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Viewpoint

RCGP Patient Liaison Group: Past, Present and Future

The RCGP Patient Liaison Group (PLG) was founded in 1983, when there were few channels for eliciting patient views on health care. This unique initiative by the College, the first of the Royal Colleges to establish a PLG, was also unusual in its composition of equal numbers of GPs and lay people, defined as those who do not possess a medical qualification. Careful recruitment of lay members, to include people with sufficient knowledge and confidence to be able to articulate what they know of the concerns, perceptions, values and interests of patients, has ensured that the lay voice is not a token voice.[1]

Membership of PLG is for four years. GPs are appointed by Council. Lay members are appointed by a nominating committee following public advertisement. The chairman is normally a lay member (who, since 1997, attends Council) and there is a lay and medical vice chairman who is a member of Council. PLG has a lay majority, still unusual within professional organizations.

The main terms of reference of the PLG are:
- to communicate to College and Council areas of concerns to patients,
- to consider ways of achieving a consistent and equitable quality of care for all,
- to respond to requests for comment from Council,
- to encourage Faculties to involve patients locally in all aspects of their activities.

During the last few years PLG has been extremely active. In 1997 it was involved in two major college publications: the *How to Work with your Doctor* leaflets and *Guidance on Removal of Patients from GP lists*. The *How to* leaflets can be photocopied or adapted, and are available over the Internet. The value and credibility of these leaflets lie in the notion that they are written by a group of lay people and GPs working together to produce information that is considered to be important and valuable. The removal of patients from GP lists is a topic of huge importance both to GPs and to patients, and shall be examined in a forthcoming Viewpoint.

Issues that are currently being discussed by the PLG include confidentiality, rationing, how the need for emergency or quick appointments are dealt with, work experience in general practice, and membership of primary care groups.

Increasingly, the PLG is represented by a lay member on other committees of Council, including clinical guidance, research, and ethics. A lay member has been appointed to join a joint RCGP/RCR working group on follow-up of patients in palliative care, and a joint RCGP/RCP working group on euthanasia. The PLG's views are sought and included in many documents sent to the College for comment. We are also regularly invited to speak to the press.

The College is to be congratulated for its pioneering spirit in establishing a PLG and for its continuing support of the group. Imitation is the sincerest form of flattery. In the last year the Royal College of Radiologists and the Royal College of Anaesthetists have established PLGs along the same principles as the RCGP, and the Royal College of Pathologists is in the process of doing so. In all cases, advice and help has been sought from the RCGP.

The PLG is about partnership and trust between lay people and GPs. This involves discussion, listening to the different viewpoints, negotiating, reconsidering and reaching a consensus. This process means that we each influence the other. Lay members of the PLG are currently involved in the pilot of lay assessors in Fellowship by Assessment. We hope that this becomes established practice and that, in the future, we will be further involved in both the education of general practitioners and in the evaluation of practice.

That is partnership.

Patricia Wilkie

1. Williamson C. Discussion paper presented to Patient Liaison Group, RCGP, 1993.

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The modular MRCGP exam's first outing

The first diet of the reconfigured Examination for Membership is now complete, and I thought that readers of these Journal pages might – I hope – be interested to learn how it went. Detailed analysis will take some time, and will be published more fully in due course. Meanwhile, here is a summary of some of the statistics (for which I am indebted to Dr John Foulkes, Consultant to the Panel), together with a provisional commentary.

A reminder of the modular format

A pass in all four of the following modules has to be accumulated within three years:

- *Paper 1* – a written paper testing mainly the application of knowledge and skills;
- *Paper 2* – a multiple choice paper testing mainly factual knowledge;
- *Consulting skills* – video-based or (for a small minority of candidates) a Simulated Surgery;
- *An oral examination.*

Each module may be failed, passed, or passed with merit. Three attempts at each module are allowed.

Statistics

1086 candidates sat at least one module. 634 took all four; the remainder were either resitting by dispensation those elements of the pre-modular exam they had failed, or were exercising their right to accumulate passes incrementally.

Results for all 1086 candidates by module are shown in Table 1. (The results given for the consulting skills component include 42 candidates who sat the simulated surgery option. This subgroup is unrepresentative of the overall cohort insofar as language difficulties, special local or personal circumstances prevented them from undertaking video assessment. Of these 42 candidates, 30 passed, 6 of them with merit, and 12 failed.)

The 634 candidates who attempted all four modules simultaneously provide the best cohort for comparison with the pre-modular exam. The results for these 634 are shown in Table 2.

The overall pass rate for candidates taking all four modules simultaneously is 462/634, i.e. 72.87%; virtually identical to the pass rate in the pre-modular examination. Of these 462:

135 (21.3%) gained 0 merits
173 (27.3%) gained 1 merit
87 (13.7%) gained 2 merits
59 (9.3%) gained 3 merits
8 (1.3%) gained 4 merits

MRCGP with Merit is awarded to a candidate gaining two modular merits, and MRCGP with Distinction to a candidate gaining three or four modular merits. Thus 87 candidates (13.7%) have passed the exam 'with Merit', and 67 (10.6%) 'with Distinction'.

Of those 172 candidates who attempted all modules, but obtained fewer than four passing grades (27.1%):

105 (16.6%) failed only 1 module
39 (6.2%) failed 2 modules
20 (3.2%) failed 3 modules
8 (1.3%) failed all 4 modules.

Standard-setting and reliability

The modular exam has tried to move away from the previous 'peer referenced' way of determining the pass rate, where a more or less fixed percentage of candidates would pass. It is generally

Table 1

	Paper 1 (%)	Paper 2 (%)	Consulting skills (%)	Orals (%)
Examined	880	956	759	889
Pass	518 (58.9)	590 (61.7)	569 (75.0)	597 (67.2)
Merit	212 (24.1)	231 (24.2)	114 (15.0)	209 (23.5)
Pass or merit	730 (83.0)	821 (85.9)	683 (90.0)	806 (90.7)
Fail	150 (17.0)	135 (14.1)	76 (10.0)	83 (9.3)

Table 2

	Paper 1 (%)	Paper 2 (%)	Consulting skills (%)	Orals (%)
Examined	634	634	634	634
Pass	379 (58.8)	384 (60.6)	471 (74.3)	412 (65.0)
Merit	169 (26.7)	179 (28.2)	101 (15.9)	166 (26.2)
Pass or merit	548 (86.4)	563 (88.8)	572 (90.2)	578 (91.2)
Fail	86 (13.6)	71 (11.2)	71 (11.2)	56 (8.8)

considered more equitable to define in advance the attributes required to pass, and to measure each candidate objectively against them.

Paper 1 was 'limen referenced': every examiner who marked an individual question also submitted a recommendation for the pass mark on that question. These were coalesced into an overall pass score for the paper. Each candidate's raw scores were scaled to compensate for minor variations in marker performance, and to ensure that all questions made equal contributions to the outcome. Candidates whose corrected scores fell not more than 1 standard error of measurement (SEM) below the notional pass score were deemed to have passed the paper.

The standard for Paper 2 was set using a modification of the generally accepted Angoff's procedure, where a group of judges estimate the performance of a notional 'just good enough to pass' candidate. For the first time in the exam's history, and in accordance with current good practice, representatives of outside bodies with a stake in the outcome of the exam were invited to participate in the standard-setting process. On this occasion the examiners were joined by representatives of Registrars, the Conference of LMCs and Directors of General Practice Education, whose views carried equal weight to the examiners'. (Apologies for absence were received from the General Medical Council, the Association of Course Organisers and the Association of Community Health Councils, who all hope to participate on future occasions.) The standard took account of the 'guessing factor' always present in multiple choice tests, and a pass was granted to candidates up to 1 SEM below the notional pass score.

The usual index of reliability in written tests, Cronbach's coefficient alpha, was:

Paper 1 $\alpha = 0.85$, and
Paper 2 $\alpha = 0.89$.

These results are better than their pre-modular equivalents, and significantly above the internationally accepted minimum of 0.80.

In the Simulated Surgery option of the consulting skills component, the pass score and the pass/merit boundary were derived by the marking examiners using a 'contrasting groups' method to define the profiles of passing and meritorious candidates. Pass/fail and pass/merit criteria in the video component were described and notified to candidates in advance; the additional performance criteria required to achieve merit emphasized patient-centred dimensions to the candidate's consulting skills. In the Orals an average score of four 'bare pass' judgements by the examiners was required to pass. Merit grades in the Orals were awarded, as indicated in the exam regulations, to the top 25% of candidates approximately.

Commentary

While there are some minor procedural arrangements still needing to be tightened, the move to a modular format has gone more smoothly than we dared to hope. The new exam appears to have met its ambition to be (in David Haslam's phrase) 'easier to take but no easier to pass'. Its pass rate for 'all modules at once' candidates is the same as previous exams, and these candidates appear to have performed slightly better than those taking only one to three modules. Time will reveal how candidates who did not take, or failed, some modules make use of the new modular process to gain an overall pass.

Despite candidates' fears to the contrary, the knowledge-based Paper 2 was passed by nearly 90% of candidates. (Success in this paper confers exemption from the equivalent component of Summative Assessment.)

The video examiners consider that the overall standard of consulting skills demonstrated on the submitted tapes is noticeably higher than in 1997. The vast majority of candidates seem to appreciate the competencies required to pass. However, the lower than expected 'merit' rate in the video component reflects the examiners' observation that there is still room for improvement in the deployment of patient-centred skills, such as tailoring explanation to the patient's understanding and taking account of patients' health beliefs.

Not least, I am delighted to report that the Examiners have carried through the programme of developing and implementing the change to the modular format with enormous skill, devotion, enthusiasm and good humour. They have delivered an exam which, in my view, is enviably placed to satisfy the aspirations of the College, Registrars, their teachers, and the profession and public at large.

Roger Neighbour

Qualitative research

Suppose I asked you the question, 'Did you like the orange-striped socks I gave you for your birthday?', and you replied, 'Yes, I love them – I wear them almost every day'.

There are three levels of meaning in relation to human experience and behaviour: what people say they do, what they actually do, and the underlying beliefs, perceptions and values that drive that experience or behaviour.[1] I can determine what you say you do (or feel) by direct interview, and I can use simple, quantitative observation to verify what you actually do (e.g. how often you wear the socks) and what you appear to feel (e.g. whether you are smiling when you wear them).

But to find out if you really like the socks I would need more sophisticated tactics. For example, I could ask you to help me choose a present for my sister, and include orange socks as one of the options. I could also get you to talk about the other items in your wardrobe and take note of which ones you spoke most positively about. Or I could wait until a mutual friend expresses an opinion about garish fashion accessories and see if you spontaneously agreed or disagreed with them.

The more ways I tried to tap into your feelings about the socks, the more likely my impressions would reflect what was really going on. No one method would give me the answer, but if all the methods gave me a similar impression then I would set more store by my conclusions than if the results conflicted. Once I had completed my research, I would probably understand not just whether you liked this particular pair of socks, but also the general nature of your taste in clothes.

What is qualitative research?

Qualitative research is what nurses do. Or, perhaps, what GPs do before they have been taught how to do research properly. Qualitative research is unrigorous, 'touchy-feely', and amateur, depending as it does on techniques such as participant-observation (hanging around pretending you are part of the team), semi-structured or unstructured interviews (letting the subject ramble on rather than answer the question), and focus groups (encouraging aimless chit-chat over cups of coffee). Qualitative research is quick, dirty, and could be undertaken by anyone. In a 'hierarchy of evidence' which has meta-analysis of randomized controlled trials at the top, qualitative research would belong at the bottom.

I don't hold these views, but I could certainly name a number of senior people in conventional biomedical research who do. Such an attitude displays a fundamental misunderstanding of what I would like to call the taxonomy (as opposed to the hierarchy) of research evidence.

A different dimension

Arguing about whether qualitative or quantitative research is 'better' is like arguing over whether rainbows are better than cheese sandwiches. Each serves a different function and has an appropriate place in the complex taxonomy that constitutes the totality of our experience. The cheese sandwich can be weighed, measured, and analysed with respect to its biochemical constituents, and for the purposes of relieving hunger, it is unequivocally better than the rainbow. But for making a young child smile with wonder on a stormy day, the rainbow probably has the edge.

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Acute myocardial infarction	By how much does prompt thrombolytic therapy improve survival in acute myocardial infarction?[9]	Meta-analysis of randomized controlled trials	Why do some patients delay seeking help when they have acute central chest pain?[10]	Individual (semi-structured) interviews Cross-validation between different interviewers
Cervical screening	By how much does a history of genital warts increase a woman's risk of a previous cervical smear?[8]	Prospective observational (cohort) studies Retrospective (case control) studies	When a woman is told her smear is "mildly abnormal", what does she think is happening?[7]	Individual (semi-structured) interviews Respondent validation
Smoking cessation	What proportion of smokers will give up when advised to by a doctor?[9]	Prospective observational (cohort) studies	What sort of smoker responds to advice to quit, and how might we improve our success rate with the remainder?[6]	Individual (semi-structured) interviews Cross-validation between different interviewers
Acute febrile illness in young children	What features of acute febrile illness predict serious disease, such as bacterial meningitis?[4]	Prospective observational (cohort) studies Retrospective (case control) studies	When worries parents when their pre-school children are acutely ill, and why?[10]	Individual (semi-structured) interviews Focus group discussions Respondent validation

There is, I would argue, no need to answer the question: 'Yes, but which is more important – relieving hunger or smiling with wonder?'. We simply have to acknowledge that there is such a thing as wonder, that it might be worth exploring the nature of this thing, and that a sense of wonder can't be weighed, measured (at least, not in the usual sense) or put on a plate. Once we have persuaded ourselves (and our critics) of that, we can begin to seek appropriate tools to undertake our research.

In health research, we are unlikely to want to explore the experience of wonder, but we may very well wish to explore the nature and depth of disappointment, pain, exclusion, fear, hope or grief in particular clinical, social, and cultural situations. Table 1 gives some examples of clinical areas in which both quantitative and qualitative research methods have been used successfully to explore different dimensions of a clinical topic.

Truth versus meaning

I hope the examples in Table 1 illustrate that qualitative and quantitative approaches are complimentary, rather than mutually exclusive or hierarchical. Clinicians require both knowledge about how best to treat a heart attack and an understanding of how heart attack patients interpret their initial symptoms and why some of them delay seeking help (thereby missing the therapeutic window for thrombolytic therapy).[7] The mutual mistrust between the 'qualitative' and 'quantitative' camps stems from an important epistemological difference between these types of evidence.

The whole of modern empirical science is dedicated, more or less, to the search for knowledge. Probably first described, and best expounded, by Karl Popper, the 'scientific method' is concerned with the formulation and attempted falsification of hypotheses ('If I do A, then B will [or will not] result') using reproducible methods that allow the construction of 'laws' or generalizable statements about how the universe behaves. Applied to clinical research, this translates into the framing of hypothesis-driven questions and the quest for precise answers to these questions through careful measurement of what happens to trial participants in particular controlled circumstances.

Conventional biomedical research assumes the positivist paradigm – that there exists an external reality separate from the observer and mode of observation whose properties can be determined through measurement and experimentation (empiricism), and whose behaviour can subsequently be predicted from laws thus derived. The debate about whether positivism is a valid paradigm in health sciences is an interesting and, at times, acrimonious one.[2] My own view is that the positivist perspective, and the quantitative research that is derived from it, is entirely valid, and very important, within certain limitations of use, but that certain aspects of the study of illness and healing require a different dimension of analysis.

The second type of research, that which aims to increase understanding (and which might be called interpretive or hermeneutic as opposed to empirical), is concerned with the search for meaning rather the search for 'truth'. Whereas scientific knowledge is objective, measurable, reproducible and generalizable, meaning is necessarily subjective, personal and highly contextual. Hence, the kind of research that promotes understanding must be recognized as being outside the paradigm of empiricist science. Such qualitative research is not concerned with deriving generalizable laws to predict the behaviour of populations, but with the here-and-now experience of particular individuals or groups of individuals. Whereas quantitative studies require the researcher to control for (i.e. systematically cancel out) the effects of the patient's personal environment, circumstances, prejudices and quirks, qualitative studies seek to identify and interpret precisely those features of the individual or the group being studied.

Validity in the exploration of meaning

Collecting qualitative data often doesn't look (or feel) like scientific enquiry. It rarely involves high technology equipment – indeed, it explicitly strives for a context that emulates 'real life', rather than the experimental laboratory. But as a number of authors have argued, both the collection and analysis of qualitative data[3,4] and the critical appraisal of published qualitative research[5] requires rigorous and verifiable methods. The detailed and painstaking analysis of dialogue in the clinical encounter is a particularly challenging qualitative research field relevant to all practising clinicians.[6]

Just as I used a number of tricks to see for sure whether you liked the socks, so a good qualitative research study would employ a variety of different methods, and its results would be deemed valid only if the findings from the different methods were broadly congruent. The responses that an individual gives in a semi-structured interview might be compared with contemporaneous written material (for example, letters, medical casenotes, minutes of meetings, and so on) and with how that individual contributes, and responds to the contributions of others, in a group discussion. Finally, the respondents themselves can be asked whether the researchers' impression accords with their own view of what is going on. This cross-validation is known as triangulation.

Differences in results obtained by different methods do not necessarily cast doubt on the validity of a study; in some circumstances they can add texture to the findings. For example, a person may express an extreme opinion in an individual interview but a less (or more) extreme viewpoint when part of a focus group, which invites a number of interpretations about how that individual relates to the peer group.

These and other finer points of validation in qualitative research have been addressed in detail elsewhere.[3,4,5]

Summary

In this article I have suggested that there are two types of research that can inform our clinical practice:

1. Empiricist research, which aims to increase knowledge, whose results tend to be expressed quantitatively; and

2. Interpretive research, which aims to increase understanding, whose results must be expressed descriptively.

The relation between these different methods should not be viewed as hierarchical but rather as complimentary, since both can (and, arguably, must) be used to gain a complete picture of any clinical topic.

Neither method, of course, can possibly justify the wearing of orange socks.

Trisha Greenhalgh

RCGP Members' Reference Book

THIS year we celebrate 50 years since the launch of the National Health Service and plans are already being made for the College to celebrate its own 50th anniversary in four years time.

An Article in the British Medical Journal earlier this year (Goss, 1998) described how the initial principle of an entirely free NHS had gradually been eroded and that the future service would increasingly depend on a mixture of private and public funding. These changes have implications for all general practitioners and for the College.

When the College of General Practitioners was founded in 1952, it was against a background of low morale amongst general practitioners caused by their perceived low status, high workload, poor working conditions and professional isolation (Collings, 1950). Since its foundation, the College has played a major part in creating the conditions which have made British general practice widely envied in almost all other countries.

In its early years the College concentrated on having general practice, as a separate discipline, included in undergraduate teaching and in ensuring that those who chose to enter the speciality were properly trained. The full implementation of the Vocational Training Regulations in 1982 (at about the time the first Members' Reference Book was published) coincided with the high point of general practice. At that time there was a temptation for the College to sit back, proud of all it had achieved, and think there was nothing else to be done. But of course complacency is always dangerous! The increasingly rapid pace of change over the past 15 years has left many practitioners breathless, some confused and a few dispirited. Most have met the challenges with courage and innovation and continue to act in their patients' best interests.

And so to Brian Goss's paper which was part of a series "Primary Care: Core Values" edited by our Chairman Elect, Mike Pringle. Reading these articles reminded me, a teenager in 1948 and a doctor who has practised all his life in the NHS, just what it was that attracted me to general practice and how much job satisfaction I have had over the years. I am sure that the College, through the MRB and in many other ways, will continue to provide the encouragement and enthusiasm which helped me.

The Members' Reference Book was edited for fifteen years by Denis Pereira Gray. I took over in a locum capacity two years ago and I am pleased to note that the new editor has now been appointed. I have tried to produce a publication which will be useful to working general practitioners who are constantly bombarded with information from numerous sources.

I am grateful to all the authors who willingly contributed their expertise, the members of the College staff who wrote much of the Annual report, Beverley Berry who checked all the references, Tracy Rees the College Publishing Manager and Tim Probart and the team at Campden Publishing who put it all together. I am sure that my successor, Rodger Charlton, will continue to develop the MRB as an important and useful publication for members of the College.

In front the sun climbs slow, how slowly,
But westward, look, the land is bright. (Clough, 1855)

DR DOUGLAS GARVIE
OBE FRCGP

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A short history of socialized medicine... 12

AGE OF GOLD OR GOLDEN AGE? – NHS matures and GPs respond

Challenged by specialist medicine (Lord Moran, Churchill's doctor, allegedly, described GPs as having fallen off the specialist ladder!) the new College and academic practice provided an infrastructure to re-examine primary care, galvanized by the re-establishment of GP vocational training in the sixties. What emerged emphasized problem-based learning, professional values, communication and clinical skills, supported by multidisciplinary teamwork. A clear patient focus contrasted with the pathology-centred approach elsewhere, and the GPs' professional role (avoiding the conventional split between mental, physical and social) was itself the subject of deeper analysis by workers such as Balint.

Financially, GPs were slipping behind (general earnings rose 20% in real terms during the fifties, but doctors' earnings declined 20%), and by the mid-sixties, the contract was also failing to deliver the necessary expenses for effective and modern practice as list sizes grew. A crisis in recruitment was followed by the adoption of a 'Blueprint for Development' from the Medical Practitioners Union, by BMA negotiations. The Charter led to sufficient improvements in pay, staff, and premises re-imbursement, to reverse recruitment trends and support practice development in parallel to academic and college innovators.

The proven success of GPs as commissioners of drug treatment, specialist referrals, their own staff, accommodation and, most of all, their own time in the early nineties, led to the GP contractor developing as a budget holder for the costs of hospitals. Such changes were always controversial; many practitioners regarded the seventies and eighties as a 'golden age'. Assertive management styles of the Secretary of State of the time did not help, the cigar smoke being a reminder of the smoky fug from BMA negotiators, which had choked Nye Bevan's non-smoking civil servants. The rhetoric, too, returned; the BMA being described as a 'nasty trade union', and a quip about wallets echoing the words of Lloyd George about 'a deputation of doctors being a deputation of swell doctors' and Bevan's claims of 'stuffing consultant mouths with gold'.

The dynamism of GP purchasing ultimately blossomed into the broader commissioning role of Primary Care Groups. Patient-centred innovation – emphasizing professional roles and clinical and communication skills from new GP educationalists midwifed a quiet revolution in undergraduate teaching. *Tomorrow's Doctors*, published in 1993, refocused attention on PC skills, reflecting the 1858 Medical Act which had established the Council to regulate and educate the profession so as to produce a 'safe general practitioner'.

As the NHS enters its second half-century, the spirit of innovative individualism of general practice retains enormous potential. In research, well developed IT infrastructure enables the epidemiological exploitation of needs and outcomes in a totally registered population. Years of independent, multidisciplinary clinical teamwork supported by technology, but unfettered by specialization, invites GPs to lead the way in the new NHS.

Jim Ford

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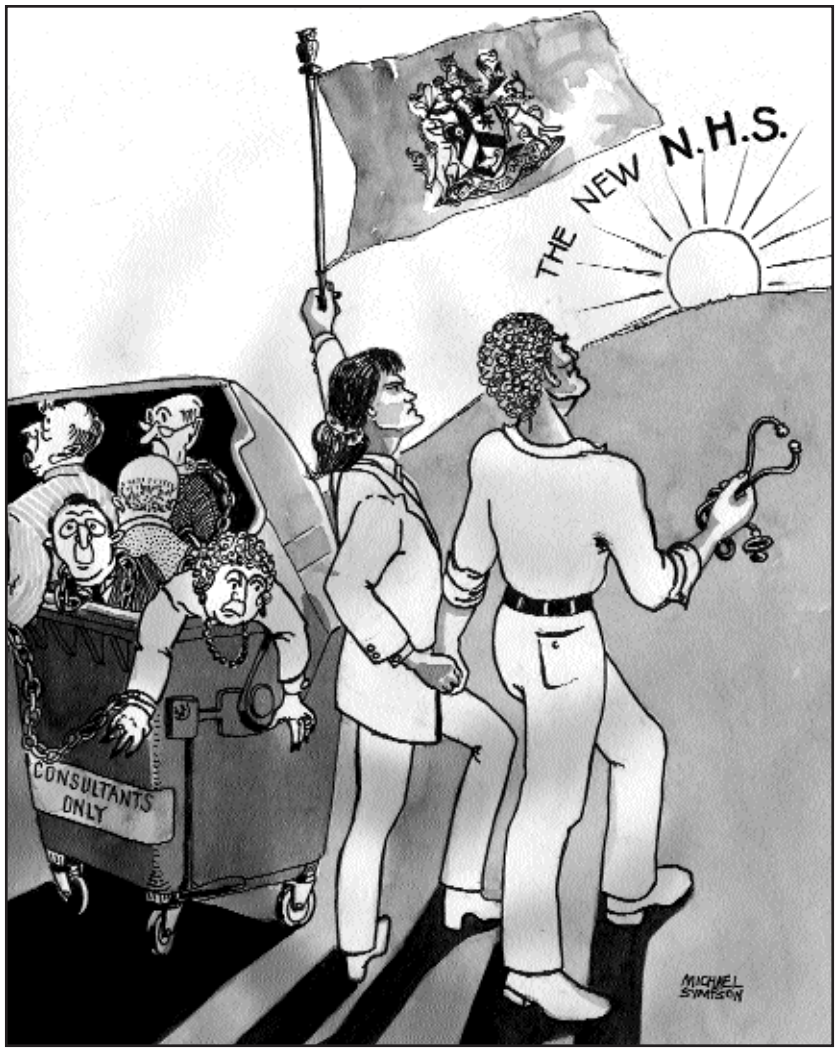

Distrust me, I'm a doctor!

Lessons from complementary medicine

Once the omnipotent heroes in white, physicians today are at risk of losing the trust of their patients. Medicine, some would say, is in a deep crisis. Shouldn't we start to worry?

The patient-doctor relationship, it seems, is at the heart of this argument. Many patients are deeply dissatisfied with this aspect of medicine. A recent survey on patients consulting GPs and complementary practitioners in parallel and for the same problem suggested that most patients are markedly more happy with all facets of the therapeutic encounter as offered by complementary practitioners.[1] This could explain the extraordinary rise of complementary medicine during recent years. The neglect of the doctor-patient relationship might be the gap in which complementary treatments build their nest.

Poor relationships could be due to poor communication. Many books have been written about communications skills with patients. But never mind the theory, the practice of all this may be less optimal than we care to believe. Much of this may simply relate to the usage of language. Common terms such as 'stomach', 'palpitations', 'lungs', for instance, are interpreted in different ways by lay and professional people. Words like 'anxiety', 'depression', and 'irritability' are well defined for doctors, while patients view them as more or less interchangeable. At a deeper level, communication also relates to concepts and meanings of disease and illness. For instance, the belief that a 'blockage of the bowel' or an 'imbalance of life forces' lead to disease is as prevalent with patients as it is alien to doctors. Even on the most obvious level of interaction with patients, physicians tend to fail. Doctors often express themselves unclearly about the nature, aim or treatment schedule of their prescriptions.

Patients want to be understood as whole persons. Yet modern medicine is often seen as emphazising a reductionistic and mechanistic approach, merely treating a symptom or replacing a faulty part, or treating a 'case' rather than an individual. In the view of some, modern medicine has become an industrial behemoth shifted from attending the sick to guarding the economic bottom line, putting itself on a collision course with personal doctoring. This has created a deeply felt need which complementary medicine is all too ready to fill. Those who claim to know the reason for a particular complaint (and therefore its ultimate cure) will succeed in satisfying this need. Modern medicine has identified the causes of many diseases while complementary medicine has promoted simplistic (and often wrong) ideas about the genesis of health and disease. The seductive message usually is as follows: treating an illness allopathically is not enough, the disease will simply re-appear in a different guise at a later stage. One has to tackle the question – why the patient has fallen ill in the first place. Cutting off the dry leaves of a plant dying of desiccation won't help. Only attending the source of the problem, in the way complementary medicine does, by pouring water on to the suffering plant, will secure a cure. This logic is obviously lop-sided and misleading, but it creates trust because it is seen as holistic, it can be understood by even the simplest of minds, and it generates a meaning for the patient's otherwise meaningless suffering.

Doctors, it is said, treat diseases but patients suffer from illnesses. Disease is something an organ has; illness is something an individual has. An illness has more dimensions than disease. Modern medicine has developed a clear emphasis on the physical side of disease but tends to underrate aspects like the patient's personality, beliefs and socio-economic environment. The body/mind dualism is (often unfairly) seen as a doctrine of mainstream medicine. Trust, it seems, will be given to those who adopt a more 'holistic' approach without dissecting the body from the mind and spirit.

Empathy is a much neglected aspect in today's medicine.[2] While it has become less and less important to doctors, it has grown more and more relevant to patients. The literature on empathy is written predominantly by nurses and psychologists. Is the medical profession about to delegate empathy to others? Does modern, scientific medicine lead us to neglect the empathic attitude

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essay

towards our patients? Many of us are not even sure what empathy means and confuse empathy with sympathy. Sympathy with the patient can be described as a feeling of 'I want to help you'. Empathy, on these terms, means 'I am (or could be) you'; it is therefore some sort of an emotional resonance. Empathy has remained somewhat of a white spot on the map of medical science. We should investigate it properly. Re-integrating empathy into our daily practice can be taught and learned. This might help our patients as well as us.[2]

Lack of time is another important cause for patients' (and doctors') dissatisfaction. Most patients think that their doctor does not have enough time for them.[1] They also know from experience that complementary medicine offers more time. Consultations with complementary practitioners are appreciated, not least because they may spend one hour or so with each patient.[3] Obviously, in mainstream medicine, we cannot create more time where there is none. But we could at least give our patients the feeling that, during the little time available, we give them all the attention they require.

Other reasons for patients' frustration lie in the nature of modern medicine and biomedical research. Patients want certainty but statistics provides probabilities at best. Some patients may be irritated to hear of a 70% chance that a given treatment will work; or they feel uncomfortable with the notion that their cholesterol level is associated with a 60% chance of suffering a heart attack within the next decade. Many patients long for reassurance that they will be helped in their suffering. It may be 'politically correct' to present patients with probability frequencies of adverse effects and numbers needed to treat,[3] but anybody who (rightly or wrongly) promises certainty will create trust and have a following.

Many patients have become wary of the fact that 'therapy' has become synonymous with 'pharmacotherapy' and that many drugs are associated with severe adverse reactions. The hope of being treated with 'side-effect-free' remedies is a prime motivator for turning to complementary medicine.[5] Complementary treatments are by no means devoid of adverse reactions,[6] but this fact is rarely reported and therefore largely unknown to patients. Physicians are regularly attacked for being in league with the pharmaceutical industry and the establishment in general. Power and money are said to be gained at the expense of the patient's well-being. The system almost seems to invite dishonesty. The 'conspiracy theory' goes as far as claiming that 'scientific medicine is destructive, extremely costly and solves nothing. Beware of the octopus'.[7] Spectacular cases could be cited which apparently support it.[8] Orthodox medicine is described as trying to 'inhibit the development of unorthodox medicine', in order to enhance its own 'power, status and income'.[9] Salvation, it is claimed, comes from the alternative movement which represents '... the most effective assault yet on scientific biomedicine'.[10] Whether any of this is true or not, it is perceived as the truth by many patients and amounts to a serious criticism of what is happening in mainstream medicine today.

In view of such criticism, strategies for overcoming problems and rectifying misrepresentations are necessary. Mainstream medicine might consider discovering how patients view the origin, significance, and prognosis of the disease.[11] Furthermore, measures should be considered to improve communication with patients. A diagnosis and its treatment have to make sense to the patient as much as to the doctor – if only to enhance adherence to therapy. Both disease and illness must be understood in their socio-economic context. Important decisions, e.g. about treatments, must be based on a consensus between the patient and the doctor. Scientists must get better in promoting their own messages, which could easily be far more attractive, seductive, and convincing than those of pseudo-science.

These goals are by no means easy to reach. But if we don't try, trust and adherence will inevitably deteriorate further. I submit that today's unprecedented popularity of complementary medicine reflects a poignant criticism of many aspects of modern medicine. We should take it seriously.

E Ernst

Where's the Evidence?
William Silverman
Oxford University Press, 1998
PB, 272pp, £39.50, 0 1926 2934 4

We should be careful, said Mark Twain, to get out of an experience only the wisdom that is in it, lest we be like the cat that sits on a hot stove and learns the wrong lesson. Never again will it sit on a hot stove, but never again will it sit on a cold one.

In a world that equates data with knowledge, those of us who fear our minds are growing as cluttered as our journals need people to goad us into asking if we're learning the right lessons. One such is Bill Silverman, one-time pioneering professor of paediatrics at Columbia University who, though he would never claim to be the father of neonatal intensive care, would be the first person a judge would send for to decide on a paternity test.

Since he retired he has, in books, articles, and lectures, sought answers to the question, 'How do we know what we know?' and, though now aged 80, remains an unrepentant student. (One of his teachers, Richard L Day, defined a student as 'someone who thinks otherwise' and suggested it was dangerous to treat this healthy state of mind.)

In 1986, an enlightened journal editor invited Silverman to write a regular column and those columns have now flowered into this collection of lively, readable essays. A sampling of their titles gives a hint of their range: Selective ethics, The gatekeeper's brouhaha, Miracle cures, Humane limits, Resolving insoluble dilemmas ...

Many, but not all, the anecdotes Silverman uses to illuminate his arguments, derive from perinatal medicine, but the dilemmas he examines confront every species of clinician. He encourages us to respond by questioning the evidence that informs our decisions, by distinguishing between the values we need when acquiring knowledge and those we need when applying it, and by recognizing that all medical privileges are granted to us by our patients.

At a time when medical 'literature' consists overwhelmingly of ill-digested information, this book resuscitates a more creative literary tradition by admitting us to the company of a wise and civilized guide who points to things and asks 'Have you noticed this?' or 'Have you considered the implications of that?'

It also offers succour to those of us who fear that most of the world's troubles are caused by people who have the courage of their convictions and yearn to hear from those like Silverman who have the courage of their doubts.

Michael O'Donnell

In a world that equates data with knowledge, those of us who fear our minds are growing as cluttered as our journals need people to goad us into asking if we're learning the right lessons...

What to do in a General Practice Emergency
Iain Higginson, Melanie Darwent, Rosaleen Gregg and Ed Peile
BMJ Books, 1997
PB, 112pp, £12.95, 0 72 799 118 X

Books like this one are useful in two situations. The first is after a critical incident, to check what you did and to learn more for next time. The second is when you need to know what to do now.

This book is designed for both situations, but works better for the former. The style is clear and accessible, and generally the information is pitched at a GP who sees occasional emergencies rather than a BASICS enthusiast. There are several useful touches – such as defining delayed capillary refilling in shock as a squeezed fingernail not going pink in two seconds, and practical hints, such as the relative merits of emergency spacer devices or the use of surgical gel packs for epistaxis.

Although written by a combination of GPs and A&E doctors, this book sometimes falls back on hospital perspectives. The description of croup perpetuates the myth of onset over days – in my experience it usually comes on between a child with a runny nose going to bed and the on-call GP going to sleep. There is also no discussion of when not to embark on resuscitation; while reminding readers that 'you're not dead until you're warm and dead', is appropriate in treating hypothermia; the question of when not to attempt CPR after sudden cardiac death is not raised.

With nearly 100 pages and little more than the standard contents list and index pages, it isn't easy to find the key pages

in a hurry and in poor light for on the spot use. For future editions, the publisher may want to address this issue, but in the meantime this helpful book is going in my car for further field testing.

Chris Burton

GP Tomorrow
Jamie Harrison, Tim Zwanenberg
Radcliffe Medical Press, 1998
PB, 204pp, £17.50, 1 8577 5203 1

The future, like the past, is another country. But while historical maps are broadly accurate, predictions of the future either risk being startlingly inaccurate or must include large vague areas marked 'here be dragons'.

GP Tomorrow chooses the latter. Indeed a kaleidoscope would be a better metaphor than a map for this book, which includes pieces of various shapes and colours likely to contribute to the future pattern of general practice, rather than attempting rash predictions.

The book grew from a conference on the future of general practice education, and mostly concerns this aspect of our future. The core of the book contains descriptions of various innovations in postgraduate and continuing general practice education around the UK. The future pattern of education, however, depends on what one is preparing people for. The first section therefore analyses social trends and the historical context of general practice, while the third looks at changing needs and expectations of doctors and patients.

The descriptions of educational innovations are relevant both to GP teachers and learners planning their future work. The historical sections are useful summaries.

The sections which speculate about the future or generalize about social trends are thought provoking but sometimes rather simplistic. Thus, for example, a central idea is the contrast between 'baby boomers' and 'generation X' in their personal and professional values under the heading of 'post-modernism'. This might make me attribute many of my dilemmas to being born midway between the two cohorts, if I did not know that conflict between achievement and affiliation, and between justification by faith and by works, has been bothering people for millennia.

The section on rural networking is valuable, but other recent developments, such as GP co-ops and multifunds, which will also change the way doctors work and relate to each other, are missing. There is little discussion of the future role of GPs in commissioning, or the effect of changes in employment options for GPs on their education. It is a shame that a book on education pays so little attention to the impact of the *Tomorrow's Doctors* reforms and house-officers in general practice, and that it was written just too early to include any consideration of the CMO's review of CPD or the Bristol GMC case, clinical governance and the quality agenda. These will have a profound effect on all our futures.

The blurb suggests that it provides a framework for the future GP's career. This is to claim a little too much. It provides some brightly coloured, interestingly shaped crystals, but readers will have to find others and fiddle with their own kaleidoscope to create an attractive pattern.

Peter Toon

Nurse Practitioners in Primary Care
Naomi Chambers
Radcliffe Medical Press, 1998
PB, 130pp, £17.50, 1 8577 5293 44

Naomi Chambers gives a perceptive and comprehensive overview of the background to the nurse practitioner's role. She has clear insight into the problems facing general practice today, and argues that the current structure, which places doctors as sole first-point-of-contact health carers, does not fulfil the health needs of modern society. The clinical focus of medical training leaves doctors ill-equipped to deal with many of patients' concerns, which are classed as 'trivia'. Consequently, doctors feel over-burdened by their heavy and disparate workload, and patients feel that they face unacceptable delays in obtaining appointments, unacceptable waits in the surgery, and rushed consultations in which their concerns are not explored.

The nurse practitioner offers the patient a choice. Her relationship with the patient is different: she is perceived to be less socially distant, more approachable, and to take a more holistic approach. She may also provide a welcome opportunity for a consultation with a woman.

The author's own research into the role of the nurse practitioner is summarized. Patients generally rated consultations with the nurse practitioner more highly than the GPs, and all of the practices seemed to find that the introduction of a nurse practitioner was a positive experience. The effect on workload was inconclusive, though studied practices were already providing quicker access to appointments than the national average, and the nursing hours were limited.

Several contentious areas are considered: the lack of an agreed definition of a nurse practitioner; the failure of the UKCC to recognize the title; the grey areas of medico-legal responsibility; and training difficulties. The support of health authorities is identified as being crucial to the development of this role. Practices with high list sizes, high consultation rates, and no female partners could most benefit from the introduction of a nurse practitioner.

This is a cohesive account of the role of nurse practitioners in primary care, and will interest those involved in practice development, and planning in health authorities and primary care groups. Essential reading for any practice team considering extending the role of the practice nurse.

Gina Johnson

education and training for primary care groups.

The Primary Care Group (PCG) Resource Unit in Oxford is dedicated to the promotion of primary care groups. It is part of the Public Health Resource Unit based at the Institute of Health Sciences, and funded by a grant from NHS Executive East Anglia and Oxford R&D department.

The introduction of PCGs is one of the most radical reforms of the NHS. If they are going to have a successful role in health care commissioning and planning, then it is doubtful whether the NHS can afford **not** to put education and training high on the developmental agenda.

In the past, the organization of education and training for GP fundholders was patchy. Some regions and health authorities organized training programmes with a mixed response. Some fundholders organized their own training. However, there was little co-ordination of the training programme. The same story was true of other models of commissioning.

The PCG Resource Unit undertook a two-part Delphi consultation, followed by a consensus conference to establish what the education and training needs of primary care are.

What were main skills?
The skills needed were prioritized. They could be categorized into three groups.

1. Creating the PCG and helping it work together:

- team working and building
- understanding the role of others (in the PCG and externally)
- co-operation and conflict
- communication (internal and external)
- influencing
- operating as a corporation
- understanding the PCG (including its decision making mechanisms and organization)

2. *Planning and management:*

- strategic planning
- commissioning
- critical/analytical skills
- project management
- clinical governance and quality management
- public involvement

3 Public health:

- public health role
- health needs assessment

Education and training delivery
A number of themes emerged:

- Most training should be delivered at PCG level.
- A co-ordinated curriculum (Group Contract for Education and Training) is needed. Each PCG will need to have the means to achieve this.
- Training should be PCG led, multidisciplinary, largely use existing sources (e.g. Health Authorities and Trusts), and be based on an audit of existing skills to determine the education and training needs.
- There may be some specialized skills required as the functions of the PCG become more obvious.
- Networking and cross-fertilization between PCGs will be important to share ideas, experiences and functions.
- Educational (NMET) consortia and medical education departments need to co-ordinate action for funding.

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A full copy of the report is available on our web site at http://strauss.ihs.ac.uk/pcgru

simr

Seriously Ill for Medical Research believes that important research into conditions such as multiple sclerosis, muscular dystrophy, cystic fibrosis *et al* may involve animal experimentation, and that such research may be threatened by a well-organized and vociferous animal rights lobby. Details at **http://www.cix.co.uk/~embra/simrind.html**, or SIMR, PO Box 504, Dunstable, Bedfordshire, LU6 2LU, or telephone 01582 873 108

academy of medical science

An inter-disciplinary Academy of Medical Science has been established in the UK to link clinical practice and science, and to encourage British academic medicine to speak with a unified voice. Of 350 Founder Fellows, 13 (3.7%) are from General Practice: Professors Carter, Haines, Howie, Jarman, Jones, Kinmonth, Mant, Pereira Gray, Pringle, Southgate and Stott, plus Dr Douglas Fleming and Sir Donald Irvine.

new publishing appointments at the RCGP

Dr Peter Toon, MRCGP, has been appointed Editor of College Publications and Dr Rodger Charlton, FRCGP, the Editor of the Members' Reference Book.

As Editor of College Publications, Dr Toon, a part-time GP in Hackney, will be responsible for all the material published by the College, with the exception of the *BJGP* and the Occasional Paper series. Dr Toon succeeds Professor Denis Pereira Gray, OBE PRCGP.

Dr Rodger Charlton, a GP in Solihull, succeeds Dr Douglas Garvie, OBE FRCGP, as Editor of the Members' Reference Book (MRB). In the post, Dr Charlton will take on responsibility for editing the content of the MRB, an annual publication which is distributed to College members. Dr Charlton is also a senior lecturer in primary health care at Keele University, and a research fellow at the West Midlands Region General Practice Unit.

Jill Thistlethwaite

Computer

The practice has just plugged in a new computer system. This one is in colour and comes complete with games for those idle hours you get in general practice. Luckily, the lucrative brain waves of Bill Gates are familiar to me. I know Windows aren't what you stare out of in the other few of those idle hours you get in general practice.

There are supposed to be four days of training. I have one hour. The once familiar sequence of updating repeat prescriptions seems to involve a lot more steps. If the tiny pill bottle to the left of the drug name is blue, then I can authorize another script. Out-of-date already: How many tablets are still dispensed in bottles?

New technology, new jargon: receptionists are getting to grips with icons, the mouse, its mat, and clicking-on. Adverse reactions flash up on screen whenever any drug is prescribed. Funny, though, I never have enough time to read them. Besides, the new VDU is so much bigger that I am making an effort to ignore it for at least 50% of the time a patient is in the room. I resist the idea of the screen becoming the third party in my negotiations with Mrs Smith, but the box purrs away, a monotonous aural reminder that the art of medicine now incorporates the science of information technology. When the machine doesn't respond to my commands (perhaps it is paying me back for ignoring it) I have to admit defeat and find an old-fashioned prescription pad. It is at times like these I fully empathize with Basil Fawlty attacking his Austin 1100 with a tree branch.

Now, I am told, there is no excuse not to go 'paperless'. Several of my partners have already converted to this Shangri-La state of ecological thrift. Dispense with all those Lloyd George envelopes, the fat ones and the thin ones. Think of the advantages. You are only able to recognize the heartsink patients by name. No more notes to lose underneath car seats. No more running out of continuation card and scribbling in ever-decreasing letters over the Secretary of State's claim to ownership. I am sorely tempted. At least this new system allows me to write essays of free text without keyboard gymnastics. But paperless?

At lunchtime my in-tray is filled with hospital letters, requests for sick notes, NHS Executive glossy magazines, details of postgraduate meetings, minutes of the last practice meeting. No records to take on visits, only two pages of printout. Ah, that sort of paperless. 'Anyone seen Mrs Smith's blood result?' 'It's on the computer.' Ah, that sort of paperless. The security of holding a form in the hand, not letting it out of my sight until the appropriate action is taken, is something from which I will have to be weaned. All pathology results are lurking in some unspecified file. The only problem is the system has crashed and we won't be connected again until the morning.

web sites of the month

Hi BJ,
This is not strictly medical, but possibly interesting. There seems to be an increasing trend on the net to live your life and bring up your family according to a set of principles. Where better, then, than Disney and Microsoft to get suggestions...?

The Disney way **http://family.disney.com/** is where Walt's successors give you choices, such as learning how to be a Grandparent, or entering the food you have in your cupboard and finding a recipe. I put in Rice and Beans (two staples of mine, as you may remember) and it came up with Cowboy Beans and Rice (I didn't have any Barbecue sauce though – perhaps I can make do with Soy. (This is all very nice, but why you should trust an organization whose mascot needs an otoplasty is not really clear.)

And then there's Microsoft **http://msn.co.uk/** those purveyors of fine software – whose Office 2000 suite is currently Beta testing, and who actually use mostly other people to supply information using Channels. (This may be the wisest way to use their content within your framed environment, since you're not responsible for any errors). Nice one, Bill :-)
Cheers,
Rob **www.schin.ncl.ac.uk**

our contributors

Chris Burton is a GP in Sanquhar, a corner of south west Scotland upon which the sun rarely shines. He maintains academic credibility by working with SIGN, progenitor of Scottish clinical guidelines, of which there are more than a few...

Professor **Edward Ernst** heads the department of Complementary Medicine, Postgraduate Medical School, University of Exeter

Jim Ford completes his *History of Socialized Medicine* in this issue of the Journal. He now returns to his day job, as a senior medical officer with the NHS Executive, in Leeds and London

Trish Greenhalgh returns to our pages untanned but refreshed after a fortnight in the Yorkshire Dales

Gina Johnson is a GP in Luton and convenor of the South Bedfordshire Practitioners' Group. Her practice has actively encouraged the development of an extended role for the practice nurse, by developing a university-accredited course based on their book *The Minor Illness Manual*

Alan Munro divides his time locuming and working towards an MSc in philosophy with the Open University

Roger Neighbour is Convenor of the MRCGP Panel of Examiners

Michael O'Donnell is Michael O'Donnell

Blair Smith is a member of the *BJGP* editorial board. He has been known to holiday in Banff

Jill Thistlethwaite is a GP in Hebden Bridge, West Yorkshire, and senior lecturer in community-based teaching at Leeds University

Peter Toon recently sang Mass in Avignon Cathedral. Less exotically, he is the new Editor of RCGP Publications

Patricia Wilkie is chairman of the RCGP Patient Liaison Group. Previously she has chaired the Patients' Association and a local health council. Having trained as a nurse, she graduated in sociology, and has a PhD in Genetic Counselling. She has been a senior researcher at Glasgow Royal Infirmary, and, more recently, with Paul Freeling at St George's in London. She chairs an LRUC, and is sometimes a reviewer for the *Lancet*.

Tim Wilson is director of the GP Commissioning Resource Unit, Institute of Health Sciences, Oxford

Alan Munro

Sailing

The sound of Harris is a desert of white sand, flooded by the Atlantic to a depth of only a metre of two and speckled with wind-torn and sea-blasted nuggets of Lewisian gneiss. Ancient among rocks, sharp and awkwardly angular among words, gneiss to boats is unyielding, plank splintering, keel gouging. The helpful folk of Harris have erected so many beacons and cairns denoting dangers and passages, that their profusion is as bewildering as the rocks themselves. We negotiate the labyrinth, all talking at once and all pointing in all directions at once. Pilotage by clamour. Chess with rocks, by committee.

We slip silently westward from the Hebrides on a benign sea in the half light of northern midsummer night. Distant lighthouses wink cheerily, and sink away. Curious fulmar accompany us now and then as faint flickering apparitions. Dawn flames a line of shower clouds over Lewis in yellow luminescence. St Kilda's cliffs and stacks rise ahead. Stiletto-beaked gannets take fishy breakfasts on folded wings from a hundred feet. Tea and bacon butties seem simpler, and incomparably delicious. The sun slowly warms our night chilled and dark stiffened limbs.

Village bay faces east. We wake, bouncing, in an easterly. A grey veil of high cloud rushes from the south to smother the new sun, which succumbs in a lurid splash of purple, pink and orange. The day passes in close reefed plugging to windward, pitching between leaden sky and sea, the universe shrunken to a mile or two of windy, grey drizzle. More dead than reckoned, the bird's nest of lines on the chart leaves a certain amount to sheer creativity when land in bits does eventually materialize in the rainy gloom.

Crossing the Minch we have a fine following wind, gathering strength through a long day, with mounting seas pressing us faster homeward. It is hard to steer the course accurately, which confuses the navigator. He is restrained with difficulty from reporting by radio to HM coastguard the abduction of the Oig Sgeir, complete with lighthouse and its keeper's three-hole golf course. (Visions of a helicopter full of big fellas in white coats) We find it in due course. We surf at exhilarating speed on black sea laced with white crests below streams of scudding cloud torn from the peaks of Rhum and Skye. We're knackered from sailing nights as well as days. We know that someone should shorten sail, but we hope that nothing will come apart before we get to shelter.

We are in a perfectly secluded pool. Ash, rowan, alder and sycamore stroke the venom from the wind. The anchor is sunk feet deep in tenacious mud. We talk of taking more care. Secretly, lest the Gods are angered, we feel immortal. Rain drums on the deck. Wavelets plop under the dingy. A last dram, and sleep.

If the chemistry of my contentment were available, bottled, in wee white parcels, should doctors prescribe it? Do we already do that?

Overdose

The line I signed yesterday -
refrain from work: depression -
waves redundantly by your bed
where you lie like a discarded half-bottle.
My silk and an arterial bead
punctuate parallel lines on your left wrist
and remind me of another line I wrote then -
no suicidal ideation. I lied too.

Blair Smith