The British Journal of General Practice

viewpoint 1

The MRCGP - Change for whose sake?

The MRCGP has had a chequered but largely venerable existence, gradually evolving over the years. In the past, it encompassed new educational concepts and ideas in a slow, reassuring manner suggestive of evolution in response to changes in understanding and ideas, rather than the quick knee-jerk reflex of a Dangerous Dogs Act. Sadly, over the past few years this pattern has changed, and the latest modularization (sic!) of the College exam is another indicator of the turmoil that froths within the portals of the College — the wish to please a widening and shifting spectrum of opinion, while pursuing the noble ideal of enlightened self-interest.

Of course, many of the developments are positive, and will be welcomed by College and candidate alike: the ability to take the MCQ component early, thus prolonging the period before achieving a pass beyond all previously recognizable limits; the opportunity to embarrass the JCPTGP by having your video passed by the College and failed by the regional summative assessment process (a none-too-rare occurrence I hear); and, of course, the financial attractions of having four separate chances at failure, thus allowing modularization of the candidate's bank account in favour of the College's.

The disadvantages are pretty depressing too. Most of all is the not-so-subtle change in approach, which results in the MRCGP attempting both to trump summative assessment and to dismiss it as something altogether different — known in the trade as having one's cake and eating it. The significance of the shift in description of the exam from one of excellence to one of 'competence to join the College' is perhaps the most worrying and the least palatable for educationalists and candidates alike. Many know what the College seems to be forgetting, that competence and excellence are not different levels of pass in the same assessment – each examination must be tailored to assess its own outcome, and simply lowering the pass threshold in a distinction exam will not allow one to identify those of basic competence. This is further borne out by the current optional use of the MRCGP MCQ as an exemption to the summative assessment equivalent, a prospect that would be welcome to many examinees in practice if it were not so clearly intellectually risible.

A beacon lighting the path to the future is illustrated by a simple observation of the recent past. We have seen the College first embrace the use of video (following summative assessment), a step it never really wanted in honesty to take, and one which has thrown practical and ethical dilemmas before registrars and their trainers. The charge that this step has contributed to a profound damage to video as a formative tool is difficult to refute. Next it started talking of competence in relation to the MRCGP (after the debate over summative assessment), and now, finally, it has introduced the full use of modules — what a coincidence, just like summative assessment. While a reassurance to the contrary would be more than welcome, it really looks as if summative assessment has become the blueprint for the MRCGP of the future, a twist of circumstance which conjures up a wagging dog with a stationary tail.

Hopefully the MRCGP will improve its credibility in the future, and strengthen many of the commendable features and concepts it pioneered so successfully, such as openness, clarity, and a rigour resistant to the knockabout medical politics of the day. Perhaps, too, we will again come to recognize the true value of skilled close observation by a specialist educator, the GP trainer, in the assessment of both competence and excellence. In the meantime however, pass me another module.

Will Coppola

(... and a module, hot from Roger Neighbour, follows overleaf...)

The Back Pages...

contents

Computers, confidentiality and Caldicott

After the heady days of childhood, GP information systems are now adolescent, and, being at that sensitive age, are hitting problems. Up to now, the accepted dogma for information has been that more equals better, and the information-industrial complex so grimly personified by Bill Gates holds governments and planners in its thrall. This childish dogma is untenable in health care.

Part of understanding our digital adolescent is the recognition that information has a downside. Like a drug, it has to be used correctly, and has a narrow therapeutic index. Pursuing,the analogy, it behaves much like any other medical intervention with a predictable risk/benefit balance. The benefits are sufficiently hyped already, but the risks are laid bare in the privacy and safety debate now getting underway with the publication of the Caldicott report.

This Department of Health report was written following BMA criticisms of the NHSE's cavalier approach to privacy of patient information. The problem is that the NHSE inherited civil service ethics for its information handling, and the administrative mind is not content without all achievable information about the subject in hand, regardless of other sensitivities. In their code, decisions made on information are of secondary importance to having acquired the data. This historical approach clashes badly with the capabilities of the electronic age, and has spawned demands for information unmatched by any demonstrable need. Our GP culture of form-filling, and now electronic links replicating those forms, exemplifies an unnecessary demand for data which needlessly compromises patient privacy. Data in the wrong hands is dangerous, and patient confidence is too precious a part of health care to be sacrificed on the primitive altar of the NHSE's Information Management Strategy.

As we continue to find, the adolescent responds better if the reasons behind a request are explained. What we must teach our NHSE masters is the unpalatable fact that they do not require much of the information they currently seek, and that they will make better decisions with limited, appropriate data.

As the Caldicott report shows, the NHSE believes that identifying patients is justifiable or partially justifiable in all administrative data flows, even those holding clinical data. This assumption needs strong rebuttal if trust in digital health care systems is to be developed, and the benefits realized. This requires the entire NHSE to understand that there are unbridgeable differences between clinical and business information flows, and that personal information must be classified as identified, identifiable under stated circumstances, aggregated, or anonymized, and each of those data classes must be handled differently.

A gap in the Caldicott report is the question of patient consent. This gap is stated honestly, and does not devalue its principles and recommendations, but it limits the report's usefulness. It is unlikely the civil service will pursue the subject of informed consent unless pushed, but we clinicians may have to give that push. For to develop truth within an information system, both the processor and the subject have to feel confident in it. In health care, this means that patients must be told what will happen to information, and agree to it. GPs, more than most clinicians, are aware of privacy issues and must face these tasks of data handling and consent as the networking of health care increases, and they become *de facto* guardians of the patients' interest. It behoves every clinician either to take a firm view on whether data flows containing clinical information should leave the GP computing base at all, or else be prepared to justify to themselves or their patients the inclusion of identity within those flows. Without fully informed consent, society in the long term will rebel against electronic data handling, and its huge potential could be damaged.

Informed consent, identity separation, pseudonymization and aggregation are new subjects which other countries have not tackled, mainly because their insurance-based systems demand clinical detail for payment. This need does not exist in the UK, and clinicians must prevent the NHSE from adopting that approach, and destroying patient privacy for no good reason. The population needs the principles of privacy and informed consent to become second nature in administration if we are to mature into an adult information society, and if we have to update some tired civil service ethics on the way, then so be it.

Grant Kelly

Up to now, the accepted dogma for information has been that more equals better, and the information-industrial complex so grimly personified by Bill Gates holds governments and planners in its thrall. This childish dogma is untenable in health care.

Reference
The Caldicott Committee. *Report on the review of patient identifiable information* - Department of Health, publishing Dec 1997.

Job Shadowing...

During the early 1990s the North East Scotland Faculty of the Royal College of General Practitioners recognized the need to address the impact on morale of doctors working in a rapidly changing NHS. The faculty supported a series of general practitioner/hospital consultant conferences. These two day residential conferences have evolved with a clear structure and purpose. Delegates working in small groups have examined the general practice/hospital interface in great detail, e.g. outpatient referrals, telephone advice, quality of referral letters etc. The small groups have worked within clearly identified areas (e.g. ENT, day surgery, radiology) and, during each conference, have worked towards identifying a project or audit to complete in a six-month period after the conference and report their findings to a follow-up meeting held one evening for the delegates and any other interested colleagues.

The outcomes have included:
- a referral guidance booklet;
- newsletters (paediatrics, radiology);
- audit of non specific abdominal pain admissions;
- review of counselling services and training.

The last two conferences have drawn in trust executives, health board managers and nursing management colleagues. Their participation has added considerably to the quality of debate and discussion.

For the past three years delegates have been encouraged to pair off with a colleague of their choice and arrange to job shadow them. These have involved each delegate spending a whole working day in general practice or hospital or, in some cases, at the trust or health board offices, shadowing a manager. These shadowing experiences have helped to break down misconceptions and barriers on how services are planned and delivered to patients.

Feedback reports an 81% rate of satisfaction about the experience. Responders talked about having a clearer perception of the pressures of work.

In surgeries, hospital and management staff were consistently impressed with the friendliness between staff and patients in general practice. They also commented on the well-established levels of teamwork. They noted how much easier it was to make decisions and have them implemented in practice. Other comments included an appreciation of the quality of premises and the high level of information technology being used.

In hospitals, GPs commented on the high volumes of work being managed in outpatients and not always in ideal conditions. Some had forgotten how it was to stand and operate in theatre for a whole morning or afternoon. GPs were aware of the frustrations expressed by hospital staff in trying to "get things done and create change".

Our earlier conferences certainly reflected a high degree of tension between consultants and managers. At least at a subjective level this now seems to have changed.

As we move towards future conferences we anticipate that our job shadowing experience will soon involve GPs, consultants, managers and now our community nursing colleagues.

Denis Durno

viewpoint 2

"Pass me another module...."
asks Will Coppola.
OK, Will, anything to oblige...

Question 1 *(Multiple Choice)*
Mark each of these items *True* or *False*:
a) The 'pass' threshold in the modular MRCGP is unchanged
b) 'Excellence' includes 'competence', but not necessarily vice versa
c) The RCGP began development work on its video component in 1991
d) The cost of the MRCGP compares favourably with the exam costs of other Royal Colleges.

Question 2 *(Multiple Choice)*
Indicate the single best answer.
The current summative assessment package and the MRCGP use some rather similar test methodologies.
This suggests:
a) Conspiracy
b) Cock-up
c) Coincidence
d) Copy-catting
e) Informed consensus.

Question 3
(Critical Reading Question)
(Reference: Neighbour R (1997) 'Easier to take, no easier to pass' — the MRCGP goes modular. *Education for General Practice*, **8**, 227-231)
The author sets out the reasons for, and history of, recent changes to the MRCGP. In what ways, if any, might a knowledge of the facts have modified your rhetoric?

Question 4 *(Modified Essay Question)*
What are the pros and cons of the RCGP and the GMSC working together in the interests of vocational training?
Illustrate your answer with reference to:
a) The Cold War
b) The Berlin Wall
c) Apartheid.

Good Luck!

Roger Neighbour
Convenor, Panel of Examiners, RCGP.

Getting doctors back into practice — new initiatives

Dr Maureen Baker's paper in this issue looks at a recent pilot re-entry course for general practice. The aim is to provide doctors not working as principals, but qualified as general practitioners, with the skills and the confidence to enter the general practice arena once more.

Anecdotal evidence of a precipitous decline in the number of qualified GPs available and prepared to take up posts in general practice suggests that such an initiative comes not a moment too soon. But is there really a shortage?

The Medical Practices Recruitment Survey 1997[1], published in October 1997, attempts to address this question. It reveals that over a sample period this year, there were an average 4.2 applicants for principal posts in England and Wales. This compares with 4.0 applicants in 1996, but 5.7 in 1995. There are no comparable statistics for earlier years, but most of us remember the dozens of high-quality applications for every decent principal post only a decade ago.

Equally worrying, Department statistics[2] reveal that while the number of names on the medical list continues to rise, the number of whole-time equivalent GPs has been almost static for the past five years.

So what is being done to address the problem? Since the discrepancy between the number of vocationally trained GPs and the number of practicing principals continues to grow, there must be an ever-increasing number of non-principals. Some of these are recently qualified GPs who have chosen to work as locums or assistants rather than commit themselves immediately to partnership. The recently formed National Association of Non-Principals now has 750 members and provides a newsletter, information and peer support for non- principals.

The RCGP, recognizing the problems of morale and recruitment in general practice, set up an initiative called Revaluing General Practice. Dr Baker's pilot course was partly sponsored by this initiative.

The Women's Taskforce of the RCGP, set up in 1993, organized a network of Faculty women's representatives to provide a point of contact for women RCGP members facing problems in their career. It published a women's resource pack and organized surveys and workshops on a variety of topics of special relevance to women GPs.

By 1997 it was becoming increasingly clear that most of the issues pertinent to the work of the Women's Taskforce were shared by men. While there are still some issues relating to the conflict between home and work that are felt, on the whole, more keenly by women, most of the problems of today relate to career progress and alternative career paths within general practice. The work of the Taskforce has therefore been incorporated into the newly launched Career Support Forum, which seeks to address career problems across the whole career span of the GP.

There are also RCGP initiatives at faculty level. Wessex faculty, for instance, has set up a learner-centred re-entry course based on facilitator-led small groups. Two are already in progress, with another two starting in the next month. The members of the groups are predominately women who have taken career breaks for domestic reasons, and the course provides creche facilities.

In the West Midlands, a survey on the educational needs of non-principals has led to the appointment of Dr Betty Muller as educational facilitator for non-principals. She and Dr Ruth Chambers have set up another re-entry scheme for general practice.

The Medical Practices Committee has been working on another initiative to encourage doctors back into practice. It has been looking into the concept of the "special category doctor", vocationally trained but not working as a principal, with a view to offering approval for increasing the workforce within a practice if that practice can appoint such a

doctor. Unfortunately they have been informed by the NHS Executive that such a scheme is unlawful.

In London, the London Initiative Zone (LIZ) assistant scheme provided financial advantages to practices taking on an assistant under certain terms. The aim was to encourage hard-pressed practices to increase their workforce, to raise standards of care and to encourage vocationally trained doctors who did not wish to enter partnership to work in general practice. The scheme is about to come to an end, but it may provide the model for "Health Action Zones" in areas of special need across the country.

The Primary Care Act Pilots may pave the way for greater flexibility in general practice, allowing the development of salaried models of practice where they are most needed or wanted. At present there is no place for salaried GPs under existing part II arrangements, but this too may change.

The Retainer Scheme has come in for more than its fair share of criticism over the years, accused of failing to carry out its remit as an instrument of continuing medical education. The GMSC produced a paper earlier this year on a combined "Retainer-Returner" scheme, which seeks to update and improve the existing scheme. This paper is being used as the basis of negotiation with the Government.

With so many alternative models of general practice being developed, there are great opportunities for addressing problems and improving quality. We must be careful to remember that, while all these schemes have something to commend them, they must share a common aim — the promotion of high-quality primary care.

Sarah Jarvis

References
1 Medical Practices Committee Recruitment Survey 1997.
2 General Medical Services Statistics England and Wales. Department of Health, NHS Executive, 1 October 1996.

The National Association of Commissioning GPs
has recently published a document:
Restoring the Vision - Making Health the Incentive.
The report is the contribution of the NACGP to the autumn White Paper.

The report develops the way forward to fulfil NACGPs vision. This is stated in the report as follows:- "To develop a comprehensive NHS that is fair to those who use it and those who work within it, efficient and effective in its use of resources, sensitive to the needs of individuals and communities, and openly accountable for its actions".

The report emphasizes the importance of cooperative commissioning as the cornerstone of a system which will replace the internal market with an environment in which the improvement of local health becomes the primary incentive for developing the NHS.

The report's proposals include the following:
- Commissioning should be based upon achieving improvements in quality, effectiveness, responsiveness to local needs and clinical outcomes
- Incentives for change must be based on professional values rather than financial levers
- Public participation should be developed at all levels of commissioning
- Resources must be reallocated as soon as possible to achieve equality of funding between fundholding and non-fundholding practices
- An electronic information infrastructure should be developed to facilitate coordinated commissioning, procurement and provision of care.

The report recognizes that new legislation may be required in order to implement these proposals. Such legislation would inevitably replace the existing fundholding legislation.
The report's proposals point the way forward for developing a National Health Service that provides high quality, cost-effective and equitable care by a workforce for whom health provides the incentive.

Further copies of the report can be obtained from NACGP, 95 - 99 Holmfield Road, Blackpool FY2 9RS.

Keeping the prayer wheels turning

"If all politicians were like His Holiness the Dalai Lama, we would have no suffering and without going through suffering we would not have the means to reach happiness." My first encounter with Tibetan wisdom was from Sonam, the young woman who met me at Delhi airport and guided me though the torrential monsoon rain and nightmare traffic to my guesthouse.

I arrived there last August to spend nine months working as a volunteer doctor in the small Tibetan refugee hospital in Dharamsala, nestled in the foothills of the Indian Himalayas.

Younten was one of my first patients — a 27-year-old, newly arrived Tibetan refugee who had contracted TB of his spine and was paralyzed from the waist down. His medical outlook was very poor, and without basic aids and physiotherapy his legs were already stiff and contracted. I never saw him bitter or complaining and, like everyone else, he always had a warm smile for you as you passed by. The other patients helped to care for him, taking him out in the borrowed wheelchair, and he kept their spirits up in the evenings by his beautiful singing of traditional Tibetan folk songs.

TB was one of the most serious health problems that we faced, and frequently the TB ward was full with newly diagnosed infectious patients, up to a third with drug-resistant forms of the disease.

The under 5's clinic, the Tibetan Delek Hospital, Dharamsala, March 1997

Although we felt that life was fairly busy dealing with the general ward too and seeing up to 40 patients a morning in clinic, much of the healing in society was done by traditional Tibetan doctors using herbal remedies, and by Lamas performing divinations and pujas. I remember once wondering what good I was doing there at all when the TB patients got together to pay for a special Lama to perform a prayer for them, and by the next week they were nearly all non-infectious and able to go home!

There was one time when no-one wanted to leave and people were actually trying to be admitted, and that was when His Holiness visited to celebrate the hospital's 25th anniversary. The air was heavy with fresh paint for weeks beforehand as cleaning got underway.

His Holiness entered, smiling, head bent low and bowing with such humility, his sparkling eyes radiating love. We all received his blessing and encouragement and certain long-serving members of staff were awarded special gifts. His gift to everyone on that day, and always, is his living example of his teachings of peace and compassion. The idea of all beings having been your mother in a past existence, and therefore deserving kindness and respect, did occasionally cause some dilemmas. I treated eight people for nasty dog-bite wounds one day in a small settlement, and we were all aware that this was a case of rabies that could get out of control. The rabid dog itself was killed by a local Indian man, but the Tibetan community refused to countenance the idea of rounding up the other dogs, who might all have been bitten, and killing them too. Even when we found a scorpion in the area where the nurses' children played during the day, there was no question of killing it — it was carefully captured and set free outside. Back in this country I find myself being appalled at the casual act of swatting a fly or stamping on a wasp — things that I didn't think so much about before.

In the weekly check-up of new refugees, many of whom had walked the month-long trek over the Himalayas from Tibet, I saw and heard tales of immense suffering. I helped to write down the story of one young monk who had been imprisoned and tortured by the Chinese for writing "Free Tibet" on the wall of his monastery. I saw nuns who'd been raped, women who'd been forcibly sterilized, and small children who'd lost toes from frostbite on the harsh journey. And yet

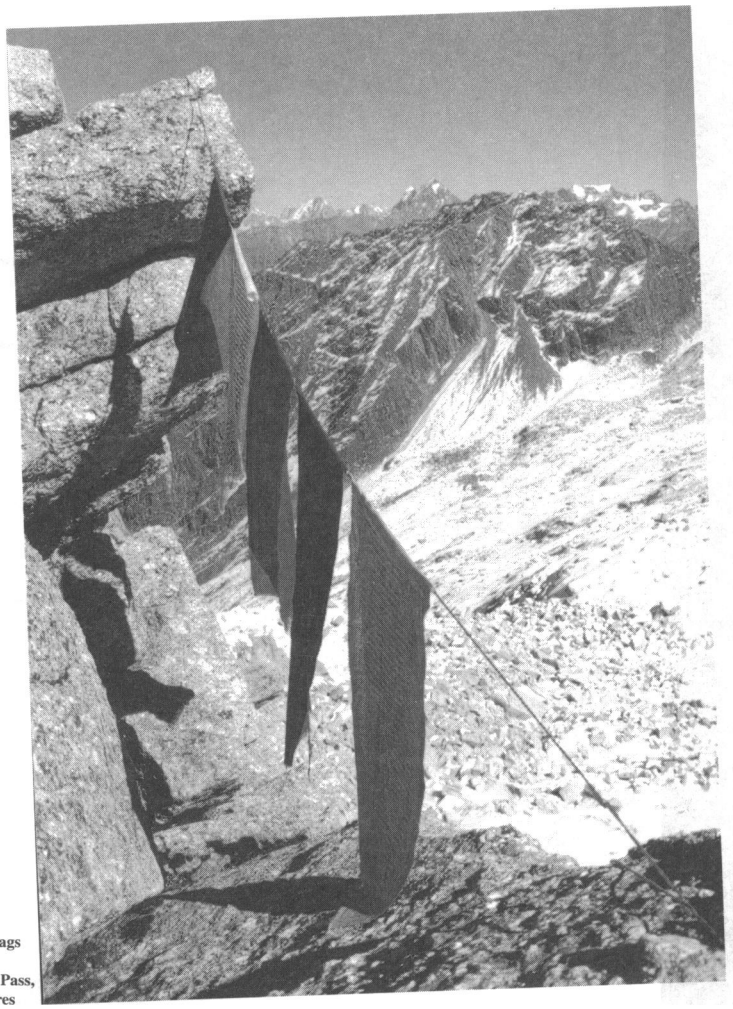
Volunteer medical posts at the Tibetan Delek Hospital in Dharamsala have been accredited by the RCGP/JCPGTGP as acceptable for general practice training. Further details from Alan Munro, **01463 870 237**

there was such a gentleness, kindness and a wealth of smiles from all.

One particular monk, Geshe Palden Gyatso, made a lasting impression on me. He had been arrested in 1959 when the Tibetan people rose up against the Chinese invaders but were brutally repressed by them. He was imprisoned and tortured for 33 years. When he was finally released a few years ago, he managed to smuggle out the equipment used to torture him, and he now travels the world trying to educate people about the situation in Tibet. He managed to survive his long imprisonment by meditating on compassion, he explains, and it is clear that he managed to survive not only intact but full of loving-kindness. A very special person.

There was one night that I felt the peace of Dharamsala completely shatter, and that was when three monks from the main monastery were found brutally stabbed and beaten. One, a much-loved teacher, was dead on arrival at the hospital, and another died soon afterwards. I accompanied the third, a young monk, on a nightmare five-hour journey to the main referral hospital, trying to cradle his battered head, and keep the drip and oxygen flowing as we were flung round the hair-pin mountain bends. The other monks in the ambulance chanted prayers for him but I could feel his life ebbing away, and he died just as we arrived at the hospital. His Holiness, speaking a few weeks after the murders, managed to make sense of the senseless, and somehow draw back the mantle of peace over the community. He talked of his deep sadness but also gently reminded everyone of the laws of karma; not in any way to justify the killings but to help develop compassion for the victims and perpetrators alike. He encouraged us not to focus too much on ridding the world of anger, but to look at the origins of anger within ourselves, as that, in turn, would bring peace to the world. "When people criticize me," he explained, "I use it to practise my patience."

These spiritual messages are the nourishment of everyday life there. As the sun rises above the mountains and its early rays pierce the clouds of incense on the holy path, people chant, spin prayer wheels, and touch their heads on the rocks engraved with mantras. Later, as they walk through the streets or come to the hospital clinic, the older Tibetans especially may be still chanting and keeping their hand-held prayer wheels moving. In between answering questions about their bowels or chest, the mantra continues under their breath and increases in volume as you check their blood pressure and write out their prescription. In contrast, other patients (often Westerners) would be trying to jump the queue and demanding to be seen as they had to be back in time for their next Dharma class!



Prayer Flags on the Indrahar Pass, 5000 metres

Acting as a channel for the healing power of the Medicine Buddha, the health worker performs his hour-long puja each morning, praying that all his treatments will work and that he will give peace to his patients. He has an unswerving dedication to serve his community with no desire for reward or thanks. No expectations — not even the thought of a holiday. "All you can do is your best," he says.

A good lesson, but so often I would feel overwhelmed and full of doubt. I vividly remember a woman in obstructed labour who was having diarrhoea with each contraction. There was no running water or electricity, and the road was washed away by the monsoon so there was no easy transfer route out. Luckily, with a team effort and a hastily put together, hand-pumped vacuum device, a healthy baby girl was born. There were many more occasions on which I had the opportunity to observe my inadequacy!

Coming back to the West felt like being slapped in the face by emptiness. Seeing a complex mesh of distractions that people cling to as being the substance of life when it is all as soft as a cloud. No monks or nuns in the streets, no prayer flags, and few smiles from passing strangers. So little to remind one of the spiritual path.

Towards the end of my time in Dharamsala, an old, wise monk was one of our patients and on each ward round he would reach over and bless us all, touching us with his scrolls. He asked us to return to our countries and pass on our experiences to others and tell people about the oppression of the Tibetan people. I hope that by writing this article I am honouring his blessing and all the blessings that I received while I was there. ***May all beings be well.***

Anne Dew

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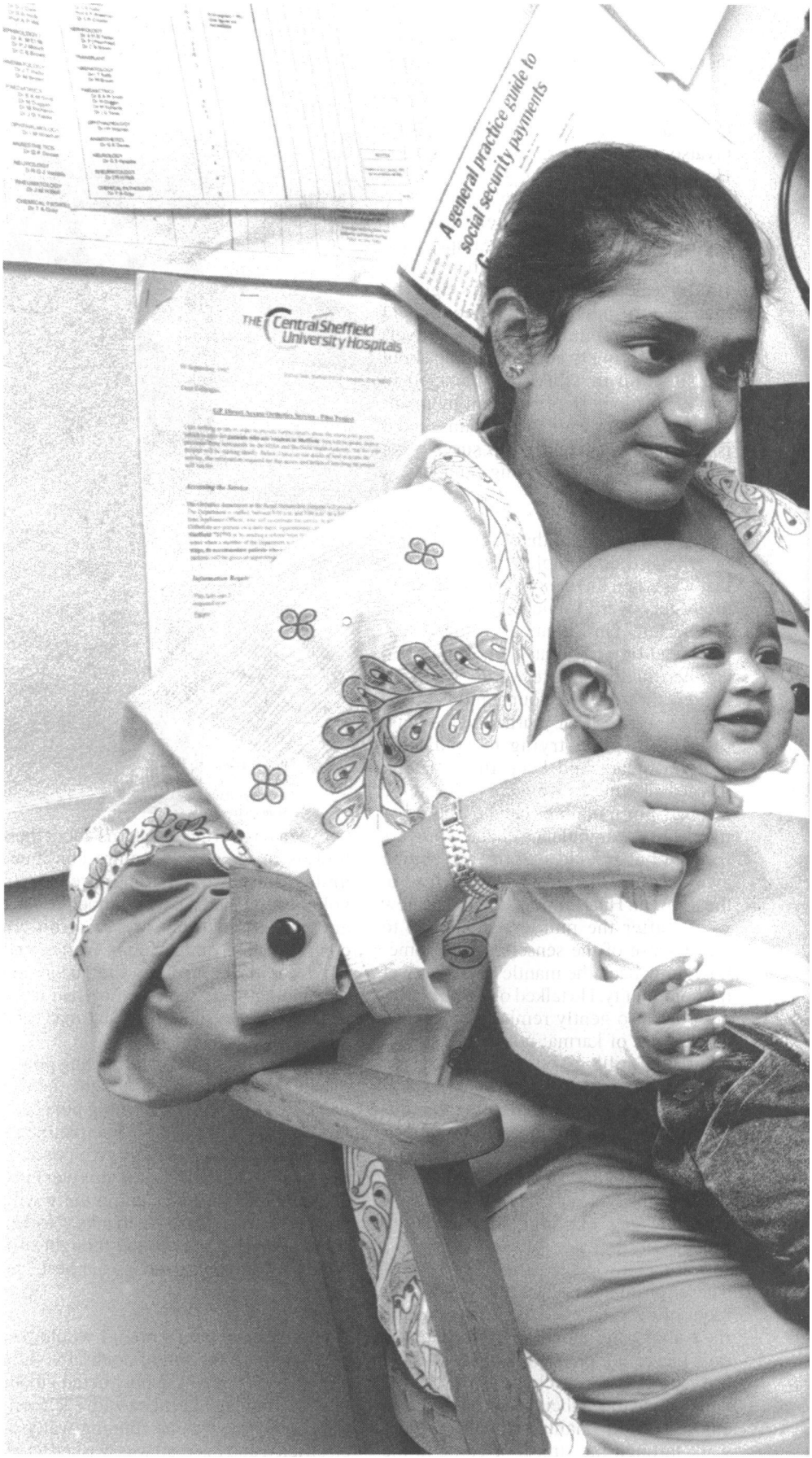
http://www.freetibet.org



Paul Schatzberger
Sheffield
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Camera Nikon F4
Lens 35-70mm f2.8 Nikkor
Exposure 1/60th at f8 bounce flash
Film TMAX 400

Subject
Dr Chris Walker, consultation, Damall Road Surgery, Sheffield. Monday evening surgery, July 1993

quality practice award in general practice launched

The Royal College of General Practitioners is inviting GP surgeries throughout the UK to put themselves forward to gain official recognition for their standards of excellence as it launches a new quality award geared specifically towards general practice.

The Quality Practice Award (QPA) in General Practice, which is being launched in Edinburgh on 6 November, aims to reward general practice teams who demonstrate a high standard of quality of care and service.

The award has been developed by the North East Scotland Faculty of the RCGP after it was recognized that, although there are currently several quality awards available to general practices, they were considered by many to look at processes and systems rather than outcomes. The QPA works by focusing on the key functions of general practice and has been developed to reflect the patient perspective by asking what they would expect of a practice that has achieved such an award.

All practices applying for the QPA will be required to meet set criteria ranging from demonstrating details of clinical care to health and safety issues, all of which must be submitted in the form of written evidence. The criteria will be regularly modified and developed to reflect ongoing changes in general practice.

Once a practice's application has been submitted and reviewed, preparations are made for a spot check and a day-long visit to the practice, during which the assessment team will interview staff and patients and inspect the premises. At the end of the day the practice will be given feedback and informed whether or not it has been successful in achieving the Quality Practice Award.

Dr Colin Hunter, Chairman of Scottish RCGP Council said:

The Quality Practice Award is an exciting development for general practice. It reflects the standards of excellence set by many of the other quality awards but with an added emphasis on criteria most relevant to general practice. It is anticipated that many practices will be interested in becoming involved in the award, which will undoubtedly enhance team development and interaction whilst improving procedures and ultimately patient care.

nhs 50

Were you practising as a GP in 1948?

On 5 July 1998 the National Health Service will be 50 years old. To celebrate the occasion, the NHS Executive is to hold a number of national events, which include conferences, exhibitions, shows, health promotion activities and a service in Westminster Abbey and will be producing a number of publications. As well as taking part in the celebrations, the College will be collecting reminiscences from GPs on what general practice was like in and before 1948.

Do you have any stories to tell?

Can you recall what technology was available then, what drugs were on the market, the most common diseases and what difference the introduction of the health service made? Do you have any 'fascinating facts' about things such as the first baby born on 5 July 1948 or pioneering treatments. Perhaps you remember your first surgery under the NHS and what patients you saw that day? You may also have some photographs from that period.

If so, the College's Public Relations department would like to hear from you. The intention is to produce a collection of reminiscences which could be made available to researchers, writers and journalists and possibly used in a College publication as well.

If you have a contribution to make, please contact
Anne Nicholls, PR Manager,
RCGP, 14 Princes Gate,
London SW7 1PU.
Tel: 0171 581 3232 ext 263.

rcgp/ppp healthcare commissioning fellowship

The first UK Fellowship to establish a better understanding of commissioning and provide guidance to GPs on its implementation has been awarded to Dr Judy Jones.

The new RCGP/PPP Healthcare Commissioning Fellowship will look into the issues surrounding the commissioning of care with the aim of enabling GPs to develop more effective health care commissioning skills. In the two-year post, Dr Jones will:

- Identify the educational needs of GPs involved in all forms of health care commissioning in primary care.

- Collate information about current activity and examples of good practice.
- Develop and/or stimulate the production of a range of educational opportunities and materials and disseminate them widely.
- Act as a channel for the dissemination of examples of good practice obtained from other sources.
- Consider the special needs of GP registrars for training in commissioning and how these needs might best be met.

Dr Harry McNeilly, Group Medical Director of PPP healthcare, who are funding the Fellowship, said:

"We are delighted to fund this Fellowship at the College in recognition of the President's long association with PPP Healthcare and also to be able to sponsor research and development into the important field of commissioning health services."

Dr Lotte Newman, immediate past President of the RCGP, said:

The College thanks PPP Healthcare for funding this Fellowship. I am confident that Dr Jones, as its inaugural holder, will make a significant contribution to the better understanding and utilization of commissioning GPs.

RCGP Christmas Closure

Please note that the college will be closed on the following dates:

From 1pm, Wednesday
24 December 1997.

all day, Thursday
25 December 1997.

all day, Friday
26 December 1997.

all day, Thursday
1 January 1998.

all day, Friday
2 January 1998.

A short history of socialized medicine... 3

MONKS and MONARCHS - Social Medicine in the Middle Ages

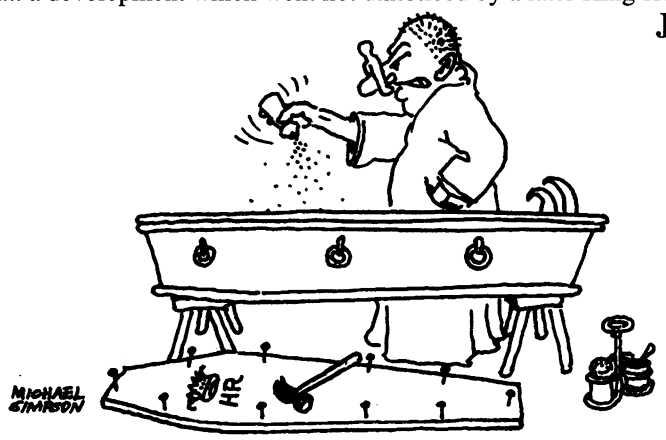
By 1050 a thriving Benedictine medical community at Monte Casino was in touch with the Greek and Arab worlds, while in nearby Salerno the first modern medical school became established. Here, theoretical speculation was re-introduced, animal anatomy taught from 1250, and the title "Doctor" first applied to medics. King Henry I was anxious for England to benefit and his reign saw a five-fold increase in hospital foundations dedicated to the poor or the infirm, such as the large leper hospital of St Giles-in-the Fields, founded at Holborn by Queen Matilda.

In 1140, Gratian, a monk of Bologna, codified the Canon Law, formalizing treatment rights for the poor by placing a moral obligation on property owners, enforceable by ecclesiastical courts. Doctors were usually priests: Richard Fitznigel, apothecary to King Henry II, an early part-time GP, combined his post with that of Bishop of London, while a Portuguese physician, Petrus Hispanus, even became pope. After 1130, clerics were discouraged from studying medicine, which became a wealthy lay profession organized by guilds and universities. Chaucer's physician had a "special love of gold", which was confirmed by a patient's view of Salernitan medical students: "... They are revered as omnipotent, because that is what they boast... Verily they have judged it unfitting ... to attend the needy ... their second maxim... has been added by enterprising doctors: 'Take your fee while the patient is in pain'" (John of Salisbury, 1159).

Practice could be unorthodox: a Bishop was offered castration for leprosy, and the Archbishop Thomas of York was recommended sexual intercourse on his deathbed in 1114 — with hesitation his Grace resisted! Monastic hospitals concentrated on regular diet, and intercession to patron saints: St Mathurn (mental illness), St Sebastian (plague), St John (epilepsy) and St Maur (gout). Sometimes mixing religion and the physical produced strange outcomes, such as the "fasting saints" who allegedly survived on only the consecrated Host. Patient compliance was not automatic; in 1135 Henry I died in France, following a meal of lampreys taken against physicianly advice. The body of the king minus intestines, eyes and brains was salted for return to England, though not before an attendant was alleged to have "died of the Stench"!

The Black Death, a virulent epidemic of Bubonic Plague, swept through England in 1348-49. With an initial mortality rate of 25%, the Death remained endemic for two generations, virtually halving the population by 1400. The resultant economic devastation was compounded by the Hundred Years of War, causing inflation and a labour shortage. Faced by growing debts and a recruitment crisis, monasteries had difficulties meeting their obligations to provide hospitality to wealthy pensioners (cordovans), travellers, the poor and the sick. A number applied to the crown for dissolution... a development which went not unnoticed by a later King Henry.

Jim Ford



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Why Dutch GPs do not certify – how murder helped

Starting from the late 1860s, infant deaths without prior medical attendance rose in some regions of the Netherlands to 25-50% of all infant deaths, from an initial rate of about 10%.[1,2] For example, in Hilversum in 1872, 410 out of 853 infants had not been seen by a doctor before they died. A suspicion grew that poverty-stricken parents were insuring some of their numerous children with a view to profit, and that many died with doctors called to confirm death rather than prevent it. In 1878, the Dutch Medical Association (NMG) started an inquiry that seemed to confirm that suspicion, especially in poor areas. Typically, for an outlay of fl 2.25 (coffin fl 0.8; gravedigger fl 1.1; sugar and brandy for mourners fl 0.49; death certificate fl 0.25), beneficiaries gained fl 8. To the NMG's call for action, the government replied that the State should not interfere with private business.

This situation changed when one woman, Goeie Mie (Handy Mary), was found to have poisoned 102 of her neighbours and relatives between 1881 and 1883, using arsenic, procured legally as flea powder. Twenty-seven died. Her nickname came from her readiness to nurse any sick person, so that the rest of the family could continue work, unaware that she also took out burial insurance on her patients, with herself as beneficiary. After poisoning her own sister-in-law, she took the three sons into her own home, insuring each of them twice. After an interval just long enough to avert suspicion, she poisoned two of them fatally. For two other children she charged the parents fl 2.15 for each week of care, insured them, poisoned them, and then charged fl 1.10 for laying out. Eventually, after poisoning an entire family of whom only the father survived, she finally met a doctor who asked questions before certifying death, and who discovered that she had insured the father's life naming herself as beneficiary. She was arrested the next day, twenty bodies where exhumed, and all contained arsenic. The Dutch being a kindly people, she spent the rest of her miserable life in prison.

The major public scandal arising from these events helped to set general practitioners in the Netherlands on an entirely different course from their colleagues in Britain and Germany. Both Bismarck and Lloyd George built national insurance systems around medical certification of unfitness for work, ensuring that prescription of money,

Eventually, after poisoning an entire family of whom only the father survived, she finally met a doctor who asked questions before certifying death...

set the course of Dutch general practice

through legitimization of benefit, was initially at least as important as prescriptions for medicines. In the first decade of this century, money was certainly a more effective treatment than medicines for most illnesses, because it could ensure minimum subsistence for families during sickness of a bread-winner. Medical professionalism seemed incapable of recognizing this, and thus of including this weapon in its armoury. In both Germany and Britain, doctors unsuccessfully resisted a central role as gatekeepers to benefit, arguing, in the words of Sir Clifford Albutt, that this would perpetuate the "perfunctory care, by perfunctory men" [3] already familiar from sweated Club practice.[4] Though, by the time of the Lloyd George Act, industrial insurance corporations were taking over the burial and sickness societies that had run Club medicine in British industrial areas, these local societies had built up the *de facto* British system of primary care ever since the late 18th century. Their administration was deeply rooted in neighbourhoods where everyone knew everyone else, with a shared concern to guard against abuse. This may have largely prevented the abuses uncovered in the Netherlands. No doubt, in that time of mass child prostitution and every kind of degrading poverty, Britain also had its Goeie Mies; but their business would have been on a smaller scale, and would never have provided a campaigning weapon for the BMA comparable with what she gave the NMG. British doctors failed to defeat imposition of a State insurance system, which, though certainly cheap and nasty, did provide an axial skeleton for what later became universal free medical care in the NHS. This was never completely attained in the Netherlands, where at least 30% of primary care is still based on private insurance, and all of it is fee-paid.

Dutch doctors, watching what actually happened to sweated medical labour in Germany and Great Britain, feared creation of a similar Arzten-Proletariat in what had been and remained a comfortable and dignified occupation.[5] They effectively blocked an Insurance Act in which they would have lost local control, and ensured that family doctors would not be responsible for certifying unfitness for work for their own patients. Instead, this was done either by each other for their colleagues, or by doctors who did nothing else, a principle described by Chief Medical Officer of Heath Sangster in 1996 as "a delicate heritage, to be cherished by all".

Certification of unfitness for work has gradually lost its central position in British general practice, and few mourn its passing. Most seem eager to rid themselves of the uncomfortable judgements it entails,[5] and partly justify this abdication from advocacy by assuming that certification by a third party would reduce work absence. Experience of sickness absence in the Netherlands does not support this assumption. In 1990, Dutch sickness absence was running at 7.1%, compared with 5% in Germany and 2.6% in the UK, with disability rates at 8.9%, 3.3% and 3.4% respectively.[7] These rankings have held stable for many years. Whether work absence can ever be much affected, positively or negatively, by gatekeeper arrangements, or whether it is even possible to judge fitness for work by any means other than asking patients what they themselves believe, remains an open question on which few seem to have sought evidence, despite the immense sums involved.[8,9] More probably, sickness absence simply reflects social morale and the balance of power and powerlessness between employers, the employed, and the unemployed. Family doctors knowledgeable about and sympathetic to their patients may do no worse than more independent arbiters, and possibly better.

However that may be, Goeie Mie seems to have helped Dutch doctors to get what they thought they needed. It's an ill wind that blows nobody good.

Peter Buijs
Julian Tudor Hart

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The Greatest Benefit to Mankind - A Medical History of Humanity from Antiquity to the Present
Roy Porter
Harper Collins
HB 831pp £24.99 (0 00 215173 1)

This is a big belter of a book with a perfectly potty title. It most certainly is not a bombastic assertion of the inestimable value to humanity of our great profession. Rather, it is a hugely enjoyable exploration of medicine and history.

The core is a history of Western medicine. But plenty of space is devoted to the relationship between health, disease and medicine on one hand, and, on the other, general culture and the flux of events. Enough is said about the classical Greek approach to life and the universe to afford a tantalizing glimpse of how Hippocrates and his colleagues came to think the way they did. The account of the colonization of the New World by smallpox and a few friends, with the Spanish as virtual bystanders, is breathtaking. From hunter-gatherer to heart transplant, a matrix of ideas and events is woven, seamlessly incorporating medicine, philosophy, science and history. For the medical reader a seductive spell is cast, coaxing us out of our burrows to look at the wider world which is the source of our ideas and into which the consequences of our actions diffuse indefinitely.

As the present day is approached, medical effectiveness is fully acknowledged, but the challenges become sharper. European doctors were recently deeply implicated in schemes of eradication of the unfit. It happens that the doctors were German. The cosy relationship between the state and medicine in the late twentieth century is sketched in terms of more subtle kinds of social control. Where conflict has arisen with government, for example over tobacco, our ineptitude is exposed. Considering the Black Report, Porter concludes that it is far from clear that the way to end class differentials in health is to provide more medicine. These later chapters are a torrent of comment on twentieth century medicine, from many viewpoints. Polemics and partisanship are absent. It is all driven at great pace by sheer breadth of observation.

I think there is a hint of confusion about just how effective modern medicine really is but, broadly speaking, I found the conclusions amply supported by the story. The prose flows pretty effortlessly, the material is well organised and anecdotally fascinating. For anyone interested in medicine's "What Next" questions, this book provides an indispensable context for modern medical perplexity.

A great read, and, at 800-odd pages, it would fill at least a few toes in most stockings.

Alan Munro

Stocking Filler I

A Sceptic's Medical Dictionary
Michael O'Donnell
BMJ Books, 1997
PB 209pp £15
(0 7279 1204 6)
... in which O'Donnell recounts, amongst other things, George Burn's staging of senility; first you forget names, then faces, then you forget to pull your zip up, and, finally, you forget to pull your zip down... A little gem of a book, guaranteed to enliven dull practice meetings and talks to the local WI... **AL**

Evidence Based Medicine: How to Practice and Teach EBM
Sackett D L, Scott Richardson W, Rosenberg W and Hayes R B
Churchill Livingstone London 1997
PB 256pp, £14.99 (0 443 05686 2)
Evidence Based and Cost-Effective Medicine for the Uninitiated
Tony Lockett
Radcliffe Medical Press Oxford (1997)
PB 93pp, £15 (1 85775 235 X)

Both these books are informative, stimulating and thought-provoking.

Tony Lockett starts with discussion of the current model for medical decision-making — 'muddling through elegantly' — and leads on to some of the problems associated with this, such as large variations in medical practice. Then he considers evidence-based medicine (EBM) as a professional decision making tool. He clearly expresses his concern about EBM, that evidence for its effects is difficult to generate and that, although many attempts have been made, these have mostly proved negative. In addition, if the principles of EBM are applied to medical practice, this leads to a utilitarian approach ('the greatest good for the greatest number'), with implications for resources distribution within a limited health care budget.

Sackett *et al* take the reader step by step through the search for best evidence; the critical appraisal of evidence; the application of evidence; and evaluation. The last section uses the principles of EBM to evaluate the efficacy of different strategies for teaching critical appraisal and concludes that, although the existing evidence is weak, it is supportive of current teaching methods for EBM. Examples relevant to the busy day-to-day clinical practice of GPs are included. EBM is an ideal topic for mentored groups of GPs to work through and would form a good basis for personalized learning plans and CME accreditation.

Lockett also looks at a cost-effectiveness model (CEM) for medical decision making as an alternative to EBM. The model is illustrated in detail using the example of eradication of *Helicobacter pylori*. This chapter leads on to the im-

portant conclusion that CEM-based medical decision making has not been associated with changing practice owing to the complexity of medical decisions. The valuable points are made that CEM is also associated with concerns about utilitarianism and market failure parallel to those seen in EBM, and a number of amendments to the process of CEM are proposed by the author.

As GPs working in the 'swampy lowlands' of Practice (as compared with the 'sunny uplands' of Academia) many of us will recognize that although the EBM and CEM models of medical decision making are crucial components in the provision of high-quality clinical care, they are not the whole story. Neither model concerns itself with the social and psychological aspects of illness, important considerations in the care we provide. A further problem in applying such models to our day-to-day care is that if there is 'no evidence' to support the provision of a particular service to patients, or if it is found to be not 'cost-effective', then logic would support its withdrawal. Indeed, neither EBM nor CEM is particularly concerned with process and it is extremely difficult, if not impossible, to quantify human suffering.

However, I do recommend both of these books highly, not only to anyone who is interested in current debates about the new models of medical decision making and the allocation of resources within the NHS, but also to those GPs who would like to make valuable additions to the 'palette of skills' they use in everyday practice.

Nigel Mathers

Whose Choice?

Saturday 1st November, Channel 4 TV

Channel Four Television marked the 30th anniversary of the 1967 Abortion Act by showing three consecutive programmes in peak evening viewing.

They looked first at the five-year struggle by the Abortion Law Reform Association to legalize abortion and put an end to the self-induced and back-street terminations, which were the highest single cause of maternal mortality in the 1960s. David Paintin, FRCOG, president of the Birth Control Trust and recent editor for the JRCOG, recalled the women — three to five on most days — admitted to his wards with 'incomplete abortions', and estimated that at least two thirds of these had been driven by desperation to the back streets. Most women, fortunately, got away without serious harm and he and his colleagues realised that they were seeing only the tip of the iceberg. A projected estimate of the incidence of procured abortion in the UK at that time was around 100 000 annually, so the central aim of the reformers was to make safe what was already taking place.

In Part Two, a trilogy of American films told the stories of three women from different decades whose lives were affected by abortion. Anti-abortion groups had already condemned these programmes as a blatant piece of pro-abortion propaganda. They had some reason in fact, because it is hard to imagine anyone, no matter how militantly 'pro-life', sitting through them without suffering some slight loss of confidence in their own moral judgement.

Finally, in 'After-Dark', a distinguished panel debated the issue for three hours without coming to any conclusion. A resolution of such fiercely held conflicting views would have been surprising but the 'sides' were numerically balanced and the brilliant level of debate made light work of sitting up so late to watch it. Dame Josephine Barnes, FRCOG, past president of the BMA, was a member of the committee which drafted the terms of David Steel's Act and also of the Review Panel which reported in 1974 that it was 'working well on the whole'. As a working gynaecologist before and after 1967 she had performed terminations several times a week 'at the end of each list'. She had found this part of her work unpleasant but these women were desperate and she did not see what else she could have done. She agreed with John Harris, Professor of Applied Philosophy at Manchester University, that 'unpleasantness' is not a guide to morality and that feelings of exasperation at a patient's seeming fecklessness should not dictate how she should be treated. John Parsons, from King's College Hospital, considered that a chaotic life-style lent even stronger grounds to a woman who wished to end a pregnancy she couldn't cope with.

It is not possible to reconcile the views of those who put the life and welfare of the mother first with those who put the life of the foetus first. By 3 am, however, the panel came near to agreeing, crucially, that morality and legality are not synonymous. In that case, would it not be reasonable to conclude that, as long as those with moral objections are not coerced, there is no supportable case for changing the law?

Joyce Poole

Rosa Lee

Leon Dash

Profile Books

PB £9.99 274pp

Medicine is interesting and trying to understand people is one of its most rewarding challenges. It can also be very frustrating when we come into contact with people we cannot understand because they live by an entirely different set of rules and values. People who have drug problems frequently fall into this category. Conventional medical research is singularly useless in helping us come to terms with such conundrums. Do other approaches help?

Leon Dash spent four years in close contact with an African American lady and her extended family who come from the hard core of the drug-abusing underclass in Washington DC. The result of his studies was this fascinating portrait of a bewilderingly chaotic group of people, and a Pulitzer Prize for himself.

This book has its faults; it is far too sanitized – I simply cannot believe that the language this family use is as genteel as reported – it is dotted with tiresome Americanisms and the glazed prose is cloying in many places. Undoubtedly this betrays the fact that the material in this book was originally produced for a series of articles in the *Washington Post*.

Despite its flaws, this book has some virtues that redeem it. Dash offers no explanations or justifications for what he observes. He has no glib solutions and at least his style, reminiscent of Alex Haley's, is easily accessible. Britain and America may be two countries separated by a common tongue but our cultures do like to mimic each other. This family will be instantly recognizable by any doctor who has worked in an inner city. It is unlikely that you will understand your patients any better after reading it, but I believe there is a value in observing such a family, if only to appreciate the universality of the problems such people face and that you are not alone in your incomprehension.

Rob Hendry

Sense and Sensibility in Health Care
ed **Marshal Marinker**
BMJ Publishing Group, 1996
PB 296pp £19.95 (0 7279 1111 2)

I see evidence of a trend. Discussions of Health Service organization and management have generally been in terms of management, business or social science. A new fashion has emerged, however — analysis in terms of literary criticism. At best these sorts of analysis can only be "as if" arguments, arguments by analogy or metaphor, and they can only be as valid as the extent of analogy or homology of the two systems. Viewing the NHS as a business is only as valid as the extent to which businesses and health care systems are identical, or at least similar.

This application of literary criticism has cropped up in my thoughts several times recently. It arose a few months ago when I was discussing the Japanese culture of Zen with some friends. We were talking about the stories in "Zen Flesh, Zen Bones" and other texts where Zen enlightenment enabled Samurai warriors to perform remarkable feats of arms, and I realized that we were discussing a literary situation, not a real one. If these Samurai tales were true, why were the Japanese always so far down the medals in the Olympics? There is a fine little piece by Alan Coren where, to paraphrase, he says: whilst I believe that the ceiling of the Sistine chapel is superior to a coat of Dulux by a very thick edge, I still wouldn't let Michelangelo baby-sit my two young sons; art and life are different. Another example crops up in a discussion between Will Self and Martin Amis when they describe Freud as a great novelist; exactly so. This goes some way to explain why Freud has such an impact on the Arts, but relatively little on the Sciences (two cultures indeed, to return to a literary model).

But enough circumlocution; what about the book?

The various chapters, or "essays" were written by individuals or small groups of co-authors, but with the participation of commissioning bodies, mostly national organizations concerned with the problems at hand, and were informed by think tank discussions; however the eventual text is the work and opinions of the authors. The participating bodies are generally listed for each article, together with the specific question being addressed (the partner; the question; the author(s); the think tank), but from all this novelty what emerges is a fairly familiar sort of book with concerns spread across the spectrum of current topics of interest to the medical profession. These include a series of essays into the relationship of the media and the case of the 'Child B', a child with leukaemia who was felt by medical attendants to be unlikely to profit from further treatment and who subsequently died following treatment elsewhere. The current hot topic of "evidence based medicine" also gets a well-balanced airing as does "the limits of professional freedom".

Curiously the most overtly political chapter, that on "the democratic deficit", appears to have no "partners" or "think tank", or at least they are not acknowledged; but there are some very innovative attempts to involve the public in decision making in the health service and these are lucidly discussed. There is one very ominous note for a potential reader. In the Introduction Professor Marinker comments on his editorial policy and remarks upon his difficulties with one particular chapter, that by John Spiers, which he describes as "deeply enigmatic". I would concur in this. Whilst this chapter contains remarks such as "... 'I' am not a probability but a person" (which is very apposite when we consider the regular failure of medicine to respond to the individual patient), there is much in this chapter that may be wise but to me is incomprehensible. The editor has sensibly, considering the title of this book, let the essay stand as it was received without trying to make it conform with some overall bland editorial tone, but it remains a serious intellectual challenge to the reader.

Nevertheless, this is an important collection of essays, the contents of which impinge on every day of our professional lives. It deserves to be read with care.

Dennis Cotton

Stocking Filler II

Love Thy Neighbour — a story of war
Peter Maass
Papermac, 1997
PB 289pp £10 (0 333 66983 5)
Maass was a war correspondent with the *Washington Post*, and spent 1992-93 in Bosnia. His book is a cathartic scream against the brutality of the Bosnian Serbs, and the hypocritical ineptitude of his government, and of the West in general. Should reportage be dispassionate? After reading this book and weeping, the answer has to be No. **AL**

Care of Drug Users in General Practice- a harm minimization approach
ed. **Berry Beaumont**
Radcliffe Medical Press, 1997
PB 208pp £16.95 (1 85775 236 8)

As drug misuse continues to grow in the UK, GPs are increasingly becoming involved in the care of misusers. There is little recent, comprehensive, accessible clinical guidance to help them. This book gathers the experiences of professionals providing treatment in primary care for misusers, with advice on effective and appropriate assessment and management.

There is much of interest here, the chapters aim to cover the field comprehensively, and it achieves its aim of presenting the essentials. Much of the content has an air of the personal view about it. Readers will pick up the enthusiasm of the authors for their subject, and should feel more knowledgeable and confident after reading it.

My main criticism is the differing style and approach between the chapters. Some are quite well referenced, others scarcely, if at all. Some, particularly those on assessment and medical care, rely heavily on lists. Such lists, whilst an excellent *aide-memoire*, need background and explanation in the supportive text to enable a critical approach by someone contemplating changing and developing their own practice.

Those reading the chapters in turn may find some repetition and minor contradictions as they progress and, as a consequence, may have preferred a clearer editorial style and approach. However, the variety of writing styles maintains interest, and the repetition enables chapters to stand independently. The contradictions point to the lack of absolute truth in this subject area, and hence the need to point readers to additional reading to enable them to inform their conclusions. Whilst the published literature is not overwhelming, it is scattered, and often in publications not readily available in postgraduate libraries. I feel an opportunity has perhaps been missed to supplement these authoritative practitioners' views with the background literature in support of their approach, and the main alternatives, without clouding the clarity of the practical message.

Those looking for a literature review in these days of evidence based approaches, or seeking to introduce a clinical service, will need to supplement their reading of this book with a wider exploration of the relevant literature. If the next edition provides a reliable means of achieving this, whilst maintaining its readability and enthusiasm, then it would be a real winner. I recommend this book, particularly to those new to the subject.

Mark Gabbay

The Doctor's Dilemma
Radio 5 Live, October 1997

"It's not the stress, it's the hours we work." Thus contributed a senior BMA spokesman on the above programme. This implausible logic was, fortunately, not completely typical of two reasonably put together, but confused, 30 minute documentaries hosted by Claire Rayner. I must confess I missed the first five minutes as I had expected them to be on Radio 4 rather than '5 live'. Somehow the juxtaposition of a serious consideration of the problems facing doctors in the NHS with the likes of Trevor Brooking and Sybil Rosco hadn't crossed my mind.

To the *Casualty* theme tune we were treated to a roller-coaster ride through nothing new to any of us, although, to be fair, medics were hardly the intended audience. In general, the profession was treated rather gently, although there were a couple of our esteemed colleagues who still seem to think Sir Lancelot Spratt a desirable role model. It was said, by someone who should have sought anonymity, that the biggest problem faced by doctors was "patients' bad manners". Additionally, discussing rationing, a well-known fundholder said everything would be OK if fundholders made the decisions on rationing, rather than (and he explicitly excluded them) health authorities, consultants and politicians. He really ought to familiarize himself with the Shaw play that gave rise to the programme's title to understand why rationing has to be a conjoint and, above all, public and accountable.

Still, it doesn't pay to be too critical. Apparently, according to several of the participants, worry about making mistakes and the stress of complaints are what doctors find most difficult. Someone also said they hated the stereotype of doctors as being omnipotent. It is a problem, of course, but who created it? Since Hippocrates, the Shamanistic element of medicine has been cultivated, refined, and exploited by all of us, with considerable positive therapeutic effect. It is a bit rich to set oneself up as apocryphally powerful and then carp about it when caught out. Doctors need to start being more honest about what they can and cannot do, what they should and should not do; and patients need to be better informed, more knowledgable about their own health, and a bit less dependent and generally less indolent in taking responsibility themselves. In management speak, we should be deciding on our "core business". At the end, Rayner said she felt the nub of the issue was communication, and, facile and simplistic though that undoubtedly is, she's quite right.

Her style, is, in truth, perfect for this kind of thing. I ought to dislike her, but really I can't. Talking nineteen to the dozen in her unmistakeably mumsy way, she rattled through an impossible task (try dealing with the whole NHS in an hour!), almost never missing a trick. Of course, she knows the area well, having qualified professionally herself, having been famously self-analytical, and being chairman of a Trust. I've long thought the NHS needs serious public reconsideration, and I had thought the best way would be a Royal Commission; now I'm not so sure. How about a Task Force with Claire Rayner for Health Supremo?

Stephen Hunter

Little Known Museums in and Around London
Rachel Kaplan
Harry N Abrams Inc, 1997
PB 216pp £13.95 (0 8109 2699 7)

The National Museums and Galleries — packed with the great posessions of State — stun you to silence, with profusion of pillar and portico, high ceilings, vast expanses of marble flooring, and huge echoing space. The voice is lowered, the breath bated as, with eyes and mouth wide open, we struggle to comprehend the artistic largesse before us. But, such largesse blunts the mind and its eye, and paralyzes perception — and this is where we turn to Rachel Kaplan's gem of a book. Herein are described thirty museums, large and small, in and around London, ranging from the wild Baroque of Waddesdon to the almost tangible squalor of the old St Thomas' Operating Theatre.

There is something for everybody. The Eternal Small Boy can gawp happily among the warplanes at Duxford. The Social Aspirant can ponder the Museum of Eton Life. The Social Historian can trace the development of the English domestic scene at the Geffrye Museum. You can also learn about the Dickens Museum, Dr Johnson's House, and the Freud Museum — these, in particular, are places whose size confers an intimacy, a humanity, and a reality that brings you into touch with their subjects, their circles and their times.

Rachel Kaplan reminds us, through her photography and her succinct, lucid prose, of the existence of all this, and makes us realize what an exciting world of history and learning is so near to us. For Londoners, at least, weekends need never be dull.

Michael Lasserson

rcgp publications

RCGP Handbook of Sexual Health in Primary Care
Yvonne Carter, Catti Moss, Anne Weyman (Eds)
Price £16.20 m £18.00 nm (0 85084 238 7)

This handbook offers practical guidance on sexual health care for those working in a primary care setting. Written by a team of experts, this accessible handbook covers a broad range of topics with chapters on:

- taking a sexual history
- well woman and well man issues
- planned and unplanned pregnancy
- building primary care teams for sexual health
- confidentiality
- making services as accessible as possible
- sexually transmitted diseases
- building primary care teams for sexual health.

Each chapter identifies key messages and lists the most important interventions that a GP or practice nurse can make to ensure optimum care. Designed to be dipped into or browsed through at length, the book will be invaluable for all busy practitioners.

" ...all those in primary care will find the information in this handbook clear to understand and simple to incorporate into their everyday experience."
Sir Kenneth Calman, Chief Medical Officer.

The Human Side of Medicine - Occasional Paper 76
by **Martyn Evans** BA PhD and **Kieran Sweeney** MA MPhil MRCGP

This latest Occasional Paper from the RCGP brings together two recent lectures, Pictures of the Patient: Medicine, Science and Humanities, and The Information Paradox. Their common theme of evidence based medicine is examined from two different and illuminating angles.

In the first of these lectures, Martyn Evans builds up an intriguing "picture of the patient" as a multi-faceted individual. The challenge posed to the GP, to reconcile the different aspects of the patient, is explored from a number of different perspectives including medical economics, sociology, science and philosophy, which clarifies the place and variety of evidence in modern general practice.

In The Information Paradox, Kieran Sweeney examines the current role of evidence based medicine in general practice. At a time when the medical profession is experiencing an explosion in both the quantity and quality of information, this very abundance may distract from the doctor's primary responsibility, the relief of suffering.

Together, they provide a fascinating insight into one of the most topical issues in contemporary general practice. The Human Side of Medicine prompts the medical profession to embrace a complex and stimulating paradox and to weigh the advantages of evidence based thinking against its principal shortcoming, its failure to recognise context and uniqueness.

Available from December 1997 through the Sales Office at Princes Gate.

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The *BJGP* is keen to publish images that in some way define the nature and mystery of general practice... *General Practice in Camera.* Please submit photographs to the Journal office. Signed consent for publication from all subjects must accompany submissions. A fairly miserly fee may be negotiated...

diary

DIARY OF EVENTS FOR 1997/8

Dec 11
Study Day on HIV/AIDS
Dec 17
Christmas Lecture for Schools

1998
Jan 14/15 Assertiveness Skills Course
Jan 22/23 Minor Surgery Course

Feb 10-14 MRCGP Course

Mar 24
Conference on Medical Negligence
Mar 31
Conference on A&E Medicine

Apr 17-18
Spring Symposium (Exeter)
Further information:
please telephone
01395 567 808 or 01392 403 031

May 11-15
International Course on Developing Teaching Skills- Module II
May 21 Research Symposium - Regent's College

Jun 4 Study Day on
Counselling in General Practice
Jun 11-14 WONCA (Dublin)
For further details please contact the Irish College of General Practitioners
Tel: + 353 1 673 3706 or
Fax: + 353 1 676 5850

Sept 8-12 MRCGP Course

UNLESS OTHERWISE STATED, ALL EVENTS TAKE PLACE AT RCGP, 14 PRINCES GATE.

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

James Heathcote

On Book Reviews and Other Perversions

I swim once a week, enjoy a fried breakfast, record the *Archers* if I can't listen to it live and shave every other day. I also enjoy book reviews.

So why? What sort of person reads about books, and if we knew more about such people would it help to write better book reviews or would we stop writing them altogether?

A good review should encapsulate an essential truth, if not the whole message, of the book in question. A tasty morsel of information, a witty quote, a one line summary of a ten chapter theory all tell me something. Lists of chapter headings, empty praise and a cliched injunction to "buy it for the practice library" leave me none the wiser. The good review both tells me why the book has been written and whether I should enjoy reading it.

A review can also be enjoyed in its own right. Unpretentious, informative, concise and sensitive writing does justice to the author under scrutiny. The genuine enthusiasm of a fellow reader sells the book far better than the publisher's hype, and minor criticisms make the work under review no less attractive. No one expects perfection.

Just as I enjoy reading about a good restaurant in some far flung city or a new play that I know I shall never see, I enjoy a well-written review. To read the review is to dream of reading the book itself. The review is an aperitif; it stimulates the reader's appetite. Yet sometimes a good review may paradoxically deter me from reading the book itself. Reading the review has conveyed its very essence and so I longer need go out and buy a copy!

Many years ago at school I ran the book shop and could talk knowledgeably, though not at length, about Moorcock, H.E.Bates and Isaac Asimov. As a student, I bought popular LPs for a record library — Genesis, Santana and E.L.O. — on the recommendation of others. And now I precribe anti-depressants, therapists and operations on a equally indirect basis. It's impossible to experience everything personally. Reviewers understand this and provide a convenient short cut for the busy (or lazy) reader.

So who is this reader and what does his profile tell us? "Swims once a week" - insufficient, but better than nothing. "Fried breakfast" - appreciates simple things done well. "*Archers*' addict" - enjoys low drama and samples life through the experience of others. "Occasional shaver" - genetically programmed, a freak of nature.

web sites of the month

Hey Doctor BJ
Found this cool website at **http://www.rcgp.org.uk**. It's the homepage of this organization called the Royal College of General Practitioners of something:-) It's got all sort of stuff from information about the College exams to practical guidelines for Docs to use in surgery!! There's also useful advice for patients (which the Docs can use too) about when to call out your Doctor. This is the sort of thing that the Web is actually useful for.
Another cool site I found whilst browsing around is UKMED3 **(http://www.ncl.ac.uk/~nphcare/GPUK/a_herd/topmenu.htm)** run by this wacky cyberphile Andrew Herd (a Doc from somewhere called Newcastle?!!). Whoever he is he pulls no punches on his editorials...really interesting. Lots of useful links too...
Check it out
Rob Wilson, Sowerby Centre for Health Informatics **http://www.schin.ncl.ac.uk/**

our contributors...

Sarah Jarvis is a full-time GP principal and a board member of North and West London Faculty of the RCGP

Grant Kelly is Chair of the Information Management & Technology Subcommittee of GMSC and a GP in Chichester. He is most accommodating.

Dennis Durno has retired from general practice in Aberdeen

...after Nine Months Near Tibet **Anne Dew** has succumbed to 'Dithering Doctor Syndrome', finds difficulty in settling back into general practice, and has ended up working for the Free Tibet campaign

Will Coppola is a lecturer in general practice at the Royal Free in London

Paul Schatzberger is both a GP in Sheffield, and a professional social documentary photographer. He has exhibited in London, Edinburgh, Cuba and Mexico

Julian Tudor Hart is Visiting Professor, Department of Primary Health Care, Royal Free Hospital Medical School, and generally famous

Peter Buijs is Senior Consultant in Social Medicine, Dutch Institute of Working Conditions, pb. 75665, 1070 AR Amsterdam, Netherlands

Nigel Mathers is Director of the Institute of General Practice and Primary Care in Sheffield

Joyce Poole has retired to rural bliss in Kelso in the Scottish borders

Dennis Cotton is a Consultant Dermatopathologist at the Royal Hallamshire Hospital, Sheffield

Mark Gabbay is a lecturer in general practice at the University of Manchester.

Stephen Hunter is a consultant psychiatrist in South Wales, and has not always been so respectable

James Heathcote is a GP in Bromley and until recently edited the splendid RCGP SE Thames Faculty Newsletter

Bruce Charlton has a job. Huzzah!

All our contributors can be contacted through the Journal office

Bruce Charlton

Serendipity

Many of the biggest therapeutic breakthroughs were made by chance — think of Alexander Fleming. A yeast floats through the window, lands on a plate of germs, kills them — and out pops the Nobel Prize for penicillin. Or so the story goes. Maybe ninety-nine of a hundred people would have cleaned out the Petri dish and, inadvertently, destroyed the evidence. The trick was to know what to notice, and what to ignore; to choose when to act upon the one-off.

Such is serendipity — the knack of making discoveries by happy accident. It is unplanned research: a kind at which clinicians have often excelled. This being the case, I wonder why serendipity isn't commoner in general practice.

How does serendipity work? It takes more than mere luck to make such discoveries. Louis Pasteur was wont to say: "Chance favours the prepared mind". The art of serendipity is to be surprised by the relatively unexpected. Until the mind is prepared, we do not know what is significant.

Our current obsession with statistics might be another reason why serendipity is so seldom seen. The lethal combination of medics with little understanding of statistics, and statisticians with even less knowledge of medical science, has led to the foolish idea that a doctor cannot learn from treating patients, but only from large randomized trials done by other people on other patients in other places. The consequence is that potentially enlightening cases are dismissed as 'anecdotes'.

But there are no guaranteed methods of discovery; and anyway large randomized trials are designed to measure already known things, not to discover the unknown. Noticing and reacting to one-off happenings in single cases is a valid and necessary element of rigorous clinical research. Noticing is the quintessential creative act: as has been confirmed by several recent publications on the history of therapeutic breakthrough. There is nothing irrational about serendipity.

Serendipity presupposes several things — an interest in discovery, relevant background knowledge and the capacity to be surprised by experience. One reason that GPs fail to make these discoveries may be their lack of interest in clinical discovery — their primary role being, of course, to help patients. Another problem may be lack of knowledge of the kind of clinical problem to which their patients may provide the answer. The ability to be relevantly surprised is certainly not lacking.

What is in short supply is confidence that the ordinary GP can make a significant contribution to research on the basis of patients seen in routine practice. Yet it is highly probable that the clinical equivalent of the patchy Petri disk turns up in surgery from time to time, just waiting to be noticed.

Of course the whole thing might turn out to be random variation, or surprise may be a product of ignorance. And even if there is a genuine nugget of knowledge, Nobel prizes are thin on the ground. But equally, something clinically significant might be staring you in the face, waiting to be recognized. When serendipity strikes, be the one who acts, not one of the ninety-nine who are too busy, shrug their shoulders and wash away the evidence.