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viewpoint

From The Royal College of General Practitioners to the College of Primary Care?

A healthy society depends on change for its survival, but Britain remains littered with organizations that don't know when to call it a day: the House of Lords, 'Top of the Pops', St Bartholomew's Hospital, to name but three. Can the RCGP seize its historic opportunity, or is it destined to join the queue for the history books?

There may be cause for cautious optimism. At this year's meeting in Exeter the College demonstrated that it was at least capable of asking the right question. The debate was: 'That the Royal College of General Practitioners should be replaced by the Royal College of Primary Care.' Profession, privilege, power and precedent were the recurring themes.

The concept of profession is relatively recent. With the birth of the modern age and the application of science to medicine in the early 19th century, competence to make judgements about the nature of reality shifted from life experience, in which patient and doctor were roughly equal, to one based on technical experience, where private judgement was surrendered to expert authority. With time, a number of stereotyped roles evolved, whose consolidation by association, and confirmation by legislation, made reversibility and integration increasingly difficult. However, society was developing into a more horizontal, egalitarian system, where the empowered consumer was demanding access to the once privileged base of medical knowledge. As expectations rose, professions came under increasing scrutiny - and were found wanting.

Fugelli[1] has suggested that patients and doctors are actors in a play written by history, directed by culture, and produced by politics. Closer to the truth, the script has been written by health professionals, directing a plot that seeks to maintain the professional status quo, and produced by narrow training and historical precedent. Hapless patients look on as innocent spectators, to a narrative sustained by power and privilege, and derived from esoteric knowledge: 'the mystery of general practice'; 'our sovereign professional territory'; 'our historic virtues distilled through time'.

However, today's performance is one where partnership and flexibility are becoming the key themes, where primary care is to be delivered by a team of mixed professionals, and where the evidence base suggests that not only can nurses provide many of the interventions that doctors undertake but can do so with better outcomes. For our profession to monopolize a mystical role based on compassion and caring infers an exclusion from a grace that is common to all - which should be promoted in every citizen, whoever they are. We should all be co-producers of the unfolding pageant.

In the next century, primary care medicine is being redefined so that it involves not just a relationship between patient and doctor, but the organization of programmes that deliver health care. Yet we remain constricted by an almost overbearing precedent. Laden with our burdens, we jostle for our places in the new Health Service.

Meanwhile, the College dithers - keeping its options open while all around changes; recognizing the danger of becoming like some ancient geological formation - ossified, fossilized but, like an animal trapped, too terrified to break away.

We can look back with pride on all that our College has achieved, but there must be fundamental change within all our professional frameworks. The world is moving on, and we must move with it - accepting the challenges, and seizing the opportunities that are within our grasp. We should aim to speak as one voice from primary care, and not on basis ourselves on the anachronistic dictates of tradition and historical prerogative.

The College must carefully examine the baggage that it carries - for to survive it may be wise to travel light.

D Kernick

1. Fugelli P, Heath I. The nature of general practice. *BMJ* 1996; **312:** 1456-1457.

The Back Pages...

"the... commitment of the GP to the needs of the individual patient, and the obligation to serve as each patient's advocate within the system, are threatened both by notions of corporate responsibility and by the requirements of rationing..."

Heath on the 1990s, page 1542-1543

contents

The Association of University Departments of General Practice Annual Scientific Meeting, Edinburgh, 1998

The 27th Annual Scientific Meeting of the Association of University Departments of General Practice was held in Edinburgh from the 8th to the 10th of July, and attended by over 300 delegates. What can be said about a conference consisting of plenary sessions, workshops and parallel paper sessions, and poster presentations? It would probably be fair to say that it is the events outwith the main academic presentations that stick in the mind. The decision to hold the annual dinner at Murrayfield Stadium, accompanied by a pipe band beating the retreat gave a truly Scottish flavour to the proceedings. The after dinner speech by Sir David Carter, the Chief Medical Officer, was a timely reminder that medical politicians can be very amusing people, and his droll remarks about general practice will probably linger long in people's memories.

Given that the main aim of the conference was the presentation of original work, one of the main themes of the plenary sessions was the extent to which the current academic infrastructure in primary care can support the rapid increase in funding, as research networks and research practices present additional demands on University Departments which are not always fully appreciated by those with limited experience of research. It is often assumed that advice on design and analysis is constantly available, yet few departments can extend their current responsibilities without a concurrent investment in support staff.

The process of construction of the scientific programme was developed according to a set of principles, which included a smaller number of papers presented to larger audiences to allow for fuller discussion, and abstracts selected on the basis of quality and interest to a general audience. A total of 270 abstracts were received with 96 (38%) being accepted for paper and poster presentations. Paper presentations covered undergraduate and postgraduate education, clinical research, organization of care, and patients' views of health care delivery. It would be impossible to summarize all the presentations; suffice to say that a large variety of relevant issues were covered.

So what were the lasting memories of this year's Annual Scientific Meeting? On the positive side, the AUDGP is alive and well, with a young and thriving membership; standards of research presentations were high and social events were thoroughly enjoyable with Edinburgh providing contrasting settings, from the imposing Murrayfield Stadium to the magnificent Playfair Library at the University of Edinburgh.

Unresolved issues related largely to how the Association can retain the traditional values of general practice while embracing the broader concepts of primary care. In addition, the support the departments can provide for the NHS R&D programme is going to be limited by current staffing structures in universities. No doubt these matters will be revisited at the 1999 conference in London.

Final thoughts in 1998 have to be about the considerable effort by many people in Scottish Departments who ensured the success of the conference. Special thanks were certainly due to Jill McDonald and Aileen Vaughan, who were responsible for the majority of the administrative arrangements.

John Bain

Gongs Galore...
At Dublin WONCA recently, the following awards were noteworthy: The Hippocratic Medal to **Godfrey Fowler**, Honorary Life Membership to **Alastair Donald**, and Fellowship to **Douglas Garvie**. Meanwhile, in Canada Professor **Ian McWhinney** has been appointed to the Order of Canada. In the Royal Borough of Kensington and Chelsea, College member **Jonathan Mundy** has been elected Mayor. And at the 127th Open Championship, Royal Birkdale, resplendent at the prize-giving, was the Captain of the Royal and Ancient Golf Club of St Andrews, **Sandy Mathewson**, formerly a GP in Wishaw, Lanarkshire, and an MRCGP.

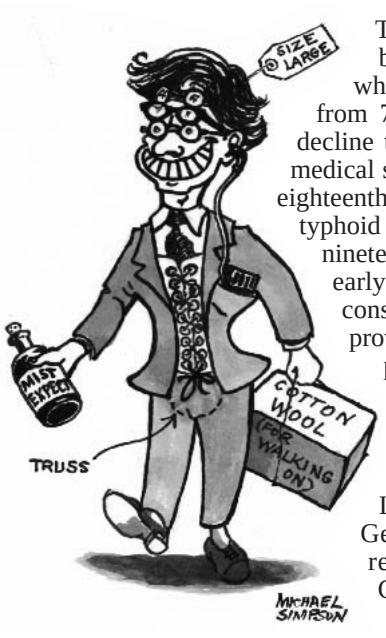
A short history of socialized medicine... 11

BORN ON THE FIFTH OF JULY- NHS dawn heralds GP college

When the NHS opened its doors on the 5th July 1948, patients swarmed into GPs' surgeries, as they had in 1913, seeking 'free' corsets, false teeth, spectacles, and even cotton wool to decorate the Christmas tree. Losing the right to sell practices, GPs gained much that the BMA had sought before the war – access to specialists, capitation for dependents, and removal of the Approved Societies. It was a long fight, with Aneurin Bevan described as a 'medical Führer and his NHS Act as 'the greatest seizure of property since Henry VIII confiscated the monasteries'.

In a BMA plebiscite, 17 000 GPs voted against his service, wishing to remain independent of Consultants, Medical Officers of Health and the Civil Service. Bevan saw the writing on the wall and dropped salaried service, a historic Labour policy ascribed to Beatrice Webb. Bevan's charisma charmed Ministry of Health officials, and BMA leaders – despite the *BMJ*'s warning that the Welsh character Aneurin, from whom he took his name, was both a warrior and a bard!

However, the price that GPs paid for independence was an income calculated from pre-war tax returns. A persistent group of GPs and others formed a College Steering Committee, and lobbyied to create an academic headquarters for GPs to raise standards and status, retain practitioners and attract recruits. They were encouraged by a respectable pay award in 1953, and also by the Worshipful Society of Apothecaries, which offered the fledgling College meeting rooms at its historic Blackfriars Hall. This ancient Society had midwifed the academicization of undergraduate training for GPs between the 1815 Apothecaries and the 1858 Medical Acts. Extensive efforts to found a College of General Practitioners during this period were opposed initially by the College of Physicians, and later the College of Surgeons.



The NHS valued the holistic and generalist branch of the UK profession, unlike the US where the proportion of GP physicians declined from 73% in 1928 to 49% in 1942, with a further decline to 12% by 1989. GPs had long contributed to medical science - including Withering and Jenner in the eighteenth century, Snow and Budd (who distinguished typhoid and typhus in his remote Devon practice) in the nineteenth, and James Mackenzie, who invented an early ECG while a GP in Burnley. The isolation and constancy of practice, with the practice population providing a denominator, permitted mapping of the progress of infectious diseases within individuals or commun-ities. However, this very isolation impeded the development of research networks.

In the absence of University Departments of General Practice, the eminent but shy GP researcher, Will Pickles, who became the College's first President, used Ministry contacts to disseminate his epidemiological work. It was not until 1963 that the first Chair of General Practice was est-ablished at Edinburgh. The first English professor was the legendary Patrick Byrne at Manchester, and only as recently as 1996 were professors appointed at Oxford and Cambridge.

Jim Ford

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The need for secondary research

Medical research is getting bigger. The MRC streptomycin trial, published in 1948 and discussed in my previous article,[1] randomized 107 patients. It changed medical practice overnight, and no further clinical trial of streptomycin in pulmonary tuberculosis was ever called for. More recently, 13 000, 37 000 and 43 000 patients with myocardial infarction have been randomized respectively to receive β-blockers,[2] thrombolytic therapy,[2] and transdermal glyceryl trinitrate.[3]

There are two main reasons why research is getting bigger. The first is that today's new therapies are, with few exceptions, incremental (and often marginal) improvements on something that already works. The second is that medical science increasingly demands not just an estimate of the *magnitude* of a particular effect, i.e. 'how beneficial is this drug?', or 'how well does this test predict the presence of disease?', but a measure of the *precision* of that estimate, i.e. 'if the trial suggests an effect size of *x*, what are the limits within which the real effect size might lie in practice?'. Larger trials give more precise answers. (see Table 1.)

Most clinical trials in the medical literature are underpowered – that is, they contained too few participants to provide a definitive answer to their own research question. Secondary research is the task of finding, and combining the results of, all valid and relevant trials in a particular clinical topic. Table 1 shows the different ways in which the research of primary studies may be combined, and hints at an ongoing controversy in academic circles on what is the 'best' of these different methods. (The general notion that any form of secondary research should have a methods section, i.e. a statement in the published article of *how* the studies were selected, analysed, and interpreted – is no longer contested.)

Table 1

Design	*Features*	*Advantages*	*Disadvantages*
Narrative (or ad hoc) review	Traditional, editorial style review in which author cites studies that support a particular viewpoint	Can be quick to produce, readable, and grounded in the reality of clinical experience author's anecdotal experience	Choice of which studies to cite, and how to interpret them, is obscure and liable to be serious, biased by
Systematic review	Review which comprises: • literature search for primary studies with comparable aims, methods and outcome measures • evaluation of the relevance and quality of each study, using explicit predefined criteria • abstraction of data on methods and results	Assures, at least in theory, a valid summary of the current state of knowledge, ignorance and uncertainty in a particular field Methods of study, selection and analysis are published and can therefore be verified (or challenged)	Time consuming to prepare, hence may be out of date before it appears Even with explicit predefined protocol, bias can occur in: • selection, e.g. selective publication and citation of 'positive' or 'significant' results, selective disclosure of unpublished data by primary researchers, or exclusion of non-English language studies • analysis, e.g. assigning high 'quality' ranking to trials which support a favoured hypothesis
Meta-analysis	Systematic review with additional fourth step • statistical analysis of numerical results to give overall estimate, with confidence intervals, of average effect size	Produces a single, precise estimate of benefit and harm Can be applied (with caution) to cohort and case control studies as well as randomized trials or 'typical' patient mix, be unhelpful in practice Routine reactions (especially sociobehavioural ones) have been adequately addressed by meta-analysis" and the method, while theoretically sound, 'often fails in use,' that are invisible to the analyst"	The 'numerical bottom line' can be distracting and overlook important sources of bias and diversity between individual trials[7,10] Conclusions expressed as recommendations for the 'average'
Qualitative overview	Systematic review in which primary studies are identified using rigorous search strategies, but the focus of the analysis is descriptive and interpretive rather than hypothetico-deductive"	Potentially, avoids the reductionism inherent in other forms of secondary research Allows studies to be interpreted in their social, economic, political and historical context"	Does not provide quantitative estimates of risk and benefit Lack of explicit methodological criteria for interpretation makes such overviews difficult to evaluate or reproduce

Meta-analysis – ultimate truth or statistical con-trick?

The randomized clinical trial is designed to emulate the laboratory experiment,[1] and works best when a single, simple and unambiguous research question is addressed in strictly controlled conditions – most commonly, when the efficacy of a drug is being tested against an identical placebo. In meta-analysis, not only must the question be simple, but all component primary studies must have addressed it in much the same way on comparable groups of participants. (See Box 1)

It is hardly surprising, then, that the best example of meta-analysis in practice is the hospital management of acute myocardial infarction[2] – a situation in which patients tend to behave (at least for the first few hours) like caged laboratory animals. They lie obediently in their beds, receive a highly standardized care package, offer little or no resistance to investigation and treatment, and are reliably pursued until death or discharge. It is also no accident that myocardial infarction has relatively objective and unambiguous criteria for diagnosis (typical ECG and cardiac enzyme changes) and outcome (death).

Those who have argued most passionately for the widespread adoption of meta-analysis in clinical research[2,4] have generally supported their case with this and other 'laboratory' style clinical examples. In contrast, those who argue with equal passion that meta-analysis is an illusory and dangerous 'gold standard' that distracts clinicians from the complexities of health and illness[5,6] and provides, at best, disease-oriented rather than patient-oriented advice expressed as 'average' effects in 'typical' patients,[7] have tended to use examples from the grey zones of clinical practice, encountered more often than not in primary care.

When, for example, and for whom, and by what means, and at what cost to quality of life, should we recommend cholesterol lowering therapy in the prevention of coronary heart disease, or salt restriction in mild hypertension?[8] In questions such as this, the 'grand mean' of meta-analysis can inform but

not direct our decision making, and we should rightly consider both the values and preferences of the individual and the competing demands on limited resources as well as the abstracted 'truth' of clinical trial results.

Heterogeneity in meta-analysis: threat or opportunity?

Two recent systematic reviews that met with a particularly controversial response both concerned complex socio-behavioural therapies. One concluded that brief interventions for alcohol misuse delivered in primary care are significantly more effective than no intervention, and substantially more cost-effective than more prolonged forms of specialized therapy.[9] The other concluded that family therapy for patients with schizophrenia is significantly more effective than individual methods, and should be offered routinely if it is affordable.[10]

Experienced clinicians in these complex and challenging clinical fields will recognize the absurdity of using a single, numerical bottom line to determine policy either at the level of the individual clinical encounter or (even more so) in the construction of local or national guidelines. In their conclusions, the authors of these overviews[9,10] themselves acknowledged this fact, but their numerical results are cited far more frequently in the literature than the cautionary discourse that qualifies them. The primary studies from which the reviews were derived were rigorously conducted and honestly reported. But they were highly selective (perhaps inevitably so), sometimes including only a fraction of potentially eligible participants and losing significant numbers in sample attrition and loss to follow-up. Furthermore, the primary studies differed in important features from one another in terms of the sampling frame, precise nature of the intervention, and measures of success or failure.[6] The aggregation of their results could be viewed as sociologically naïve, and the apparent increase in the precision of the effect size achieved through quantitative meta-analysis as spurious and misleading. Other authors have drawn more cautious conclusions from the same primary studies and argued for a more sophisticated theoretical approach to the underlying clinical issues.

Was a systematic review in these cases, then, a waste of time? Not at all. If population-derived numerical data are used for no other purpose than to justify a superficial analysis of the problem and a flawed clinical decision, then this is 'evidence based' reductionism at its most inept and dangerous. However, the statistical techniques of meta-analysis can potentially be used for a different and altogether more sophisticated purpose – to generate new hypotheses through careful reflection on the nature and possible causes of heterogeneity between studies.[16,17] Briefly, mathematics can tell us which studies produced the largest effects, and which the smallest. The addition of clinical common sense may then generate new theories about what features of the study methods contributed to success or failure, and which categories of patient might respond best (or worst) to different variations in the method.[11]

Conclusion

Meta-analysis is a tool, not a weapon. The complex interplay of biomedical, psychosocial and cultural factors in primary care generally requires a more thoughtful approach to decision making than a knee-jerk application of an odds ratio or other summative statistic.[6] Descriptive and rhetorical overviews may allow primary research studies to be interpreted in their social, economic or cultural context. Hypothesis-generating meta-analysis is in its infancy, but this exploratory and creative use of the statistical techniques of secondary research has considerable potential in the 'grey' areas of primary care.

Trish Greenhalgh

Box 1: Strengths and limitations of meta-analysis

What can meta-analysis do?

A properly conducted, up-to-date meta-analysis can

- increase the precision of estimates of risk and benefit derived from simple, controlled studies on defined and comparable population samples
- allow definitive conclusions to be drawn from trials that, individually, were too small to address a common research hypothesis
- systematically describe and explore bias and diversity between different individual studies

What can't meta-analysis do?

In general, meta-analysis cannot

- meaningfully contrast the numerical results of studies that addressed different research hypotheses or studied different population samples
- fully address the variable characteristics and treatment responses in different individuals, protocols and populations
- provide estimates of risk and benefit that are generalizable across all health systems or sociocultural contexts
- allow retrospective analysis of effects in subgroups that were not defined at the outset of the study[2]
- remove the inherent potential bias of trials that are commercially sponsored and product- rather than problem-oriented[18]

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the 90s

In 1990, the Government imposed changes on the National Health Service, introducing, almost simultaneously, the purchaser-provider split and the New Contract for General Practice. The changes were driven by ideology rather than understanding, and were to prove deeply divisive. A minority of general practitioners saw and seized an opportunity to take more control over the services that their patients received, both within primary care and after referral on to secondary services. They received generous financial incentives and responded with many innovative improvements to patient care. On the other hand, a majority of general practitioners were left feeling profoundly disturbed by the changes;[1] increasingly aware of the conflict between their role as the individual patient's advocate on the one hand, and, on the other, their growing role in decisions about the distribution of scarce resources within a population. Despite recognition of the need for effective and rigorous financial management of the NHS, there was a strong feeling that if individual doctors were asked to make both clinical and financial decisions simultaneously, the whole moral and ethical basis of health care would be changed. General practitioners have always sought to treat patients as whole people, seeing them and caring for them in the context of their families and their communities, taking into account their individual histories and aspirations; suddenly it seemed as if we were being asked to break care up into little bits, each with its own price tag.

Never before had patients been prioritized for NHS services on a basis other than clinical need. A service founded in social justice had suddenly become unfair...

We were seeing the accelerating commodification of health and health care,[2] and the result was a profound fall in the morale of general practitioners. Conservative politicians were genuinely at a loss to understand this (to them) unforeseen consequence of the changes. The GPs they spoke to, those in the vanguard of fundholding, seemed full of confidence and enthusiasm, but falling recruitment and the rush to early retirement told a completely different story. For a time there was a serious danger that the profession would split, and both the GMSC and the RCGP chose not to adopt a specific stance on fundholding in a concerted effort to keep the profession united.

The deep divisiveness of the changes had other manifestations. The size of the health service bureaucracy exploded with the creation of contracting departments in every trust and health authority, and these tiers of management on each side of the purchaser-provider split formed a buffer at a local level between general practitioners and their specialist colleagues, disrupting direct communication. For the first time, the NHS began to offer a two tier service, with patients of fundholding practices – who had money available – prioritized over patients who still relied on the cash-starved health authorities to fund their hospital care. Never before had patients been prioritized for NHS services on a basis other than clinical need. A service founded in social justice had suddenly become unfair.

Yet some good did come of fundholding. As GPs took responsibility for purchasing secondary care, they began to assert the standards of care and communication they expected. In this way the balance of power between generalists and specialists shifted beyond recognition. GPs, who for years had been both maligned and marginalized by hospital specialists, found that their opinions were suddenly both sought and valued by specialists and by managers, in both trusts and health authorities. Such problems as open access to investigation or poor discharge arrangements, which had seemed intractable for years, were solved apparently over night. GPs in some areas insisted upon a much greater focus on the previously neglected areas of service provision for older people, those with mental illness, and those with drug and alcohol problems.

While all this was going on, society itself was becoming more divided. The gap between rich and poor widened throughout the 1980s at an unprecedented rate, and inequalities in health increased in parallel.[3] However, the Government was unwilling to acknowledge this and only after a long struggle was an investigation into 'variations' in health allowed. And while society's responsibility for the worsening health status of poorer

communities was denied, more and more responsibility for health was loaded on the individual. A huge amount of attention was focused on the lifestyle causes of ill-health, and GPs were exhorted to bring about lifestyle improvements. Real deterioration in the health status of the poor, the rise of consumerism in health fuelled by initiatives such as the Patients' Charter, and the rhetoric of health promotion, led to rises in demand for general practitioner services. General practitioners felt simultaneously beleaguered and undervalued.

Slowly, the profession began to respond by articulating the sense that essential transactions of patient care were being undermined by the pressures of market forces and imposed contractual change. The BMA produced 'Core Values for the Medical Profession in the 21st Century'[4] and the RCGP published 'The Nature of General Practice'.[5] Both were reaffirmations of central values and critiques of the rapidly changing context of health care. The same concerns were explored by many individual writers including, most notably, James Willis[6] and Peter Toon.[7] Academic research generated a flood of evidence on the effects of adverse social conditions on health, until the case became unanswerable.[8] The tide had turned.

On 1 May 1997, a huge electoral swing produced a landslide Labour victory and it seemed that the whole country was responding to the divisiveness of the preceding years. Suddenly, the disourse changed. There was, after all, such a thing as society. The destructive effects of poverty and social exclusion were acknowledged and doing something about them was expressed as a priority. Within weeks of assuming power, the new Government appointed Sir Donald Acheson to conduct the Inquiry into Health Inequalities. His long awaited report was due to coincide with the 50th anniversary of the NHS in July, but seems to have been delayed.

A succession of policy documents have reintroduced notions of planning, collaboration and openness in place of competition and secrecy. Yet all has not changed. Pressures on general practitioners remain enormous. The escalating volume and complexity of clinical work is matched by many new non-clinical responsibilities in the commissioning of care, the management of budgets, education, research and development. More recent challenges include the imperatives of evidence-based practice and the new concept of 'clinical governance'.[9] Both are to be key functions of the newly proposed primary care groups, which are destined to replace fundholding.

It is clear that the move to primary groups is founded on Government commitment to 'managed care', within which GPs are expected to combine the care of individual patients with a corporate responsibility to a wider organization. In this way, Government hopes simultaneously to raise professional standards and to offload responsibility for rationing decisions. The central empathic commitment of the general practitioner to the needs of the individual patient, and the obligation to serve as each patient's advocate within the system, are threatened both by notions of corporate responsibility and by the requirements of rationing.

I am eighteen months younger than the National Health Service. I grew up under its care and, perhaps, survived childhood because of it. Its very existence played a major part in my decision to train as a doctor. I wanted to work within a service which offered health care as a right to all who needed it, irrespective of their ability to pay, and in which no-one made a private profit from the illness and misfortune of others. I had the wonderful good fortune to start in general practice in 1975, probably at the peak of 'the golden age' which followed the 1966 GP Charter. For me, and many like me, the changes made to the health service in 1990 seemed a betrayal of the most fundamental of our values. As we approach the 50th anniversary of the National Health Service, it is heartening to witness the rediscovery of many of its founding principles, but it is clear that the central values of the extraordinary discipline of general practice remain under threat.

Iona Heath

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The Pocket Guide to Grant Applications

Ian Crombie, Charles du V Florey
BMJ Books, 1998
PB, 68pp, £16.95, 0 7279 1219 4

Applying for research grants can be a disheartening business. Really successful researchers expect 30% of their applications to be accepted. Two years ago, Ian Crombie was asked to facilitate a workshop for members of the Scottish departments of general practice (ADEG) on how to improve their chances. As an epidemiologist with a history of successful collaboration with GP researchers in Dundee, and a member of several grant awarding committees, he was well placed to offer this advice. After the workshop, one of the GPs suggested that the material would make a good book. By collaborating with his experienced head of Department, Charles Florey and BMJ books, that prediction has been proven correct.

It is a concise (65 page) step by step guide to the application process, accompanied by a computer based aid (Windows 3.1, 95, NT) which indicates what is expected throughout the application process. Like any experienced guide, the book begins by outlining the route ahead, with some inside knowledge on the best places to go. It gives advice on what awarding bodies expect in different sections of an application but not the technical information which requires further reading. For example, in the quantitative research methodology section: 'Formal sample size calculations are now a requirement ...'. The fine details of how to conduct the calculation are not provided. Rather, the reader is directed to relevant books, articles and web sites. Just as a guidebook inviting you to abseil off the top of the Inaccessible Pinnacle on Skye would not provide you with details about abseiling.

Frank Sullivan

Mens Health

Tom O'Dowd & David Jewell.
Oxford, 1998.
PB, 277pp, £30, 0 19 262 5810

As yet there is no other book on men's health for general practice, so this multi-author work is both welcome and timely. It covers most male health issues, although the presentational style does vary considerably between the 21 contributors. While specific male health areas are dealt with in detail, there is a degree of unavoidable overlap. This is particularly seen in the sections dealing with work and work related problems. A slightly uneven balance makes for over emphasis on some topics while others would benefit from greater detail. Alcohol abuse is referred to throughout the book but also has its own section of 20 pages. 'Later life', by contrast, has only 12 pages. The authors correctly identify male reluctance to seek help as one of the major factors for the health anomalies they extensively quote. One section, Getting Help, deals specifically with this problem and how to address it.

Courageously, the book deals with violence in the home, with men as the perpetrators and the recipients. This makes for uncomfortable reading, particularly as general practice often does not deal well with these issues. Some men would question whether violence which emanates from men is a male health problem. The section successfully convinces you that it is.

Male sexuality is dealt with in standard text book fashion, with no insight into the relationship which exists between male doctors and their male patients. Not only does this flavour the consultation but we are also guilty of avoiding opening that particular can of worms for fear of not getting the lid back on again. This section relies too heavily on case histories and could have dealt better with the practicalities of treatment rather than defining the problems with which men present. As the author says in conclusion 'The constraints of such an overview have of necessity, meant that the coverage is somewhat superficial'.

I would suspect that all the inevitable problems of working with so many contributors may have delayed the publication as a number of sections have references no later than 1994. The overall style is rather heavy block text broken with occasional graphs which unfortunately gives it a dated appearance and does not welcome the reader to absorb the enormous amount of valuable data it contains.

These criticisms are by no means serious and this excellent piece of extensively researched work which will be seen as the first genuine attempt at highlighting an area of health which is not always considered politically correct to discuss. This is hinted at in the preface with a near apology,

‘However, this book is emphatically not an attempt to take attention away from the women’s health agenda or to depreciate the attention that women rightly receive in the health arena’. I have yet to see any book on female specific health issues, and they are many, make such a statement with regard to male healthcare. When I presented a paper on a similar theme to BMA Council one leading GP member attempted to rubbish it by labelling it as ‘anti-woman’.

I strongly recommend it to general practitioners, the obvious target readership, but also social workers, practice nurses and managers will find the information most valuable.

Ian Banks

uk council, june 26

Good Medical Practice
Council welcomed the forthcoming second edition of Good Medical Practice from the GMC. Council noted that there is at present great pressure on all of the medical profession in the area of self-regulation, pressure reinforced by recent events in Bristol. Council accepted that patients now expected measurable results. General practice has, therefore, to tackle the issue of variability. This will involve local arrangements, as it is clear that it cannot be dealt with centrally. Council agreed to issue a statement setting out the College's strong support for Good Medical Practice, the values of which underpin the College's views on Membership, Fellowship and good general practice.

Council agreed that self-regulation must mean the maintenance of appropriate standards throughout the medical profession. This will mean a far greater emphasis on performance, with the duties of self-regulation extending throughout the practice and beyond. In supporting self-regulation, the College should give priority to supporting general practitioners who are failing. The GMC should continue to act as the disciplinary body. The Council Executive Committee will look at the whole issue, including identifying possible future areas for discussion, such as risk assessment.

Clinical Governance
Paper to be published and disseminated soon.

Recognizing Quality Of Care In General Practice
Mike Pringle presented a paper on 'Recognizing quality of care in general practice'. This set out recent developments, such as the greater emphasis on clinical indicators. The paper states that general measures of quality, which encompass all or most of the important aspects of general practice, are more appropriate than discrete performance indicators. Furthermore, any criteria used to assess quality must be transparent, openly available and externally validated. Council welcomed the paper and suggested some areas for expansion, including reference to the College's current policy on the Examination for Membership and appropriate patient involvement.

Practice Accreditation
Council welcomed Theo Schofield to the Meeting to give a progress report from the Practice Accreditation Working Party, chaired by him. The Working Party was set up in 1994 to examine methods of assessing the performance of primary care teams in practice, and to make recommendations to Council on accreditation and reaccreditation. The Working Party has concentrated on quality improvement rather than pass/fail criteria. Council endorsed the areas being pursued by the project and thought the work to date, particularly the 'user-friendliness' of the pilots carried out in 12 practices, was most useful. Council noted that the project would make recommendations in particular areas in September, including research and development, dissemination and training and approving accreditation programmes. It was emphasized that there has to be coherence between all the College's activities in assessment; the Assessment Network will consider ways of ensuring this.

Accredited Professional Development
John Toby introduced a progress report from the Working Party on 'Continuing professional development' (CPD). In view of the rapidly changing scene, the timescale for the work will be pushed ahead as quickly as possible.

The Examination For Membership And Summative Assessment
The May meeting of the JCPTGP had agreed to set up a group to look at bringing closer together the processes of assessment. The College desires to support Registrars, and to rationalize assessment as soon as possible.

Membership By Assessment Of Performance
Iona Heath introduced a report from the Working Group on Membership by Assessment of Performance (MAP). The Group have produced a revised set of criteria for MAP, and have begun to pilot these in a variety of practices. Council agreed that the revised criteria be approved and that piloting be continued. A resolution will be brought to the 1998 Annual General Meeting (AGM) proposing to introduce a system of MAP as soon as practicable in 1999.

Primary Care Groups
Mike Pringle presented a report on possible risks and opportunities concerning Primary Care Groups. Although the terms of the letter from Alan Milburn to the GMSC Chairman were noted, it was agreed that there were nevertheless perceived risks around unified budgets and management control of PCGs. Council agreed that there would have to be adequate resources applied to the management and administration of PCGs. Mike agreed to amend the paper to take account of concerns expressed, particularly about PCGs in rural areas and the need for flexibility as regards co-terminosity. He will bring the paper to the July CEC with a view to early publication.

Premises for Scottish Council
Current rented offices are not suitable for the College's work in Scotland, given the imminence of the Scottish Parliament. Council agreed that the purchase of a property in Edinburgh be pursued by the Chairman of UK Council, the Chairman of Scottish Council and the UK Honorary Treasurer. Active negotiations continue.

Next Meeting of UK Council
Saturday 19 September 1998,
Princes Gate.

National ballot for election to Council - successful candidates
Dr Tina Ambury, Dr Dominic Faux, Dr Richard Fieldhouse, Dr Iona Heath, Dr Has Joshi, and Dr Richard Maxwell.

Queen's Birthday Honours
Members and friends of the College who received honours in the Queen's Birthday Honours List...
Dr John Toby - CBE
Dr Peter Enoch - OBE
Dr Robert Davenport - MBE
Dr Robin Robertson - MBE
Dr Norton Short - MBE
Edward Reynolds - MBE

Professor Brian Jarman OBE, Sandy Macara, and Alan Langlands - Knights Bachelor

Michael Dixon

A matter of words

'It's not what you say it's the way that you say it', as the song goes. This is as true of the medical encounter as it is of the romantic one. There is only one job that I would truly covet in medicine, but unfortunately it does not exist at present – professor of medical semantics. Witness the following comment by a patient seen on call a few weeks ago: 'Dr A thinks I have got a kidney stone but Dr B thinks it's my nerves. I think Dr B is right because I was rushed to hospital a few years ago with a suspected nervous breakdown'.

To study and record exactly what patients say is not only practically useful but also an absorbing pastime in itself. Indeed, it can become as interesting as trying to find out the real reason why the patient attended in the first place and equally as confusing. Well practised, it can enliven the consultation in very much the same way as Bertie Wooster used to spice up his vicar's sermons by recording their exact length. Indeed, the more exactly and obsessionally you record the words the better it gets. Gems from my last few surgeries include: 'I had a friend, he was a smoker, he went to see his doctor with some chest pain he was having and the doctor said, "you'd better lie down, you're having a heart attack"'. Another patient told me: 'I've tried day nurse and night nurse and put on Mr Muscle like there's no tomorrow'. Another patient recounted, rather sadly: 'Dr Tracy used to shout rather a lot and frightened us. Or course, I was much younger then and he was an awfully good doctor, but he did shout a lot'. Finally, and again rather sadly, 'I went to see the general practitioner, of course it was the family doctor in the old days'.

For some unknown reason, the most interesting use of language frequently comes from gynaecology. Witness the following: 'Dr M said that I had a thyroid on my womb, I didn't know you could get them down there'. Another lady commented: 'He shoved a telescope up my doofer and said that he wanted to take out the Fallopian tubes to stop them waving in the wind'. The war of the sexes continues unabated within our bodies, as testified by one male patient who recently complained 'her mucus keeps attacking my sperm'. The laugh, of course, is not on the patient but on us. The patient's reaction only reflects the idiosyncratic way in which we also mix technical and everyday language. Somewhere between the doctor and the patient the explanation becomes 'half-baked', and it is perplexing why intelligent patients, who use computers and drive cars by day, are quite happy to live in Teletubbie land when it comes to explanations about how their bodies work.

The philosopher P F Strawson commented that the meaning of what a person says is no more and no less what an ordinary person would take it to mean. It doesn't matter what we intend to say. It is what the patient hears that counts. Conversely, though we may frequently understand what our patients are saying, we are in danger of missing the body and bouquet of the consultation if we ignore the manner in which they say it.

web sites of the month

BJ,
Found another *coooool* acronym. WONCA!!!!! **www.wonca.org**
You may laugh, but this has nothing to do with Buckets, Oompa-Loompas, or even old Willy himself. (If chocolate is what you're after, check out **http://www.choc.com/** or **http://www.caliebe.de/e/cyberchocy.htm**)
Anyway, WONCA (the World Organization of Family Doctors) is actually derived from:
the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. Try saying that one after a couple of pints of Riggwelter!
Anyway, it's a sort of WHO for GPs (which can't be bad) and they have their own Journal, newsletter, and even ties. They've even got a list – **gp-wonca** – which is a completely risk-free zone:-)
Anyway, check it out and I'll see you soon.
Rob
www.schin.ncl.ac.uk

our contributors

David Kernick is lead research GP at the St Thomas Medical Group Research Unit in Exeter

John Bain is professor of general practice in Dundee

Trish Greenhalgh combines academic general practice and normal general practice, with authorship, medical journalism and motherhood

Iona Heath is only slightly subdued by comparison. She has been a GP in north London at the Caversham Group Practice since 1975, and is author of the seminal *Mystery of General Practice*, available from the BMA Bookshop 'if you twist their arm...'

Ian Banks is a GP in Northern Ireland. He is the BMA spokesman on men's health issues, and chairman of the Men's Health Forum

Michael Dixon is a principal in Cullompton, Devon. He was a founder of the Mid Devon Doctors' Commissioning Group, and is author and co-editor of the *Locality Commissioning Handbook* (Radcliffe 1-85775-272-4). And he likes fishing.

Bruce Charlton will become famous, but not rich, as one of the *BJGP*'s regular columnists.

All our contributors can contacted via the Journal Office

Bruce Charlton

The amateur tenor

Men mature late as singers. This fact nurtured the hope I might grow into a great tenor. I clung to this vain aspiration long after it should have been obvious that I was not even a tenor - never mind a great one.

Amateur choirs up and down the land are full of strangulated baritones such as myself. Real tenors are so rare they have automatic access to the solo roles; so choruses have to put up with the tight underpants brigade for lack of anything better. Yet most of us still nurture fantasies of producing a ringing 'top C' on the stage at Covent Garden - a note so loud and pure and thrilling that the performance has to stop while we are pelted with bouquets.

It is hard to find a suitable place to practice one's top notes… well perhaps 'practice' is not strictly the verb. When I was a sixth former, just after my voice had broken, my best friend happened to live beside large field. He also had a piano quite near to some French windows. Naturally, we had regular high note competitions - the point being to sing up to a pinnacle of pitch without swerving into a Micky Mouse falsetto on the one hand, or cracking like an operatic version of Jimmy Saville on the other. Imagine the scene. A muffled musical phrase from the dining room, then one or another gangling youth would burst forth, dash into the middle of the pasture, fling his head back, and bellow a snatch of recitative exerpted from HMS Pinafore to the uncomprehending cows.

I am a pretty bad singer, but twenty five years down the line I still haven't stopped inflicting myself on the public. WS Gilbert described 'the amateur tenor whose vocal villainies all desire to shirk'. But there is more to this phenomenon than meets the eye. Properly considered, we are all 'amateur tenors' of one sort or another.

No matter what the level of achievement, everybody would prefer to have been differently gifted. Prime ministers would rather open the batting at The Oval, Presidents fancy themselves as Charlie Parker; even Pavarotti prefers to discuss his footballing prowess. Whatever the level we find the same thing. The clown who wants to play Hamlet is merely an amateur tenor writ large.

And this is exactly as it should be. Absolute excellence is so rare as to be off the map - it might as well not exist so far as everyday life is concerned. If I refused to sing because I wasn't going to be Pavarotti, then - to be consistent - I would also have to give up science because I am not going to be Francis Crick. That attitude wouldn't get me out of bed in the mornings, let alone pay the mortgage.

But this isn't quite honest, because of course I am Pavarotti and I am Francis Crick - in my waking dreams, when singing or doing science. As I write this I am GK Chesterton and Ralph Waldo Emerson rolled into one. And so presumably, deep down in their dreams, Pavarotti is Caruso and Crick is Darwin. So it goes: onward and upward and down.

So long as they are a spur to creativity - then I am all for dreams. The stage, the lights, the frenzied crowd roaring 'Bravo bravo! Viva amateur tenor'.