The British Journal of General Practice

Viewpoint

Building bridges in no man's land

The NHS slogan machine seems to be pulling in two directions. On the one hand we have a 'primary care-led NHS' with services translated from secondary care into primary, and on the other the notion of 'managed networks of care' with a specialist hub and spokes radiating out to primary care. There seems to be a no man's land of patients not currently receiving potentially beneficial treatment, who fall between hospital medicine and traditional general practice. From the centre, secondary care can advance into this no man's land with outreach teams; from primary care the notion of the specialist GP may once again be on the political agenda. But are either of these appropriate for improving the care of the ordinary patient in the ordinary practice?

Cardiovascular diseases are one area where this tension applies, and many aspects of the problem surfaced at a recent consensus conference on atrial fibrillation, run by the Royal College of Physicians of Edinburgh and held, to mark the research institute of James MacKenzie, in St Andrews. The conference brought together a panel, speakers and delegates from primary and secondary care for two days of presentations and debate. Agreement did not come easily: where there was little 'evidence' choices were fairly empirical, and where there was 'evidence', for instance on stroke prevention with warfarin, its limitations were highlighted and the same data were seen to mean different things from different perspectives. Cardiologists argued in favour of every patient with atrial fibrillation having an echocardiogram; others pointed out that it would make a difference to very few. Enthusiasts for well controlled warfarin, arguing that almost anybody would want to take it if they knew the facts, were countered by others who saw patients with different priorities and belief systems.

Reflecting, a week or so later, I find myself thinking that nobody has it quite right. The specialists have striven to build knowledge, carefully weighed and balanced, but have inadequate breadth of vision to use it fully. Many GPs, on the other hand, although well placed to deliver or develop best care, do not quite have the knowledge or resources to do it. So, what are the ways forward? Hospital outreach services could deliver the best knowledge without adding burdens to primary care, yet they would almost certainly do it in a disease-centred model, fragmenting whole-person care.

In this context, 'primary care specialists' could become attractive, but does seeing an unfamiliar doctor from a neighbouring practice about just the one problem really benefit anyone? Perhaps it does if it means that waiting times are minimized, but that may be at the expense of missing out on a 'proper' specialist opinion. Instead, I believe we need to look at ways of bridging the gaps with a managed network — not of care, but of information. This would use a new type of specialist GP: not in the old way by having them see patients as 'specialoids', but working with primary care teams as translators or interpreters between current (and, of course, changing) knowledge and real-life primary care. Many practices still need to build core skills within the team (although not necessarily in all doctors) in managing patients with cardiovascular diseases. A network, supported by a specialist GP, could enable practices and practitioners to develop skills and guidelines appropriate to their practice while preserving the unique long-term patient–GP relationship. Such networks have not yet been widely explored. Perhaps now would be a good time to start.

Chris Burton

The Back Pages...

When the patient finished his monologue the doctor slowly rolled up the newspaper, stood up, and hit the patient on the top of his head several times, shouting "Pull yourself together man!"

Michael Dixon gets empathic, page 1811

contents

Clinical Governance

In the true spirit of clinical governance which, as a concept, will affect the whole of the primary health care team, the Scottish Clinical Governance Conference, hosted by Scottish Council RCGP, attracted a multi-disciplinary audience of over 200 delegates from throughout Scotland. There would have been more, if the venue was able to accommodate them!

The one-day conference, entitled 'Promoting Good Practice', was in four parts, and dealt with an agenda which was designed to be informative and also to provide opportunities for delegates to contribute.

The conference opened with a keynote address from Sir David Carter, Chief Medical Officer for Scotland. Admitting that all the answers were not yet available, Sir David pointed out to the audience some of the issues that he felt still needed to be addressed. These included the questions of who should do clinical governance, and where; at what level central guidance should be given; how flexibility can be retained; how professional self-regulation will fit with clinical governance; how openness can be encouraged while still retaining confidentiality; and how cost and time implications can be monitored and, indeed, where primary care fitted within the clinical governance agenda. He clearly recognized that clinical governance needs to be profession-led, it needs to be facilitated, and it needs to be properly resourced.

Following Sir David's scene-setting introduction, part two of the conference dealt with perceptions of the impact of clinical governance, from the perspective of the General Medical Council (professional self-regulation), the patients, and the managers. Key points that arose included the current changes affecting the work of the GMC in relation to the clinical governance agenda: the need to educate patients and to use more lay terms; the need to see quality from a patient's perspective (since definitions of quality may vary), and the need to adopt a 'cockpit culture' within primary care. After all, a pilot would be expected to have a co-pilot to help fly a plane safely. Similarly, there may be a need for GPs in particular to recognize that they should not be 'going it alone'.

Following coffee, the conference heard about some of the initiatives and tools that may be helpful in implementing aspects of clinical governance. These included the work arising from the Acute Services Accreditation Group, the Practice Accreditation Initiative, the RCGP's Quality Practice Award, and an IT-based audit package developed in the West of Scotland.

Questions from the floor were encouraged, and covered a variety of points. There was a need for patients to be involved, but to have reasonable expectations at the same time; there was also the need for a range of positive incentives to be made available for those undertaking clinical governance. Evidently, new and re-directed resources would be required, and both structure and process in clinical governance were of immense importance. There was a tremendous emphasis on the fact that clinical governance should be profession-led.

The conference was very much about facilitating discussion, and in the afternoon 13 small working groups tackled a number of key questions. In the short feedback session there was clear acceptance of the principle of clinical governance, but some obvious concerns over practical issues such as a lack of available time, or any clear incentives, and concern over both inadequate IT support and where the resources were going to come from. There was a strong commitment to effective team working, and the recognition that not all practices and individuals would be starting from a common point, or would be able to work on the same time-scale. Standards, not targets, had to be both measurable and achievable, and they had to be seen to be essential to good practice. Under-performance had to be clearly defined and dealt with by facilitating change.

The delegates shared many common issues, and this conference provided the participants with the opportunity to discuss their concerns, and to recognize also that there was a common will to embrace clinical governance in Scotland, if the issues discussed above — raised time and again by delegates and speakers throughout the day — could be addressed.

Gill McDonald

Breaking the Sound Barrier:
Report on the Royal National Institute for the Deaf Hearing Test Campaign for GPs

It is estimated that one in five adults may have a hearing loss problem. Despite this, fear and embarrassment often prevent patients presenting for many years, and even then they may not be referred, because they (and their doctors) believe that all that will be offered to them is a hearing aid of dubious benefit.

A public campaign, aimed at people whose lives could be improved by a hearing device, is seeking to raise public awareness about the need for regular hearing tests and early intervention. A pilot seminar was held recently in connection with the campaign, which was designed to update GPs and to encourage early referral.

The seminar was very successful, in that it demonstrated the many technological advances in audiology available today. Stands belonging to the NHS and RNID — as well as a number of commercial stands — displayed a wide variety of hearing devices, remote controls, information leaflets and other resources. Many were new to me, such as the RNID's TypeTalk service, funded by British Telecom, and also a cheap portable device suitable for use by hearing-impaired patients during GP consultations.

Representatives from nine North West audiology departments were available to talk to their own GPs, and 11 trusts provided useful information sheets with names, referral guidelines and details of clinics.

Up to a quarter of patients referred directly to audiology services have problems that require an opinion from an ENT specialist, thus delaying the fitting of a hearing aid. Conversely, some patients are referred unnecessarily to consultants. Eugene Kobbe, a Tameside ENT surgeon, provided a useful checklist for appropriate referrals. These criteria are repeated in the RNID Hearing Test Campaign material, tel 0870 605 0123.

Sheila Kabbani, a chief audiology technician, was enthusiastic about the public campaign. However, she highlighted the need for adequate numbers of highly qualified staff. She pointed out that initial and follow-up assessments take approximately 30 minutes, and hearing aid wearers are never discharged.

Professor John Bamford from Manchester University reviewed the causes of acquired hearing loss, emphasizing that it was the degree of functional disability which mattered. In addition, high quality services were relatively inexpensive, considering the benefits that could accrue.

Hearing therapists are members of a relatively new profession, and these individuals can offer both practical and emotional rehabilitation to adults who have lost all or part of their hearing. Lucy Handscomb graphically described their problems, and some of the solutions.

This free seminar was PGEA accredited, and should improve GPs' knowledge and willingness to refer, with obvious benefits for their hard of hearing patients.

Melanie Wynne-Jones

Research in primary care: getting started

The first five articles in this series focused on the nature of primary care research and its application in practice. This final article is intended for health professionals working in primary care who wish to undertake original research themselves. There are five questions to consider.

1. Is it really research you want to do?

Research, as I have argued previously, is the process of finding valid and generalizable answers to simple questions. Many people who embark on a 'research' project, however, have a fundamentally different objective, as illustrated in Box 1.

You should be particularly clear about the distinction between *audit*, which is a two-stage data-gathering exercise designed to inform and improve one's own practice against an established standard of good practice,[1] and *quantitative research*, which involves the collection and analysis of data for the purpose of testing a hypothesis — and hence, perhaps, establishing a new standard (and, ultimately, improving other people's practice as well as one's own!).

Audit of one's own performance is laborious and time-consuming. The findings are often an eye-opener for the practice team. A well-designed audit usually improves patient care in some way. It may reveal important deficiencies in communication or record-keeping within the practice. The methods used in audit need not be original or unique. It is relatively rare for a practice audit to have a generalizable message for other practitioners. For all these reasons, papers describing even the most exemplary practice-based audits tend (rightly) to be rejected by medical journals, whose chief aim is to publish original research.

The same can be said of needs assessment in primary care. The essential task of establishing and prioritizing the health needs of a community, which from April 1999 will be a contractual duty of UK general practitioners (executed through the Primary Care Group),[2] involves the systematic collection and analysis of both quantitative and qualitative data.[3] Many of the techniques for needs assessment — selecting a sample, measuring health or disease status, charting improvement, or deterioration over time — are identical to those used in epidemiological research, but the two tasks should not be confused.

2. Do you want to 'fly solo' or link in with others?

One reason why so few primary care teams are actively involved in research is that, despite recent advances in information technology, most general practitioners remain geographically, professionally, and intellectually isolated both from their peers and from formal sources of academic support. There is no direct equivalent, for example, to the hospital 'grand round' in primary care. Furthermore, the disparate and unselected case mix of general practice (most of the patients we see are 'grey cases' or not 'cases' at all) mitigates against tidy research studies into the kind of discrete conditions that are recognized in textbooks. Indeed, an increasing proportion of the workload of both general practitioners and practice nurses involves managing asymptomatic people who are at risk of serious illness, rather than patients *per se*.[4]

It is not surprising, then, that (with some commendable exceptions[5]) good research in primary care rarely comes from individual practitioners working in isolation, and that a formal programme of apprenticeship and support leading to accreditation has been proposed for practices embarking on research for the first time.[6] Box 2 shows some possible links that an individual or practice team should consider making to gain support, collaboration, shared funding, and advice on practice-based research projects.

3. Do you have a specific research question in mind?

Professor John Howie has suggested that a good research question should be important, interesting (indeed, driven by the burning intellectual curiosity of the researcher), and answerable.[7] I would add two additional requirements: first there should be a high chance that the results of the study would benefit patients, either by confirming the value of existing practice or by supporting a change in practice. Both the NHS Research and Development Programme and the Medical Research Council now require applicants for research grants to address the question of clinical outcomes in their initial application. Secondly, the results should be practically and financially implementable.

Colin Bradley lists a number of examples of clinical questions that would *not* lend themselves to good research, including questions of clinical diagnosis ('is this rash eczema or tinea?'), unethical questions ('would saline injections discourage "heartsink" patients from attending?'), unfocused questions ('are home visits worthwhile?'), questions that pertain to the behaviour of a specific individual rather than a definable subgroup ('why doesn't Mrs X leave her violent husband?'), and questions that are readily answerable from the published literature ('are inhaled steroids effective in asthma?').[8]

Bradley also notes that reflecting on one's own clinical practice may generate important, interesting and answerable questions that challenge established but perhaps unjustified practices (such as recommending no food for children with acute diarrhoea).[8] He suggests that many relevant and important questions would be recorded if general practitioners kept a notebook for ideas that arise during clinical

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20. To join this group, send an email to postmaster@mailbase.ac.uk with the mes-sage 'subscribe evidence-based-health'.)

Box 1: Research in primary care (and things that are commonly confused with it).

Objective	*Appropriate means*	*Example*
To produce a generalizable answer to a hypothesis-driven question	Quantitative research study[1]	Do patients with simple sore throat get better more quickly if they take an antibiotic?
To gain in-depth understanding of the nature of illness or healing	Qualitative research study[2]	Why do patients with simple sore throat come to the doctor?
To learn more about a particular clinical topic	Problem-driven literature search as part of ongoing personal learning plan[3]	Should I be prescribing antibiotic therapy for simple sore throat?
To find out what's going on in one's own practice	Systematic data collection[1]	What proportion of our patients with simple sore throat receive an antibiotic?
To compare one's own clinical performance with a professional gold standard and attempt to improve it	Audit[1]	Let's try to reduce the proportion of our patients who receive a prescription for antibiotics for simple sore throat
To assess and prioritize the health problems in one's practice population	Needs assessment exercise[3]	How big a problem is simple sore throat in our practice population?
To get published in a medical journal	Reflect on your reasons, e.g. to: • express an opinion (letter) • share a clinical story (case study) • assist colleagues to understand a topic (literature review or editorial) • gain academic recognition (research)	For example, to: • challenge a paper advocating antibiotic use • describe a critical incident in your practice • summarize the published evidence on management of sore throat • describe a survey of patients' concerns
To get a postgraduate qualification	Study specific university requirements: • MD or PhD thesis (major piece of original research with literature review and critical discussion essential) • MSc thesis (original research desirable but some institutions allow audit project, literature review, or reflective essay)	For example: • randomized controlled trial comparing different management strategies in sample of patients with sore throat • completed audit project that includes literature review and full audit loop with two stages of data collection

Box 2: Primary care research: links and networks.

Link or network	*Description*	*Contact*
Medical Research Council General Practice Research Framework (GPRF)	National network of about 600 general practices who obtain core funding, training and central academic support from the Medical Research Council. The GPRF undertakes large-scale epidemiological studies from a primary care base (e.g. treatment of hypertension,[4] role of practice nurses in depression,[5] and prophylactic thrombolysis[6]). All GPRF practices have an attached research nurse who is trained and employed by the MRC	Dr MR Vickers MRC Epidemiology and Medical Care Unit Woolfson Institute of Preventive Medicine Charterhouse Square London EC1M 6BQ
Research General Practices (overseen by Royal College of General Practitioners)	General practices who have received a grant for setting up and running practice-based research. This initiative was begun by the RCGP[7] to pump prime and stimulate Regional R&D sources (now subsumed into Culyer funds[8]). A 10 000-patient designated research practice would receive around £15 000 per annum.	Royal College of General Practitioners 14 Princes Gate, London SW7 1PU RCGP website (http://www.rcgp.org.uk) will shortly contain details of research funding opportunities for UK primary care teams
Local primary care research networks	Group of volunteer practices in a geographical locality, linked through community trusts and/or academic departments of primary care who provide training and support. Networks bid collaboratively for funding and undertake shared projects	Details of local initiatives may be obtained via academic departments of primary care.
Royal College of General Practitioners National Morbidity Surveys	150 general practice sites in England and Wales, which act as sentinel practices for morbidity data. Co-ordinated through a central academic unit which provides data collection, statistical support and training for research staff[9]	RCGP Birmingham Research Unit Department of General Practice University of Birmingham Medical School Edgbaston, Birmingham B15 2TT
National special interest groups	Interest groups (e.g. diabetes, asthma, rheumatology) often part-funded by the pharmaceutical industry, which aim to support and promote best practice and which may offer opportunities for collaborative research	No central database of these interest groups is available. Note that sponsorship for research may come from drug companies with a commercial interest.
Internet-based research initiatives	Several collaborative projects have recently been proposed by GPs via internet discussion groups. This form of collaboration is likely to lead to new research networks in the near future	See, for example, the discussion group evidence-based-health[10]

encounters in the surgery.

4. Who will do the research, when, and how?

The detailed 'scoping' of a research project is an important task. The resources in terms of staff, time, and materials should not be underestimated. Anyone who participates in the data collection will require training, and at least a sample of data sources will need to be double-checked for quality control. Assistants, technicians and receptionists working extra hours for cash may take longer to complete particular tasks than the professional staff who envisaged the project. Sampling and response rates suffer when research staff are inadequately trained in the principles of epidemiology or do not fully share the commitment to scientific quality. [9]

The project plan, including the background to the study, the hypothesis or research question, the methods to be used and the details of how results will be analysed, should be constructed in detail and circulated to colleagues for comment before a formal grant application is submitted. A protocol for such a plan has been suggested by Professor Yvonne Carter.[10]

5. Who will fund the study?

If your research project is part of a collaborative bid with other practices, seeking funding from appropriate sources will probably be the task of a central co-ordinator. If you are 'flying solo' or taking the lead on the grant application yourself, you will need to put together a formal grant application, and I would strongly advise you to follow a standard published protocol for this.[10] Note that the process of obtaining funding is often a slow one, and you should allow at least six months between submitting the application and receiving the funds. The Royal College of General Practitioners is about to launch a research web page on the Internet, with details of funding sources and training courses in research methods. The WISDOM website (http://wisdom.wellcome.ac.uk/) is another useful source.

Conclusion

It has been argued that sustaining quality in general practice requires a commitment to professional development, teaching, and research.[6] Both the case mix and the organizational aspects of primary care make good research in this environment a particularly challenging task. The development of a variety of networks, providing opportunities for collaboration, training and academic support, have made the vision of research a reality for many practitioners. I hope that this article, and the others in this series, will spur more practices into taking the first steps to becoming part of the growing research base of primary care.

Trish Greenhalgh

Climate change, population health and the general practitioner

General practitioners have an understanding of pathology, a role as healers, and an insight into both the fragility and value of our human endeavour. They have daily contact with the communities they serve. The richness of this contact, with its frequent delights and occasional tragedies, could motivate GPs to play a role in protecting our planet. GPs are trusted: their leadership may be crucial for promoting ecological sustainability.[1]

In 1992, more than 1500 leading scientists, including many Nobel laureates, issued a warning to humanity. They called for fundamental changes in global policy to cope with problems including climate change, loss of biodiversity, overfishing and overpopulation. Since then, many commentators, including some public health specialists, believe that environmental conditions have worsened. [2,3,4]

Our climate is changing, and the composition of our planet's atmosphere is changing. Concerns that rising levels of carbon dioxide and other greenhouse gases will lead to climate change appear to have been borne out. Proxy measures for temperature, using data from tree rings and corals, suggest that the 20th century has been the hottest since at least the 14th century, when available data starts. More conventional measurements, using thermometers, show this decade to be the hottest ever, with last year again breaking a record. Unfortunately, a warmer climate does not simply mean wine-making in Newcastle. Sea levels will rise, with less glamourous consequences, as warmer oceans expand. Tropical paradises, such as the Maldive and Cook Islands, will be submerged, along with other less economically significant island states. Their plight may be rendered inaudible by more powerful voices, such as that of the fossil fuel lobby.

The melting of the ice-caps threatens to increase the rate at which sea level rises. In 1995, an iceberg the size of Oxfordshire broke away from the Larsen Ice Shelf, consistent with a prediction made in 1978 that global warming may lead to a shrinking ice cap. While the main Antarctic icecaps seem safe for the time being, processes may already be starting which may cause them to collapse in the future, making subsequent catastrophic flooding inevitable. Probably though, we, and even our grandchildren, will be safely dead, even if tissue banks and new hormones extend the average human life in the rich countries past a century. But, unlike the past, our crowded earth now has hundreds of millions of people and trillions of dollars of infrastructure, as well as precious cropland, situated near coasts. Our increased technology has not made us invulnerable.

Increased extreme climatic events

The rise in sea level, a high tide, and a severe storm may combine to cause an 'extreme event', with widespread flooding of heavily populated regions, such as Florida or Bangladesh. Computer modelling suggests increased windspeeds and stronger storms are likely in a greenhouse environment. Rainfall has become heavier, yet large scale forest fires are becoming more frequent, and are themselves contributing to greenhouse gases. As deforestation increases, forests become more vulnerable to fire. This is partly due to an 'island' effect, created as the forests dry out along their increased perimeters.

Meanwhile, global warming may be linked to more frequent and intense cycles of both El Niño, and its sister, La Niña. These have had a range of climactic and health events, from droughts and fires to floods and hurricanes. Plankton blooms, normally associated with warmer seas, have been linked to cholera outbreaks in both Bangladesh and Peru, while rainfall changes can modify vector-borne diseases, including malaria and dengue fever.[5]

Disinformation

Sharon Beder's book, *Global Spin*,[6] documents how, in responding to environmental non-government organizations such as Greenpeace, corporate interests such as the fossil fuel industry (who stand to gain most from denial of impending ecological catastrophe) use state-of-the-art public relations techniques and industry-funded front groups to lobby for corporate interests. Some of these have benign sounding names such as the Global Climate Coalition. According to Beder, a key technique used by industry is to cast doubt and sow confusion, rather than to issue categorical denials – tactics well known to doctors in their dealings with tobacco barons. The controversial anti-environmental *Against Nature* programme, recently broadcast in the United Kingdom by Channel 4 television, demonstrated such techniques in action. Create a 'straw man' of the environmental movement – one who opposes the rights of those in impoverished countries to develop by using fossil fuels – then associate, by default, those who work for social justice with what is, in effect, racism.

Forces in favour of Business As Usual are able to marshall enormous resources. In March this year, many thousands of US scientists were mailed an invitation to sign a petition rejecting the Kyoto treaty. An accompanying eight-page review article rejoiced in rising carbon dioxide concentrations as 'a wonderful and unexpected gift', 'producing' an increasingly lush environment of plants and animals. The article, presented in the same format as a

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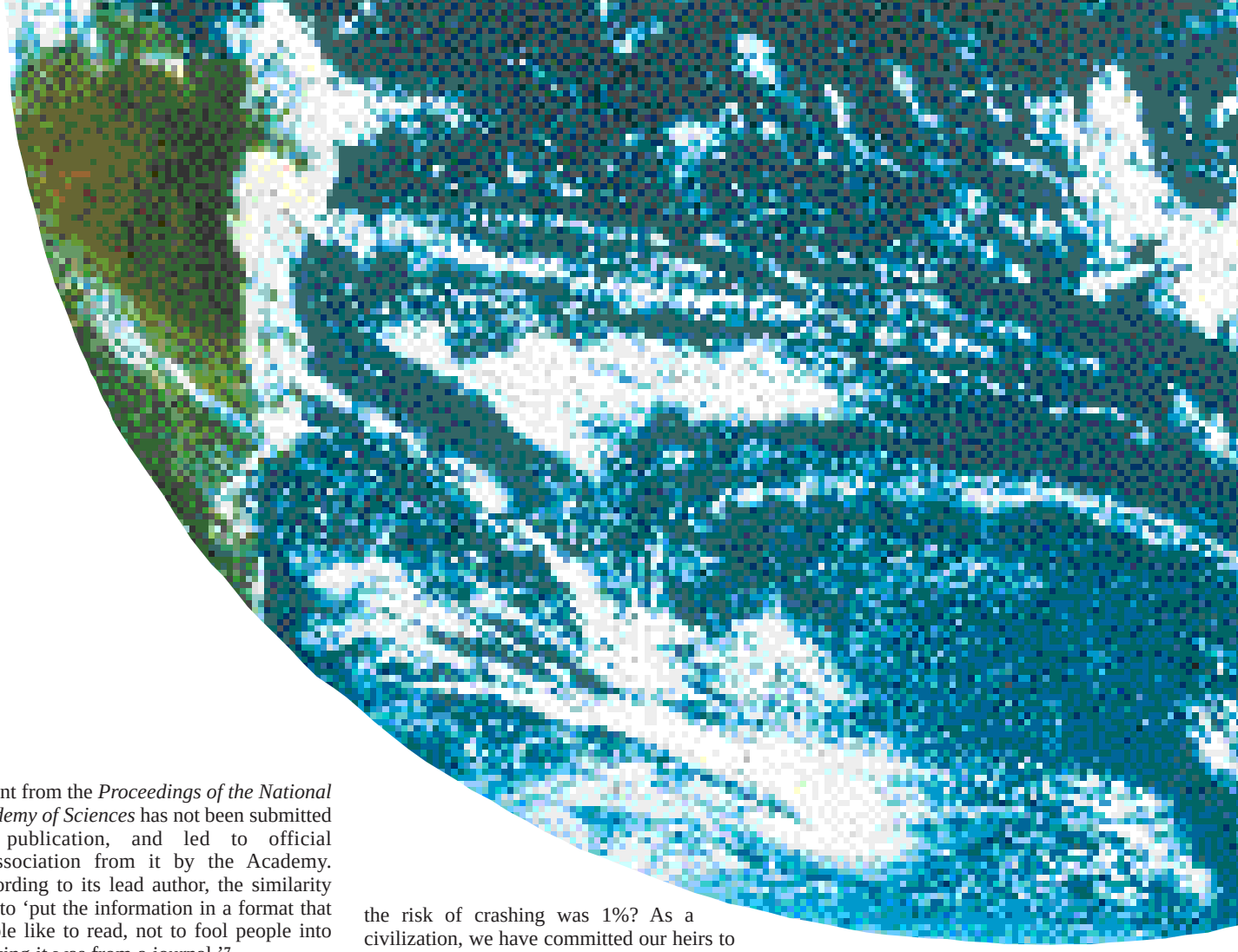


reprint from the *Proceedings of the National Academy of Sciences* has not been submitted for publication, and led to official disassociation from it by the Academy. According to its lead author, the similarity was to 'put the information in a format that people like to read, not to fool people into thinking it was from a journal.'[7]

Putting our children at risk

A ton of CO_2 emitted today will, on average, remain in the atmosphere for a century. The atmospheric level is rising rapidly now, in response to the vast expansion of the global industrial economy since World War II. Even if the Kyoto Protocol is ratified, CO_2 levels in 2010 are estimated to rise to 380 parts per million (ppm) compared with a figure of 381.5 ppm if there is business as usual.[8] (The level is now about 365 ppm, having risen from 280 ppm before industrialization).

The 21st century and beyond will inevitably be one of ever-increasing levels of CO_2, no matter how frightening the evidence of adverse effects becomes. We are conducting an enormous, uncontrolled natural experiment with the climate, and perhaps also with the quality of life of our children. Possible outcomes include an increased risk of war over scarce resources such as food. Recent floods in China are almost certain to reduce the Chinese rice harvest.

If we are lucky, ecological impairment will not cripple the civilization we leave. The risks of environmental catastrophe are unknown, and may be low – perhaps as low as 1%. But would our policy makers fly if the risk of crashing was 1%? As a civilization, we have committed our heirs to a flight on spaceship Earth which appears to have at least this risk of environmental disaster, on a scale far bigger than anything yet seen. Unlike real flights, our children have no choice but to take their seats.

Signs of hope

It is easy to despair at the apparently overwhelming difficulties facing our planet, particularly if we are aged over 40. Yet many of the advances which have contributed to our problems might also rescue us, including satellites, the market and renewable energy technology. The annual global population increase is falling rapidly, and though the per capita grain output has also fallen, we still produce ample food to feed nine billion vegetarians. With the global population not yet having reached six billion, there is still some time.

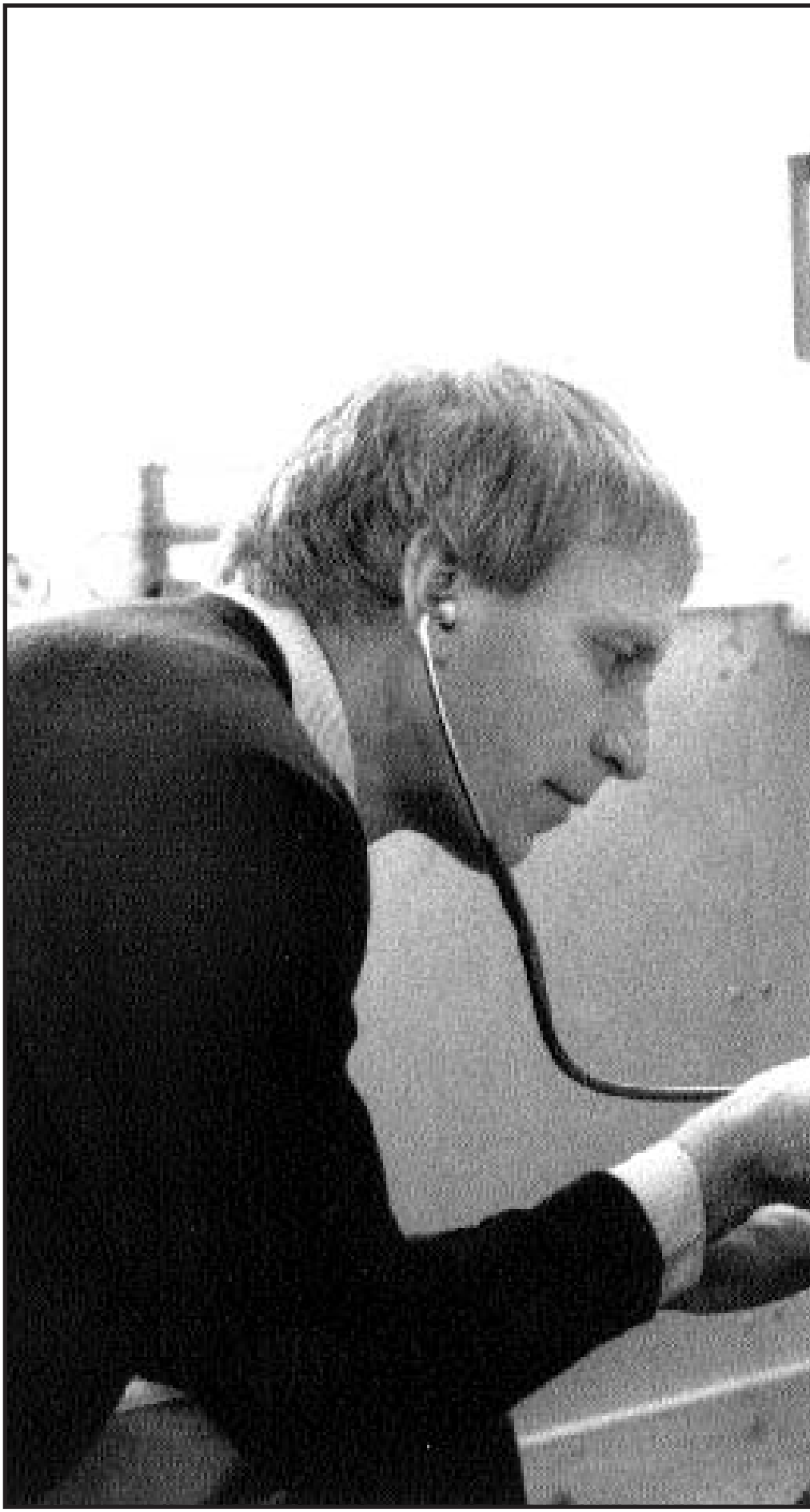
Switching to bicycles for short journeys, and using improved public transport will improve cardiovascular fitness and air quality. City farming may reduce transport costs and at the same time give urban dwellers a more direct understanding of humanity's fundamental dependence on the environment, from the weather to the quality of the soil and water. Market forces and entrepreneurs will promote technological transition, if sufficient economies of scale can be allowed to develop, and restrictions and subsidies which benefit the *status quo* are dismantled.[9] New York City recently invested $1.5 billion to protect the water purification ecosystem service in the Catskill Mountains, thus saving more than $5 billion.[10]

Learning from the future eaters

Flannery[11] describes 'future eating' as the effect of the introduction of human populations on virgin ecosystems, such as in Australasia. He describes how people in New Guinea eventually adapted to maintain sustainability, for example by tabooing certain species. On Indonesia's Mentawai islands, home to the 'singing' siaming monkey, it is considered taboo to catch the monkey while it is singing; the monkey's singing reveals its position, giving the hunter an unfair advantage. There are lessons here for modern economists.

I believe GPs have an important role in changing society and societal attitudes. Of course we must look after the interests of our patients as they present – warts, big tonsils, cost-benefit analyses, and all. But outwith our consulting rooms there are also questions of global health that we ignore at our peril.

Colin Butler



Paul Schatzberger
Sheffield
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Subject:
Dr Roger Smith, morning surgery. Andrew Bradbury presents with a cough and a cold. Diagnosis: upper respiratory tract infection. Antibiotics not prescribed. [Full consent to publication has been obtained]

Place: Heeley Green Surgery, Sheffield

Date: Tuesday 24 November 1987

Technical:
Camera: Leica M2
Lens: 35mm f2 Summicron
Film: TMAX 400 uprated to ISO 1600
Exposure: 1/60th sec at f4

two november highlights...

Managing Emergencies in Primary Care Conference
Tuesday 17th November, 1998

The conference aims to:

- examine ways of reducing emergency admissions by introducing new forms of primary and community care
- consider the appropriateness and effectiveness of models of out-of-hours provision
- consider the lessons for primary care groups in commissioning services
- help the primary care team understand the educational and employment implications of emergency care

Topics will include:

- **Models of emergency care**
  Jeremy Dale, Professor of Primary Care, School of Postgraduate Education, Warwick University
- **NHS Direct**
  Dr Geoff Royston, Central Project Manager for NHS Direct
- **Co-operatives: how they operate**
  Dr E Mark Reynolds, Chairman of the National Association of GP Co-operatives
- **Working with the Ambulance Service**
  Dr James Cox
- **The patient-doctor partnership**
  Dr Catti Moss

Keynote Speaker
Lesley Hallam, from the National Primary Care R&D Centre

Health Priorities for People with Learning Disabilities Conference
Wednesday 25th November, 1998

Draft programme includes contribitions from **Michelle Kelly** and **Jillian Hulme** (Threads Workshop, Sefton), **Anya Souza** (stained-glass artist and self-advocate), **Margaret Flynn** (Prince of Wales Fellow, Learning Disabilities, Assistant Director, NDT), **Dr Mary Lindsey** (Consultant Psychiatrist, Department of Health), **Kirsty Keywood** and **Sara Fovargue** (Law Faculty, University of Liverpool)

Workshops:

- Consent to medical treatment
- Advocating for health
- Working with people with a dual diagnosis
- Delivering primary health care to people with learning disabilities

For further details of speakers, fees and the full programmes, contact:

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http://www.rcgp.org.uk

career support...

The new RCGP Careers Support Forum Website discussion group has just started. The site is a place where anyone with comments, problems or solutions to career problems in general practice can air their views. The site is publicly available at **www.rcgp.org.uk**.
Go to the drop down list of discussion forums in the middle of the home page and press ‘go’ when you’ve highlighted Careers Support Forum. Please contribute and help to make this a vibrant and useful discussion forum.

Shaun O'Connell

Michael Dixon

When Opposite is Apposite

Depressed? Frustrated? After an evening surgery, do you find yourself elbowing spouse and children out the way in an unseemly haste to get to the drinks cupboard? Has your consulting room become just another branch of Joe's No-Hope Saloon? If the answer to any of these questions is 'yes', then here's a tip.

It was 6.15 pm during a recent Friday evening surgery when he was discussing his rear end yet again — it was clearly not malignant, but neither was it interesting. We had double booked for the evening's Christmas festivities, and the wife had said rather menacingly as I left the house that morning, 'If you're not back by 6.30 pm I'll kill you'. As the patient finished speaking I reached for the emergency button. 'Those piles of yours are so very interesting ... I could sit here talking to you about them all night ... they look just like pretty little worms ...' A few choice expressions of this sort and the patient looked up, bemused, made his excuses, and left rapidly. We got to the party on time.

There is no better way of staying in a rut than continuing to do what you have always done, and no better way of getting out of it than doing exactly the opposite. So this month's advice is: 'When the going gets tough — try the unexpected'. If you are bold enough then do it on a regular basis. When it happens by mistake — such as when we inadvertently leave the notes at a patient's house and he or she finds out what we really think of him/her — things frequently change for the better.

Our forebears were probably better at the unpredictable. One patient on my list recounts how he was telling a former partner in the practice about all his various aches and pains. The doctor was apparently not listening to him, and during the conversation picked up a newspaper and started reading it. When the patient finished his monologue the doctor slowly rolled the newspaper up, stood up and hit the patient on the top of the head several times shouting 'Pull yourself together man!' Did he lose his capitation fee? The patient has told me several times since how this is by far the best thing that any doctor has done to him, and is now probably one of the least demanding patients in the practice. Another partner used to call one of our patients 'a great fat cow', which she took as a term of endearment but which for him was an effective way of releasing frustration.

Learning to do the opposite of what your inclinations tell you is difficult, but what else is there to do when you are in a jam? When a patient tells you that your medication is no good and he plans to see a 'homotherapist', what good will it do to tell him that in fact it is a 'homeopath' and that there is no evidence base for seeing one anyway. Much better to light a metaphorical Hamlet cigar and bid him cheerily on his way, telling him that he needs to try it for at least 12 months before it is worth his while coming back to see you. As you begin to 'do the opposite' in all those entrenched situations the clouds start lifting, you begin to smile, and freedom will return. Nothing is so potent as the flow of emotion from a doctor who is normally reserved and barricaded. The opposite is a powerful message and powerful therapy. If acting it out is too difficult then what about a bit of creative visualization — many doctors have alter egos, who keep machine guns in the top drawer of their desks and frequently splatter the consulting room with blood and bullet holes.

All of which, you say, is homespun nonsense when the practice and patients are against you, the spouse is taking pills and the dog has gone incontinent. Sometimes there is simply no solution. On such occasions, make your apologies to the patient in the room, find your passport, set off for a desert island beach and soak up the sun. Of course, just the thought may be enough.

our contributors

Chris Burton works in windy Sanquhar

Colin Butler graduated in medicine at the University of Newcastle, Australia, in 1986. He worked mainly in rural general practice in Tasmania, and also made several trips to India, working mostly with Tibetan refugees. Increasingly concerned with impending global environmental crisis, and frustrated by trying to improve health on a background of apparently intractable global poverty, he abandoned full-time general practice in 1996, moving to the UK to study epidemiology at the London School of Hygiene and Tropical Medicine. He is now back in Australia, as a full-time research student at the Australian National University in Canberra. His thesis is entitled *Inequality and Sustainability*.

Following his last 'amateur tenor' column, **Bruce Charlton** has been awarded a spot in a Gilbert and Sullivan Christmas entertainment. He will be singing the words 'Fa la la la la la' as a soloist, he tells us rather smugly

Michael Dixon is the chairman of the NHS Primary Care Group Alliance. Details of their action-packed Annual Conference can be found in our *Diary* column

Trish Greenhalgh's series of articles on Research Methodology in primary care concludes with this issue of the *Journal*. She now returns to two thousand or so other ongoing projects

Gill McDonald is the development manager of the RCGP in Scotland

Paul Schatzberger is a GP in Sheffield. An exhibition of his work will be seen at the RCGP Spring Symposium, if sponsorship is forthcoming

Melanie Wynne-Jones is a GP trainer in Marple, Cheshire

Bruce Charlton

The platitude test

A few years ago, I introduced the 'platitude test' as a tool for the evaluation of managerial pronouncements. In field trials, this has proved itself to be a valid, reliable, highly specific and sensitive bullshit detector.

'Bullshit' is a useful word — with a useful double meaning. Its older meaning, in army slang, was 'pointless make-work designed to enforce army discipline'. The other, more familiar, usage refers to pretentious nonsense. The combination makes a perfectly nuanced term to describe the nature and justification of those managerially-imposed bueaucratic tasks which take up so much time and energy nowadays.

The essence of the platitude test is to invert the meaning of a statement in order to ask whether any sane person could hold such an opinion: if not, then we're dealing with a platitude. For instance, I have read that 'medical practice should be based upon the best evidence', this being boldly asserted as if it were in any way a controversial statement — as if anyone outside the confines of a padded cell was going to assert the principle that medicine should be based upon the *worst* evidence, or no evidence at all.

Mission statements are another example. I once spent a delightful lunch hour running throught the *Times Higher Education Supplement* and reading dozens of different versions of the phrase 'committed to excellence in research and teaching', fearlessly proclaimed, as though universities might — as an alternative — have been organized purposefully to propageate careless scholarship and slipshod pedagogy. Although admittedly common enough, these outcomes are accidental by-products, rather than consequences, of explicit policy.

We should not, however, underestimate the importance of platitudes to modern management. Platitudes are more than the occasion for a snigger — they are a vital manipulative ploy, a softening-up technique. Having identified a platitude; it is logical to react with a rapid escalation in vigilance, because when we are being asked to assent to a platitude, someone is trying to pull a fast one — usually imposing a new and intrusive management system.

High quality is platitudinously a good thing. However, the problem is the assumption of conceptual identity between 'quality' as a valued generic attribute, and a particular 'quality assurance' managerial system for audit and control — which is the thing being pushed. Or the link between the public and public accountability, clinicians and clinical governance, or evidence and evidence-based medicine. The falsity of the argument lies in the weakness of the linkage.

Modern management works by equating general platitudes with specific policies. The agreed platitude justifies a controversial bureaucratic proposal. We are lulled by gentle words then entangled in red tape. Signing up to a truism, we find our name has been appended to a contract. Then it is too late: the small print reveals that we have mortgaged our freedom and are mired in bullshit.

Clichés are covert threats in the mouths of the powerful. Like a canary in a coal mine, we can deploy the platitude test as an early warning system — self-defence against the toxic emanations of officialdom.