound academic justification for this. All the players in the game have the same goal — to raise standards in British primary care and protect the public from poor doctoring. Mathematics and academic parochialism will not deliver it. As Brian Keighley (Chairman of the Joint Committee on Postgraduate Training) and Stuart Murray (architect of the West of Scotland Summative Assessment package) said in their recent book[3], "Whatever develops in the next few years it is clear that the status quo will not remain. The key to managing that change will be doctors from the RCGP and the universities working in harmony with those from the GMSC/LMC axis." Patients and GP registrars will applaud these sentiments but will expect them to be translated into action. Now is the time for humility, compromise and co-operation. I hope the forthcoming changes to the MRCGP examination, co-existing with the present Summative Assessment package, will bring an appropriate indicator of competence within the grasp of all who require it.

Roger Neighbour

References

1 Haslam D. The MRCGP goes modular. *Br J Gen Pract* 1997; **47**: 610-611.
2 Full details available from the Examination Department, RCGP, or on the RCGP's Internet website, http://www.rcgp.org.uk
3 Keighley, B & Murray, S. *Guide to postgraduate medical education.* BMJ Publishing Group, London, 1996

PEP talk...
New Disks

Earlier this year three new disks were added to the PEP self-assessment computer program covering asthma, emergency medicine, and therapeutics and prescribing.

After 10 successful years the future of the PEP initiative is being considered by College Council. Currently the programs are produced in their research and development phase with the support of major grants from the Scottish Council for Postgraduate Medical and Dental Education and Zeneca plc that have enabled the programs to be issued free of charge to registrars and established principals.

The further development of PEP is likely to take the form of one CD-ROM allowing access to a generic program and menu of specialty areas. One of these areas will be dermatology where a program has just been completed with the assistance of Dr Heather Cameron and the department of dermatology at Ninewells Hospital, Dundee. This program, in Windows, allows high-definition pictures to be presented and explanations provided after each question. However, College Council has yet to decide as to whether PEP programs can continue to be issued free of charge or whether they will require to be marketed once the educational grants for research and development come to an end.

Your views will be welcome.

Programs available through Princes Gate, the Scottish Council Office, or from Zeneca representatives.

Alastair Donald

The University of Warwick has appointed its first professor of general practice. He is Jeremy Dale, formerly senior lecturer at King's College in London.

primary health care & gay & bisexual men

Sheffield Centre for HIV and Sexual Health in collaboration with Sheffield Health Promotion have just produced a new resource entitled 'Primary Health Care and Gay and Bisexual Men'. This 20-page publication is intended to help primary care teams in addressing the health needs and concerns of gay and bisexual men, enabling them to feel confident that they are offering a sensitive and appropriate service.

The emphasis on a primary care led NHS is growing, with developments such as GP fundholding and locality purchasing. If we're serious about providing a "national" health service that provides for all its citizens, then we must address the needs of gay and bisexual men within it at every level.

Those working in a primary care setting have a clear role to play in allaying these concerns and offering a sensitive, welcoming approach. Gay and bisexual men don't necessarily want 'special' treatment from their doctors, but rather a relationship that includes being able to talk about themselves and their lives without fear of being judged or pathologized.

The Centre for HIV and Sexual Health has a history of developing work with primary care teams around sexual health in primary care settings. This resource is another significant development within this work. The publication costs £7.50 (including postage and packaging) and is available by contacting the Centre on **0114 2678806**

Anne-Marie Reynolds an appreciation

We want to pay tribute to the memory of Dr Anne-Marie Reynolds, who died on 5th September 1997. She was the representative of France on the First Leeuwenhorst European Study Group, which created a shared definition of a general practitioner appropriate for most European countries. She herself was for many years a practitioner at Palaiseau, a suburb south of Paris, and also a lecturer in what was the earliest general practice training contribution to undergraduate medical education in France. This was — and still is — at Bobigny, one of the medical schools attached to the University of Paris.

An independent thinker, in single-handed practice, she contributed powerfully to the European Group her lasting concern with the interpersonal rather than the technical aspects of medicine. She was strongly influenced by psycho-analytical ideas and, in more recent years, her work was closer to that of an analyst than to the norms of French general practice. Nevertheless, with her second husband, Louis Velluet, she continued until her death to organize intensive two day courses twice every year, to which general practitioners came from all over France.

Links between general practitioners in France and those in Holland, Scandanavia or the United Kingdom have always been relatively few, largely, though not entirely, because of language. French practitioners have had far greater difficulty in being accepted as teachers or researchers by the university hierarchy than their colleagues in those other countries. It is difficult for single-handed practitioners who depend on fees from each item of service to play a part in international discussions — the more so when competing national organizations at home limit their capacity to act as representatives.

We remember with gratitude the many stimulating discussions which we owe to Anne-Marie between 1974 and 1982, when the original members of the eleven-nation group retired and handed over to younger ones, who now come together from twice that number of countries.

Jan van Es and **John Horder**
Past Chairman and Secretary
The 1st Leeuwenhorst
European Study Group

the uk-nordic medical educational trust

The idea of a structure to enhance cooperation between GPs in Nordic countries and the UK took root at the WONCA meeting in London in 1986. Incorporation as a charitable Trust followed in 1993 (registered number 1022546). The Trust has produced regular newsletters which have proved very popular.

There have been several landmarks, in particular the UK-Nordic workshops in London in 1990 and in Copenhagen in 1993. The former produced the book *General Practitioner Education - UK and Nordic Perspectives* (Springer-Verlag 1992) and the latter a supplement to the *Scandinavian Journal of Primary Health Care* on *Research in General Practice - new strategies, new methods* (Vol 11 supp 2, 1993). We work closely with the RCGP.

Following an idea from the late Professor G'sta Tibblin, 12 four-day workshops have been run in Oxford on 'The Consultation'. These were followed by five on 'Communication' for Finnish GPs, the last in August 1997. Authors of research papers and theses, whose first language is not English, have benefitted from the 'text-polishing service', which offers immediate language editing.

A major commitment of the Trust has been collaborating with the Norwegian Medical Association in the highly innovative 'Learning in Medicine' conferences which occur every three years in Oslo. These four-day events have only three 20-minute lectures, and the rest of the time is spent in *ex tempore* workshops. These were reported on a computer and appeared as a newspaper at 8am the next morning. This year, we went a stage further and the reports went out on Internet the same night!

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Peter Pritchard

50th anniversary of the national health service 5 July 1998

Plans are being put together to celebrate the 50th anniversary of the National Health Service, introduced in July 1948. Most of the celebrations will take place during the first week in July. There will be a service in Westminster Abbey on 5 July, conferences organized by the British Medical Association and the NHS Confederation, exhibitions at Earl's Court and Olympia in London and all kinds of local events. The steering group, which comprises representatives from patient groups, royal colleges, the professions, the trade unions, NAHAT and others, is coordinating national events and supporting local initiatives. Hospitals and surgeries are being encouraged to open their premises to the public on 5 July. The Royal College of General Practitioners will be marking the occasion in some form, but details are not as yet finalized. An anniversary resource pack has been produced by the NHS Executive containing fact sheets, ideas for events and copies of the logo. Copies of the resource pack can be obtained from -

NHS 50, Communications Unit, NHS Executive, Quarry House, Quarry Hill, Leeds LS2 7UE.

A short history of socialized medicine... 1

AESCLEPIUS to AQUEDUCTS - Social Medicine in Classical Times

Soaring aqueducts, baths and sewers stand testament to Roman faith in public health, the benefits of a healthy environment having been promoted by Hippocrates in *Airs, Waters and Places*. Roman doctors, sometimes female, were low in status, and commonly Greeks, freedmen or even slaves - "grammarian, orator, geometer, painter, wrestling-master, prophet, tightrope walker, medical man, wizard — he can do anything, your penniless Greek..." quotes Juvenal (AD60-130).

Practitioners followed the Hippocratic Corpus, written between 420 and 370 BC, and were characterized by close observation of symptoms and way of life. There was openness to various explanations referring to an imbalance between 'humours', 'powers' and 'fluxes', and emphasis was on prognosis. Hippocrates was said to be descended from Aesclepius, the god of healing, his astute clinical observations recorded as his 'Aphorisms'.

Roman citizens were hardly easy patients; as the satirist Martial quips, "Lately Diaulus was a doctor, now he is an undertaker. What the undertaker now does the doctor, too, did before".

The Romans developed incentives and systems; Julius Caesar granted citizenship to foreign doctors, and there were tax privileges. A public medical system run by municipal physicians, known as archiatri, continued a tradition of tax-funded doctors which had started in the Greek city states in 600 BC. Vespasian (AD 69-79) even provided public teachers of medicine, probably to supply the fighting services.

Medical "Schools" existed but were just loose associations of practitioners with similar doctrines teaching by demonstration and the spoken word. Neither were there yet formal qualifications — anyone could proclaim himself a doctor. A successful physician could have many apprentices, who assisted their master and undertook nursing duties; their tenderness was not always appreciated — "I was sickening; but you at once attended me Symmachus, with a train of a hundred apprentices. A hundred hands frosted by the North wind pawed me; I had no fever before, Symmachus; now I have."(Martial)

Later, written knowledge led to centres of learning being established at Alexandria, Athens and Constantinople. Galen (AD 129-216) emphasised training for the "philosopher-doctor" and he reinterpreted the science, philosophy and medicine of Aristotle, Plato and Hippocrates, stressing observation, clinical examination and dissection.

The Romans built hospitals (Valetudinaria) for slaves and soldiers, caring institutions for citizens only developing in the Christian era. About AD 85, there was one at Inchtutchil in Scotland with 64 wards capable of treating 250 soldiers simultaneously.

In Roman Britain the first identifiable doctor was Ariovist, a famous Celtic eye surgeon. The tombstone of the last known Romano-British physician, one Melus, who lived about 500 AD, can be found in Llanghian on the Lleyn Peninsula. Its inscription, in both Latin and Celtic Ogham script, indicates the imminent arrival of a new world order.

Jim Ford

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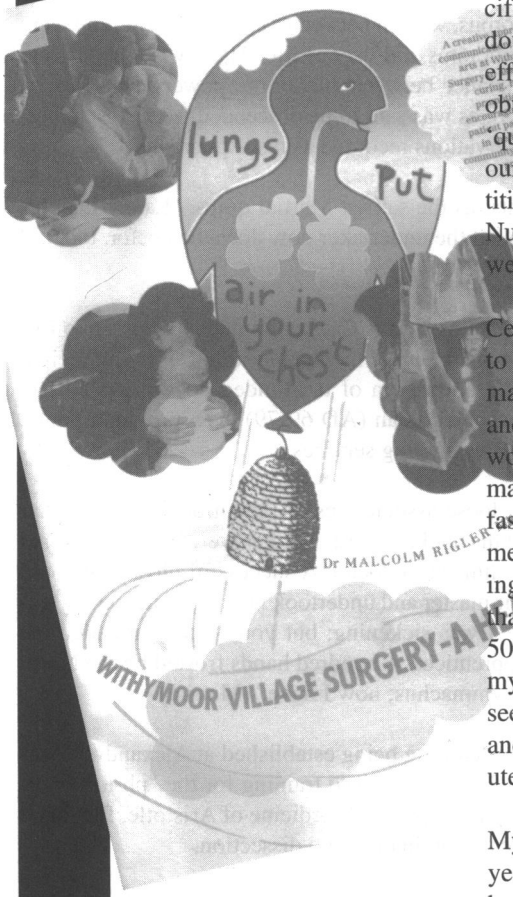
The arts as medicine — a postcard from Withym



... for many GPs their heart is no longer in it, and medicine has become rather like the work of the checkout girl in the supermarket — rapid pattern recognition and the fast prescribing of pills or hospital treatments...

The reader who believes that medicine can only be practised if its practitioners maintain a dispassionate gaze will find no comfort in this piece of writing. I offer not another sort of Mimms List of 'arts remedies' full of tested therapies for specific conditions, treatments supported by double-blind controlled trials to prove efficacy, remedies that could be easily obtained and applied. I offer in fact no 'quick fix' but ask you first to reflect upon our own way of thinking as general practitioners and our own way of doing things. Numerous authors have made it clear that we are, as a profession, in deep trouble.

Certainly medicine is still seen as a way to status and financial security, but for many GPs their heart is no longer in it and medicine has become rather like the work of the checkout girl in the supermarket — rapid pattern recognition and the fast prescribing of pills or hospital treatments, followed by the receptionist crying "Next, please". Small wonder then that many GPs wish to retire at the age of 50 and so few want to join us. As one of my locums put it recently, "So many GPs seem to have learnt how to get people in and out of their rooms within five minutes, but I don't think that is medicine!"

My personal quest led me to see some years ago that medicine should actually be about helping people to cope with life in all its complexity. It is about helping patients and communities to find health, vitality and balance.

With this insight I began an exploration, with other health professionals, educationalists and artists looking more closely at 'non-medical' influences on health. With colleagues, largely outside of the established medical circles, I have been looking into the question "what do we have to do truly to ascertain, and respond to, the health needs of suffering people?" (given that much distress, suffering and ill-health arises these days from psychosocial problems).

Various authors have influenced my thinking (see Further Reading) and it has now become clear that a variety of projects can be initiated in all kinds of community venues including the GP practice. Such projects bring people together around non-threatening and enjoyable arts activities and have proved to be very helpful to those who are lonely and to people suffering from mild to moderate anxiety and depression, including those people suffering from panic attacks. The projects help build social relationships and help people to improve their written and verbal communication skills. Their listening skills, self-confidence and self-esteem are also improved and patients learn to express concerns about issues affecting their health and the health of their communities. Although still anecdotal, evidence exists that patients involved in projects later take steps to improve their physical health and improve also their relationships with their families, friends and peer groups. Because there is usually a final product to the sessions — a poem, a lantern, an art work that can be displayed in the waiting room — patients gain a sense of personal achievement and, perhaps most important of all, they enjoy themselves and have fun. Such projects have in fact been able to meet patient's needs for mental health and inner balance. The work has enabled me to see that Professor Ashton is quite right when he states that "health promotion is much more complex than we have so far realized; it involves community development, policy analysis, community organization, advocacy and legislation." I would add to his list that it also involves community arts, especially music and dance, and that it is in fact an activity of great artistry.

I have found too that the general practice building itself can play an important role in stimulating the education of the inner life of patients and staff alike, so promoting improvements in morale and opportunities for the development of a network of health-promoting relationships between the practice and other agencies in the community.

Although much has been achieved in theory and practice through our own and other projects, I still felt until recently that there was a missing link. The work did not quite seem to fully connect with the

scientific community. Over recent months, however, the importance of the artistic frame of mind in pursuing scientific activity has become clear. First, through Harry Kroto at Sussex University (Nobel Prize Winner for the discovery of the stable C_{60} molecule) speaking recently on the radio and from the heart said how very important is the imaginative life of the scientist. Secondly, in her book *Lifting the veil of the feminine face of science*, Linda Jean Shepherd confirms that good science, like good art, depends as much on the qualities of feeling, nurturing and intuition (qualities usually associated with the artist) in the scientist as on the ability to think coolly and rationally, and keep a distance from the object of study. So now I see that medicine, by encouraging the development of the artistic traits of intuition, feeling, imagination and openness to new ideas — capacities to nurture and stay close to a context — is actually, by doing so, promoting the required attitudes and capacities of a good scientist. I have found that really successful scientists stay close to their object of study and develop strong feelings towards their molecules, the genes in their wheat plants or whatever else they study.

Of course we have seen among us this kind of excellent, truly scientific attitude many times before. One such was William Pickles who, in his pioneering epidemiological work, patiently collected data about infections in his practice over many years. He certainly lived "close to context", serving his community on a daily basis, caring deeply for the individual subjects of his observation. In his day, infectious diseases were seen to be the big killers so his work focused on that. In our own time psychosocial problems are to the fore and medicine in its scientific, epidemiological aspect must now focus on the collection of the appropriate data. This data must now be "person-centred", unlike the disease-focused studies with which we are familiar. Person-centred studies that have been undertaken to date seem to confirm the findings of Ken Judge that lack of social support, unemployment and poor education are now the major causes of suffering and distress in our society. They are, in fact, the big killers of our time.

Involved as we are now in multi-funds and locality commissioning we at last have the opportunity to consider what to commission, to think again about what we really mean by health promotion (our own and our patients'). For my part I am convinced that person-centred epidemiology studies should be given the highest priority and should be undertaken in each locality. I am equally sure that many of the problems uncovered by such studies will not be remedied by treatments available at the pharmacy or the hospital. The suffering uncovered will only be relieved, I feel, if we push aside the artificial boundaries that exist between science and art, between ourselves and those involved in education, community development and community arts. I feel sure that it is only then, when we have formed alliances with other professional groups (a very difficult art) that we shall be able to offer people opportunities for personal growth and development, opportunities to build new social networks and engage in new forms of voluntary work. We must offer opportunities for people to learn the new skills they will need to cope with new forms of employment, but most important of all a chance to become utterly enchanted with being human, a chance to be able to enjoy all that is going on.

In summary then, as we help our patients and ourselves face up to and tackle the wide variety of psychosocial and other health problems that trouble us, we must create and promote alliances with head teachers of the national network of schools and community colleges, and with cultural organizations. Of course in England we have been slow to realize the importance of this kind of cultural change. In the Netherlands some years ago the Department of Health became the Department of Health, Welfare and Cultural Affairs. And in Scotland, since the 1997 General Election, the new Labour Secretary of State for Health, Sam Galbraith, has rejoiced under the title 'Minister for Health and the Arts'.

All is not lost so long as we get it clear in our minds, and as soon as possible, that people can only be healthy within healthy communities — communities in which the creativity of everyone is valued highly. Of course, our own personal creativity in all this will be pivotal, so we must remind ourselves constantly about the importance of our own imaginative life and actively develop our own aesthetic sensitivities (exercise our own imaginative muscles, so to speak) by exposure and engagement in the arts, for "if we resign on our creativity we give up on our humanity."

Malcolm Rigler

Further reading

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10 Pickles W. *Epidemiology in Country Practice,* 1939 (republished 1972, 1984, 1994). Royal College of General Practitioners, London.

11 Anderson D. *Utopianism in Museums.* Lecture given at the Science Museum, London, at the International Conference on Scientific Literacy, 9 November 1994 (private communication).

Copies of "Withymoor Village Surgery — A Health Hive" can be obtained from Malcolm Rigler, Withymoor Village Surgery, Turners Lane, Brierley Hill, West Midlands DY5 2PG. Please send cheque or postal order for £10 (inc p&p).

On communication...

Relating to the Relatives
Thurstan Brewin
Radcliffe Medical Press 1996
PB 192pp, £13.50 (1 85775 0810)
Improving communication between doctors and patients
RCP March 1997
PB 38pp, £7.00 (1 86016 0549)
Communication Skills in Medicine Ed. RK Hind
BMJ Publishing Group 1997
PB ***pp, £** (* **** **** *)
The Doctor's Communication Handbook (Second Edition)
Peter Tate
Radcliffe Medical Press 1997
PB 152pp, £16.50 (1 85775 2562)

Books and doctors are judged by their ability to communicate. Doctors writing books on communication are therefore setting themselves up for a fall. Not only do they have to say something important about communication but they have to communicate it effectively as well.

I have just read four books on communication by doctors and you are entitled to ask whether I think the experience has done me, as a doctor, any good. The answer, and I can't think of any other aspect of medicine to which this would apply, is that I am helped with each and every patient.

So, who communicates well about communication? Inevitably subjective, my criterion is this: Is the writer talking about a process? Or is he talking about the real thing? Very sadly, my conclusion is that it is not the general practitioners who hit the mark (as I would have expected) but the specialists. Pre-eminently it is an oncologist, Thurstan Brewin, in his book *Relating to the Relatives*, who over and over again shows us how it should be done.

Is the writer talking about a process? Or is he talking about the real thing?

One thing is certain, communication as a subject for serious attention has arrived. The Royal College of Physicians' working party on **Improving communication between doctors and patients** was chaired by the President, Leslie Turnberg, no less, and has produced a clear, unpretentious and helpful report. Partly, no doubt, because its 15 members included Michael O'Donnell. The report is intended to be read in conjunction with the Audit Commission's report, *What seems to be the matter? Communication between hospitals and patients*, which is a shame because it won't be, but it stands admirably on its own, covers the subject matter well in a logical way and finishes with an excellent Appendix on the Do's and Don'ts of communicating bad news. It doesn't say enough about the importance of discharge letters but it will do a lot of good. That is, if its slim A4 format can be found on the shelves without a name visible on its spine.

Somehow this august committee manages to speak with a single, if impersonal, voice. The same is not true of the collection of articles edited by Charles Hind for BMJ books — **Communication Skills in Medicine**. After the editor's brief introduction it consists of 13 chapters by 18 authors, of varying styles, lengths, formats and qualities. The list of subjects seems arbitrary, and invites a search for omissions — for example, if a chapter on asking permission for a post-mortem, why not one on recruitment to a clinical trial? The authors often repeat each other's points (many of them stress the importance of maintaining eye contact and re-tell the news that communication skills can be taught) but they have such different approaches that one recommends exactly the form of words that another has just been deploring.

Taken individually, some of the chapters are moving and full of insight. Jonathan Marrow, casualty consultant, is superb on the subject of the sudden death of a family member. "The suddenly bereaved effectively become our patients, every bit as deserving of our care as the person who has died". There are two excellent chapters by paediatricians, one on breaking the news of severe abnormality, and another on talking to the parents of a brain-dead child. The management of cot death is done much less well and seems to entirely discount the role of the GP (who in my sadly considerable experience is usually the professional most immediately involved). The eight pages devoted to the immensely difficult subject of suspected child abuse are totally inadequate. And again, the one chapter written by a GP, on the "difficult" patient, was disappointingly obscure and theoretical.

And that is the problem with Peter Tate's

The Doctor's Communication Handbook. It is all about technique, while communication is inhibited by technique. It struggles to make a science of something which is quite obviously an art. It is enlivened by examples and anecdotes (perhaps slightly trivialized by cartoon-style illustrations) and that part is good, helpful and enjoyable, but it left me lonely in my incomprehension of its doctor's and patient's "Circles of Learning" and if it "influenced [my] Locus of Control", I have to say I am none the wiser. I am worried by the thought that such a book is used as a text by aspiring GPs, still more by junior hospital doctors to whom it is also clearly addressed (although, significantly and again sadly, it is not amongst the 69 references in the RCP Report). Surely you do not talk to experienced young colleagues like this: "However, the first chapter may have started you thinking...".

Nor do you say the following: "The general practitioner's primary duty is to protect his/her patients from hospital medicine." Here is Thurstan Brewin, in **Relating to the Relatives**, dealing properly with the same subject: "It goes without saying that as far as is compatible with truth and sincerity, the hospital doctor should aim to give both the patient and the relative the maximum confidence in the family doctor — and the latter should do the same when speaking of a specialist."

This is typical of Brewin's writing. With every sentence he communicates something of importance. His particular subject is talking to relatives, but it's all here, including things that all the other books have left out: the use of the telephone, the unique value of home visiting, optimism, pessimism, sincerity, sympathy. He combines a deep respect for his audience with immense wisdom and experience. "Some readers may feel that in no way do they need me to suggest things of which they are already well aware, or are a matter of personal taste. I can only plead that this thought frequently occurred to me; and more than once nearly led to abandoning the whole idea." That, I believe, is the state of mind that leads to success in communicating such crucially important ideas.

James Willis

Medical Futility and the Evaluation of Life Sustaining Interventions
MB and HD Zucker
Cambridge University Press, 1997
PB 192pp, £15.95 (0 1223 325196)

The debate over when a treatment can fairly be described as 'futile' has several facets which make the discussion complex and not easy to resolve. We might agree that if a treatment never works it is futile, but if it works in a small number of cases is it futile? Well, how small a number and with how much success? Then there is the question of the patient. Is it acceptable to use a life-prolonging treatment (as distinct from palliation) on a patient who is dying, and does it matter whether the patient is nine or ninety years old? I said is it 'acceptable', but acceptable to whom, and do we mean morally, or economically? It might seem morally acceptable to an oncologist, say, to urge the use of an expensive chemotherapy on a dying eighty-year-old, on the grounds that it has a 15% chance of prolonging life for a few months. Should the oncologist (morally) do this, and would a hospital trust be within its rights to try to stop it? Suppose, however, that it is the patient, or more likely the relatives, who urge the use of this expensive treatment. Are the oncologist and the hospital trust within their rights to refuse the request on the grounds that the treatment, in this case, is futile?

These are some of the questions discussed in sixteen short chapters in this multi-authored book. It is written in an American context, where the problems are more acute than they are here. Nevertheless there have been several court cases in the UK over the past few years involving some of the questions outlined. The American experience is that in the first phase of high-tech treatments (1970s) it was the doctors who were gung-ho in attempting heroic but futile rescues, but in the 1990s it is patients who are demanding them and the doctors who are more circumspect. Against this second wave of demand for futile treatments, doctors are now staking their own professional integrity. Whereas in the 1970s and 1980s US doctors thought they were bound to respect the patient's autonomy no matter how contraindicated they held the patient's demands to be, they are now increasingly refusing to go against their professional judgment. Indeed, in the UK this position is supported by the Courts. Lord Justice Donaldson stated that "courts should not require a medical practitioner..... to adopt a course of treatment which in the bona fide clinical judgement of the practitioner was contraindicated" (Re J. 1992). This must be correct in moral as well as legal terms.

This book is clearly written and raises issues as important here as they are in the US. It is relevant reading for managers and politicians as well as doctors and patients.

Robin Downie

ABC of Clinical Genetics
Helen Kington
BMJ Books
PB £16.95 84pp (0 7279 1101 5)

"This comprehensive, reader-friendly introduction to clinical genetics will prove invaluable to doctors, medical students, nurses, and midwives."

So the promotional material on the back of this book proclaims. I'm afraid this reader did not find the text to be so amicable. This slim volume of 74 pages attempts to cover a wide range of relevant topics. Although the style is mercifully low on jargon, abbreviations and acronyms, it is, probably inevitably, condensed to the point at which many sentences appear to be merely expanded check lists.

The book includes a large number of facts, but it fails to illuminate and explain. For a reader who already has an understanding of the subject the book may be useful to retain for reference, although a true reference text needs to be much more comprehensive.

Having achieved a revised second edition, someone must be buying it. I would be surprised, however, if the expectations of the purchaser were fulfilled.

Clifford Kay

Columnists...

The Back Pages has space for two or three columns per issue. Subject matter can be as varied as general practice itself. We invite sample columns, of 500 words, typed, double-spaced, backed up on disk (TXT), with skeletons for two more. ***Submissions should reach the Journal Office by 1 December.***

digest

Reviewers should simply review the book — not try to be clever

BMJ 315:62, letter

Discuss...

There are few things in life as certain for today's general practitioner as death, taxes and dealings with the legal system...

Medicolegal Essentials In Healthcare

Jason Payne-James, Peter Dean, Ian Wall (eds)

Churchill Livingstone

PB 177pp (0443 052409)

There are few things in life as certain for today's general practitioner as death, taxes and dealings with the legal system. Any book which provides a concise summary of important medicolegal issues is therefore timely and useful. The aim of this text, edited by three London 'forensic physicians', is to provide an overview of those legal issues most relevant to individuals working in the health care professions.

The first two chapters set the scene by describing the legal system in England and Wales and the structure and functions of the General Medical Council. These are followed by a series of chapters summarizing the law as it relates to the extremes of life (abortion and contraception, the Children's Act, euthanasia and death certification), mental health and organ donation. A strength of the authors' approach is that they summarize the landmark legal cases upon which current practice rests. Thus the trial of Bodkin Adams is dealt with in detail and Lord Devlin's famous direction to the jury is quoted verbatim. Other important topics covered include confidentiality, medical negligence and the ethics of randomized controlled trials.

Although not aimed specifically at general practitioners, this book does provide a good introduction to key medicolegal issues. The chapter on living wills, in particular, is clear and to the point. Nonetheless it is a pity that the editors did not invite a contributor from 'north of the border' to write a chapter on the Scottish legal system.

Tim Stokes

Cain's Book

Alexander Trocchi

Calder Publications Ltd

PB £6.99 252pp (0 7145 4233 4)

I've always felt a bit sorry for Cain. "But unto Cain and to his offering the Lord had not respect." That a self-styled monster chose this title to make his offering to the world intrigued me.

Alexander Trocchi was an outstanding young philosopher from Glasgow who "dropped out " in the 1950s, moved through existentialist Paris and on to nearly thirty years as a heroin addict in the USA. Hailed in his youth as a literary genius fated to cut a swath through the world, he died almost unknown in 1984.

Despite, or more likely because of, an obscene publications trial when it first appeared in the UK, *Cain's Book* became a cult classic and remains in print. Seven years in the writing Trocchi explores his life of addiction and seeks to expound his views on drug use in society. The potential for a revealing quest into why people use drugs and the hypocrisy and confused reactions that their behaviour invokes in others beckons the reader: a towering intellect brought to focus on a fascinating question; a chance to hear from the "cosmonaut of the inner space", as Trocchi described himself, was a prospect I relished. One hoped we would find a vision more illuminating than that presented by contemporary chemical culture writers like Irving Welsh.

Sadly this is not on offer. Written in a style which seeks to offend to impress, this book has been overtaken by the coarsening of popular culture. Expressions that horrified polite society in the early sixties have a mildly embarrassing and adolescent quality in today's society, where maiden aunts can watch Tarentino movies on television. Lacking the brutality of de Sade, the style of Camus or the originality of Beckett, Trocchi emerges as a selfish, pretentious, empty and rather sad character who feels himself superior to the world about him but is unable to justify this belief. One is left wondering which came first: his personality or the heroin abuse. Trocchi has betrayed his genius. Just like Cain he went out from the presence of the Lord, and dwelt in the land of Nod, on the east of Eden.

Anyone interested in the use of recreational drugs will find this book of interest as a piece of cultural history; however any anticipated insights proved to be illusory. I'm afraid Cain's offering has not my respect.

Rob Hendry

Strategies for Managing the Menopause

Jean Coope

Publishing Initiatives Books

PB 196 pages, £19.95 (1 8738 39375)

Jean Coope is a generalist who is internationally renowned for her work on the menopause. This book reflects this; the aim, stated in the preface, is to "provide the scientific basis for advice and prescription for those working at the grass roots of medicine."

The book is small and easily readable though the compact size does make some figures difficult to understand. The benefits of HRT, as one might expect, are clearly set out. The sections explaining the low risk of breast cancer and deep venous thrombosis for most HRT users are especially useful. However, as with many enthusiasts, some statements seem to be unsubstantiated; an example is the suggestion that women prefer to attend dedicated menopause clinics in general practice. Another example is the statement that, at this age, male erectile dysfunction is more important than female sexual problems such as vaginal atrophy or lack of lubrication.

A large section of the book deals with mental health. Here it is contradictory; the author states there is no link between psychological problems and the menopause in carefully conducted studies, and yet goes on to advocate the prescription of HRT in moderate depression in addition to antidepressants. Several questionnaires such as the Beck Depression Inventory are included; clearly, accurate individual assessment of all a woman's problems will guide prescribing in the surgery.

In short, the book includes much useful information, but perhaps tries to cover too wide a field. It is not simply a collection of strategies for managing the menopause, but a commentary on helping women at the end of their fertile years.

John Howard

A Doctor's Dilemma; Stress and the Role of the Carer
John W Holland
Free Associaion Books
PB 250pp £15.95 (1 85343 3063)

Having misinterpreted the title, I was surprised to discover that, for once, this is a book which is intended to help GPs look after themselves. It makes absorbing reading, and begins by succinctly describing those pressures that arise not from shortage of time or resources, but from the interaction between ourselves and our patients.

Personal anecdotes illustrate that Dr Holland has experienced the anger, frustration and distress that affect all GPs faced with unreasonable demands, inconsiderate call-outs, and falsely high expectations. Having warmed his readers with all this empathy, he goes on to argue that GPs can make things worse by their own behaviour. He rightly points out that many doctors who enter the profession are, in fact, responding to their own needs to be needed, and may be sitting ducks for the feelings which patients try to project on to them. The chapter "Using and Being Used by People" neatly describes how doctors, in turn, can end up feeling anxious, angry or powerless.

However, Dr Holland believes that the way to cope with these stresses is not to indulge in self-pity, but to examine and change the way that we react to them. The second half of the book concentrates on how doctors can distinguish between their own feelings and responsibilities, and those of their patients, explaining how this knowledge can be used to improve consultations and the doctor's well-being.

Many doctors will be able to think of patients to whom they can immediately apply this approach. Interestingly, Dr Holland provides a convincing argument for using the same technique to resolve interpersonal difficulties in GP partnerships, and may give dispirited partners the courage to try again.

A thought-provoking book, that may help some GPs to avoid burn-out.

Melanie Wynne-Jones

"A History of Psychiatry: From The Era of the Asylum to the Age of Prozac"
Edward Shorter
John Wiley and Sons Ltd
HB 436pp (0 471 15749 X)

Carl Wernicke, the eponymous neuropsychiatrist, was killed when a truck collided with his bike in 1904: "I'm perishing of autopsychic disorientation" were his last words as he lay dying on the road. "Wernicke's vocabulary," notes Edward Shorter in this new history of Psychiatry, "did not outlive him".

His acerbic comment is typical of the book: this is a history illuminated by individual stories, informed by contemporary politics and culture, and — above all — by the unashamedly partisan view of its author.

He describes the painstaking development of a medical understanding of the brain, and is dismissive of the parallel untangling of "mind". Psychotherapy is viewed as a diversion, and the travails of a myriad of counsellors, social theorists, philosophers and social workers get short shrift. He rails against "zealot-researchers" who have "seized the history of psychiatry to illustrate how their pet bugaboos have converted protest into illness".

This adamant stance makes for engaging reading. Shorter has a pithy, almost journalistic prose and an eye for telling personal detail. He begins with a vigorous defence of early institutional care ("the rise of the asylum is the story of good intentions gone bad"), before progressive ideas were swamped by the ten-fold rise in psychiatric admissions from the mid-eighteenth century.

The first "biological" psychiatrists such as Griesinger, Wernicke, and Nissl were stymied by technological inadequacies, and later by the political implications of degeneration theory — that mental illnesses become worse as they are passed from generation to generation. Nazi abuse of such concepts rendered any discussion of psychiatric genetics taboo for decades, and encouraged the flight of thousands of (mainly Jewish) psychoanalysts to the US and UK before the second war.

The American middle classes were captivated by Freud, and sought the "talking cure" in unprecedented numbers. Shorter believes this to be a response to a popular revulsion for asylum life, and a desperate search by psychiatrists for a theoretical understanding of any kind (helped by a canny eye for a lucrative business opportunity). Only with the discovery of chlorpromazine in the 1950s was the medical model of mental illness to regain ground.

Many will disagree with this perspective. Shorter damns both Freudian theories, and the fissiparous "cream puff" analysts that followed him in the earlier part of the century. But he fails to mention later, more scientifically respectable, research into attachment theory and early development, and omits altogether any discussion of British thinkers such as Balint, Fairbairn, Winnicot and Bion. Surprisingly, Shorter also neglects to mention the World Health Organization's massive research effort to classify mental illness in the seventies, despite a careful account of the US equivalent, the Diagnostic and Statistical Manual. Yet it was this international research effort that finally laid diagnoses such as "masturbatory insanity" and "wedding night psychosis" to rest, and permitted scientifically grounded development to take place.

Nonetheless, his book serves as a useful counterargument to an "odium psychiatricum" that is still perceptible today. *From the Age of the Asylum to the Age of Prozac* is the important story of psychiatry's rise to medical respectability, and Shorter tells it well.

Michael Smith

RCGP Publications

Osteoporosis - Prevention and Management in Primary Care

Colin Waine
RCGP Clinical Series

It is estimated that 60,000 hip fractures occur annually in the UK, with a peak age of incidence between 70-80 years, contributing substantially to morbidity, mortality and NHS costing. This places on primary care teams the responsibility of advising on preventive measures concerning diet, sunshine, exercise, avoidance of smoking and high alcohol consumption, HRT and adequate intakes of calcium and vitamin D at all ages. In only 21 pages this recent addition to the RCGP clinical series deals succinctly with skeletal development, pathophysiology, clinical presentation, consequences and preventive options. The pros and cons of HRT at the menopause, methods such as DEXA for measuring bone mass, the range of medications and their costs, are all discussed. Specific groups of young people, suffering from nutritional, endocrine and genetic disorders including female athletes and anorexics are included. Dr Waine advocates the benefits of dedicated clinics and suggests the roles of GPs and practice nurses. The utmost use of space is made by clear headings, subheadings, tables and diagrams.

The introduction states that osteoporosis affects one woman in three, and one in 12 men by the end of their lives, though later we are told the risk factors for men are the same as for women, owing to deficiency in testosterone. In fact, involutional osteoporosis causes women to lose about 80% of their trabecular bone and about 35% of their cortical bone with ageing, while men lose two thirds of these amounts. Geriatricians now distinguish between Type 1, affecting women 15-20 years after the menopause, when, owing to its greater surface area, trabecular bone loss proceeds at three times the rate of the cortical bone, rendering vertebrae specially vulnerable to acute collapse; and Type II which is age-related and slower, in which painless vertebral deformities of the multiple wedge type occur, leading to dorsal kyphosis. This explains why elderly women with residual bone loss from the menopause many years earlier have twice the incidence of hip fractures, while rates from slow bone loss are otherwise similar in both sexes. In what is now a multi-racial society, mention should have been made of rank order in bone density of black, oriental and white people. It would have been helpful to have included the address and telephone number of the National Osteoporosis Society.

Thoroughly researched, with 74 references, and clearly presented, this is an important text for those in primary care.

Keith Thompson

The Role of Counsellors in General Practice -Occasional Paper 74

Bonnie Sibbald, Julia Addington-Hall, Douglas Brenneman and Paul Preeling
19pp £9.90 (0 580184 230 1)

Most GPs assume that they already understand the role of counsellors in general practice, and would not immediately see the need to read this qualitative study.

It is a well-structured enquiry into the nature and funding of general practice counselling services. In-depth telephone interviews with GPs and their counsellors were conducted, and the evidence analysed.

Counsellors are a relatively recent addition to the primary health care team. In England and Wales fewer than 20 practices had a counsellor in 1988. However, by 1989, fuelled by the 1990 contract, one third of practices had one.

Counsellors working in general practice fall in to three main categories: community psychiatric nurses, psychologists and practice counsellors, all having different perceptions of their roles and needs. Amazingly, 28% have no formal qualification in counselling or in any of the psychotherapies. Equally surprisingly, there are no studies on the cost-effectiveness of counselling services.

The authors make three key recommendations:

- research into efficiency and cost-effectiveness
- minimum national standards for training of counsellors working in medical settings
- better education for general practitioners on the organization and role of counselling services in GP settings.

This paper is essential reading for all GPs and counsellors already involved in, or considering involvement in, counselling in general practice.

Nicola Toynton

diary

16 October
Float through the sea of change.
A study day for GPs on coping with changing work patterns led by Sally Irvine and Hilary Harman.
Venue: The Bull, Long Melford.
Information from Dr Nick Steel on 01603 624844/748043.

28-29 October
Teambuilding skills.
Venue: RCGP, London.

30-31 October
Performance appraisal course.
Venue: RCGP, London.

3-7 November
Promoting excellence in teaching general practice.
An international course for teachers of general practice. (Module two: 11 to 15 May 1998).

12 November
Towards healthier doctors.
Shaping an occupational health service for general practice.
Venue: RCGP.

14 November
Measuring general practice.
Joint conference with the Association of Primary Care Medical Advisers.
Venue: RCGP.

20 November
Environment and health - opportunities in primary care.
A joint RCGP/Kings Fund conference aimed at all those interested in the development of primary care and healthy communities.
Venue: King's Fund, Cavendish Square, London.

21 November
Annual General Meeting.
Venue: Royal Geographic Society.

22 November
Council meeting

26 November
Good health is good practice.
Workshop on health & safety at work.
Venue: RCGP, London.

28 November
RCGP seminar on Culyer funding for primary care R & D.
Venue: RCGP, London.

17 December
Christmas lecture for schools.
Venue: RCGP.

For further details of any of the above events please contact:
RCGP Courses & Conference Unit, 14 Princes Gate, London SW7 1PU.
Tel: **0171 823 9703** Fax: **0171 225 3047**
Email: **courses@rcgp.org.uk**

John Bain

Feelings and Focus

The following could be a brief account of a case presentation by a GP registrar during a group discussion at a day release programme.

Pamela is a 22-year-old single parent with two boys aged 4 and 2. Married at 18, divorced at 21, she is currently working as a supermarket checkout assistant. A year ago, her father, aged 45, died of lung cancer and since then she has been living with her mother who is largely responsible for the day care of her children. She has a brother aged 25 and a sister aged 20, who live in the immediate neighbourhood. Pamela has a long-standing problem with acne and during the past year has also presented frequently with non-specific headaches, abdominal complaints and bouts of dysmenorrhoea. Her most recent consultation with the GP registrar was ostensibly for a repeat prescription for tetracycline. A casual remark about how she was coping resulted in a flood of tears and expressions of dismay about how doctors were unable to treat her skin condition. Further exploration of her feelings revealed that she has been bottling up a lot of grief about her father's death and the impact on the family. In these circumstances, two young people – the doctor and the patient – are confronted with emotional issues that are not easy to disentangle.

This is not an unusual story from general practice, where unorganized illness is often the norm rather than the exception. In the midst of the flurry of white papers, guidelines, consensus statements and headline-grabbing about resources (or lack of them!) general practice is in danger of being submerged by policy documents that seem far removed from the daily interaction between doctor and patient. The 'patient' is now a 'customer'; the 'apostolic function' is in danger of disappearing within 'managed care'; 'non-organized illness' is frowned upon as 'evidence based medicine' takes central stage. The driving forces of 'purchasing', 'providing', 'commissioning', and 'cost-effectiveness' are far removed from the reality of situations that cannot be easily compartmentalized.

The resistance of general practice to many of the NHS reforms has probably been not merely about resources, but more about a plea for greater recognition of 'The Art so Long to Learn' in dealing with the Pamela Wilsons of this world. The medical model of disease, which seeks to define tightly structured characteristics of illness, sits uneasily with the loose outlines of presenting problems in primary care. Organized services bring financial rewards, yet the increasing focus on these types of services may lead to an erosion of the skills required to unravel the unorganized illness that patients bring to the consulting room.

The present 'focus' in documents on health care delivery make little comment about general practitioner's feelings about the skills they require to tease out the astonishing variety of undifferential problems that await them every day. Despite advances in medical science, the problems that patients bring to the privileged isolation of the consulting room remain largely unchanged. 'Evidence based medicine' has yet to provide any significant demonstration of 'managed care' leading to improved outcomes for 'unorganized illness'.

our contributors...

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The redoubtable **James Willis** is a GP in Alton, Hampshire, and author of the seminal *The Paradox of Progress*, an eloquent vindication of generalism.

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Blair Smith

On Annapurna

That part of me that remained — that had not been deposited in a semi-liquid form in the name of dysentery in the last dilapidating hut, built over a midden chicken-run, with a hole knocked out of the floor indicating the need for meticulous aim — stilted its flimsy way up the hillside to another temporary halt. The green shirt was black with a perspiration that could not evaporate, and still every skin pore streamed. This, the absence of infection-free water to drink, the rarefaction of this air, 6000 feet higher than breakfast, the tropical sun at midday crisis point, with the monsoon humidity and my deteriorating frame, all imposed both a decreasing interval between halts for respite and an increasing duration of these, growing proportions of which were spent in the snarling struggle for sated lungs.A greater initial fitness and a relative absence of purgative disease had ensured that my two companions were several miles ahead and several thousand feet higher, leaving me to steam in this treeless terrain and abandon my trust to the map of proven inaccuracy and to providence. (Barefoot smiling Nepalis jaunted impossibly heavy loads in the opposite direction and variously estimated the walking time to my scheduled pinnacle, Tatopani, somewhere between two and eight hours.)

It must be lunch-time. From my pack I drew my slightly stale bread and a tin of sardines which, when exposed to the deficient Himalayan breeze, acted as a beacon for those flies that form a nebulous halo around their victim. My scarcity of appetite, caused by my feeble and fluctuating gastric status, had meant that this repast had been arranged out of habit and perceived need rather than true desire, and I was not therefore too disappointed at having to abandon it to the amassing swarm; the negative calory equity did, however, cause me considerable anxiety.

As I approached my lonely nadir I felt something strange, almost imperceptible at first, but steadily forcing its way into my battered consciousness. Like an itch or a trickle of moisture, as though one had spilled sardine oil on one's foot, an impression that could be reinforced by the observation that this bit of me was attracting particular entomological attention. But then the sensation became intense, more like a needle or a foreign body, as I saw a slow stringy creature wriggling from a tiny hole in the pattern of my training shoe. With a jerk of energy drawn from the supply that I keep for these occasions I tore off my shoe and peeled away my sock. There, upon the caseating mass of tissue which had become my foot, were 5 (FIVE) slow stringy creatures! Only their prolonged engorgement on my precious plasma and corpuscles rendered them no longer stringy but spherical, and not slow but comatose. Leeches.

I remembered my reading, which told me first of the need to dispose of these bastards with a burning cigarette and secondly of the prolonged itch, irritation and discomfort if one did not. Lacking both the wherewithal and the courage, and further lacking anything at all pleasant save the knowledge that in mortal life nothing is eternal, I gouged at my offending foot, rose, swore at the towering mountain that mocked my puny efforts, and began to teeter towards the next enforced rest.