The British Journal of General Practice

Viewpoint

From PCG to PCT — should angels fear to tread?

The Chief Officer of the Primary Care Group (PCG) in which I practice expressed an interest, within weeks of appointment, in progressing our Level 2 PCG to Level 4 Primary Care Trust (PCT) next April. In fairness, she has made it clear that such a move will depend on securing a substantial mandate from the general practitioners in the group. A figure of 66% has been mooted.

This has concentrated our minds wonderfully on the issues implicit in a move up the organizational scale. On what basis can I, as a GP, form a view on what the best course of action is for my patients and myself?

Clearly, there should be some benefits in Trust status as compared with PCG status; what can we do more effectively as a PCT than we can do as a PCG? And it is at this first fence that we start to become unstuck.

Nobody yet knows exactly what a PCT will look like. The latest guidance on the subject[1] is strong on generalities, and is supposed to be augmented by more specific details in July. The publication date of the latter document has already been deferred once, to August. Decisions to proceed to Trust status are supposed to be ready in September, with a final commitment in December.

Such haste is hard to understand. Not only do we not know what a PCT will look like, we also don't know what a PCG could be capable of. If the freedoms held out to PCGs in The New NHS[2] are honoured, considerable autonomy can be devolved to them by their parent health authorities. Thus, many of the advantages of independence, influence, and agility held out as advantages of progress to Trust may already be available in great measure as a PCG.

Where are our patients in the midst of these abstractions? I have heard no appeal for more flexibility or better quality in relation to any specific, locally identified patient needs. It is here that I might feel secure, that I might find a solid criterion on which I could base a decision. The Health Improvement Programme, which might yield local health priorities, is as yet an embryonic process. This has not been helped in our locality by the redefinition of health authority boundaries in April this year.

Novel approaches to patient problems require good working relations between the agencies involved; typically general practice, community teams, hospital trusts, and social services. I would expect to see plans agreed between these agencies for cohesive action in response to defined problems as a prerequisite for Trust status. All of these agencies are already reeling from the combined effects of policy fatigue and resource constraint. To expect effective joint planning in advance of new organizations developing an identity, and with new and untried management teams, might well be optimistic.

What of our professional interests? The assurance that PCTs will not be able to provide general medical services is disingenuous; the newly coined 'personal medical services' subsumes general medical services but with constraints that are far more appropriate to managed health care than the vagaries of the Red Book. This may appear paranoid, but I see too many strings of coercion tightening for my peace of mind. The problem, once again, is uncertainty. And uncertainty on an issue that has such profound implications for my professional prerogatives arouses my deep disquiet.

Meaningful decisions on change demand a defined present problem, and a preferred future solution. Present and future are disturbingly obscure in the existing policy fog. It may be that the tide of change is irresistible. If so, I expect that we will be swept along regardless of my opinion. For the present, change remains contingent on the active support of general practitioners. A meaningful response of any kind, supportive or otherwise, is impossible to offer in the face of present uncertainty.

Joe Neary

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The Back Pages...

I can just see future generations of schoolchildren queuing up ... to become Ms McKechnie's prescribing adviser

Neville Goodman, page 687

contents

Why Should Primary Care teams work with Housing Agencies? A conference on housing and health, Birmingham, 29th June

Our sense of home is intimately interwoven with our sense of self and fundamental to identity, security, and self-esteem. Our address is part of how we define ourselves and how we are defined by others. Yet the housing that constitutes our home can offer us protection or put us at risk.

Susan Smith, Professor of Human Geography at Edinburgh University, used the first keynote address to unravel, with wonderful clarity, the processes by which health determines opportunities for housing and, in turn, housing determines opportunities for health. Damp, cold, and moulds are now established as health risks, and some housing makes accidents at home more likely. The psychosocial impact of housing stress probably undermines health by compromising immunity. The geographical location of housing can enable or impede access to more or less good health care services. In all these ways, health is determined by housing. In turn, health status affects opportunities for housing provided by state sponsored bureaucracies or by private markets, dictating mobility within and between different tenure sectors. These processes can result in individuals or families being filtered into better or worse socioeconomic and physical environments which, in turn, deliver relative protection or risk, and the cycle starts again.

The rationale for awarding housing priority to people with health problems and mobility needs is threefold: compensation in kind for income inequalities, providing for needs the market cannot meet, and using housing interventions to make health gains. Housing for health is a widely accepted principle with a long and glorious history. Medical priority for rehousing can be effective in securing health gains, but the system has come under hugely increased pressure as a result of the selective sale of housing stock and the growing needs of vulnerable groups. The whole system is now under threat in many areas, but is crucial to the success of community care and still has much to offer if housing and health professionals can find innovative and creative ways of working together.

Health problems, particularly mental health problems, cause difficulties for individuals but also difficulties for communities, and those with particularly challenging problems tend to be concentrated within the most stressed and deprived communities. The tensions between the individual and the community are mediated by social landlords. The most vulnerable and marginalized often have huge difficulties sustaining a tenancy and a casework service may make very sound sense in terms of avoiding problems of arrears, damage to properties, neighbour nuisance, and eviction. Often, health and housing professionals are in frequent touch with the same vulnerable individuals and there is much to be gained from closer working and sharing information if consent is given.

For me, the defining moment of the conference came when a housing manager from South Wales described how, for a majority of her clients, response time is much more important than continuity of personnel; however, for a significant minority, which includes the most vulnerable, the reverse is true. She could so easily have been talking about general practice and we had discovered that we shared much more than a preoccupation with the ways in which housing can either promote or undermine health.

This was the first time that the Royal College of General Practitioners has collaborated with the Chartered Institute of Housing to run a conference. It attracted an audience of practitioners and researchers from across primary care and housing. We have only just begun to discover how much experience we share and how much we have to learn from each other. This conference must be the first of many.

I would like to thank all the keynote speakers and all the workshop leaders who contributed so much to the success of the conference.

Iona Heath

Appreciations — Martin Lawrence and Professor Robert Harvard Davis

Martin Lawrence finally lost his courageous fight against cancer on 27 February 1999. He was both an outstanding example and a huge inspiration to all who knew him.

A scholar at Winchester and an Exhibitioner at Clare College, Cambridge, he graduated first in mathematics at Cambridge in 1965 and then in medicine at Oxford in 1970. Despite obtaining his MRCP just one year after qualifying, he decided primary care was his vocation and took a training year at West Street Surgery, Chipping Norton. He became a partner in 1974.

In 1984, he joined the Oxford University Department of General Practice and became their Senior Lectuter in 1993. He was an outstanding teacher and published widely, especially on audit and quality improvement. He developed important and strong academic links with Nordic countries, and became one of the few general practitioners to be appointed a Fellow of an Oxford College (Green College). He was the first organizer of the annual Faculty CME 'New College Course', and in 1997 he inspired the highly acclaimed conference, 'A Celebration of General Practice'. He was very active in the RCGP Thames Valley Faculty and completed his Chairmanship only three months before his death.

Those of us who worked with him in practice will remember his unstinting commitment and uniquely personal service to his patients, his team at West Street, and his devotion to the wider community.

His interests went well beyond the field of medicine: he was an avid theatre and opera enthusiast and undertook a great deal of foreign travel. He championed the local community, especially his home village of Church Enstone, in particular master-minding the renovation of the local Saxon church.

It was Martin's wish that other terminally ill patients should have access to skilled nursing care and support to enable them to die at home if they wish. A charity has recently been launched in his memory, the Lawrence Home Nursing Team. The Oxford University Department of General Practice is instigating a memorial scholarship to enable medical students to study in Nordic countries.

Martin was a man of tremendous energy and vision who did much for primary care, both at home and abroad. Yet, despite his lofty achievements, he never lost his deep concern for the individual and his determination to encourage each person to achieve their highest possible potential.

Jonathan Moore

On 16 January 1999, **Robert Harvard Davis**, one of the most influential reformers of general practice this century, died. He was a man who made a difference and he lived to see his ideas put into practice. He saw many colleagues whom he had trained go on to achieve their ambitions and deliver even more of his own ideals. The support of his wife, Valerie, was essential to him, and their two children were a central interest in their lives.

The most basic detail of his career will be found in an obituary in the *BMJ* (1999; **318:** 878), but there was so much more to the man. Brought up in a medical family, he gained a Cricket Blue at Oxford and went on to qualify at Guy's. When he joined his father in practice, he soon realized that the system of general practice then in force was totally inadequate to cope with the technical advances in medicine and the expectations of patients. It failed to give patients what they needed and was a hopeless vehicle to exploit the intellectual aspirations of a new generation of young doctors. General practice was still a cottage industry, looked down upon by much of the profession. Few of those in practice at the present time can appreciate what conditions were like at that time. There were virtually no supporting staff, premises were very limited (mainly part of a doctor's house), and most of the work that is now undertaken in practice had to be passed on to specialists.

Robert knew what had to be done. He had the vision, intellect, and drive to bring it about. The answers lay in education and research. He managed to persuade the then Welsh National School of Medicine to take some interest in primary care and he was given an appointment as a senior lecturer in the Department of Social and Community Medicine and Public Health. Slowly his ideas took root, but he was handicapped by the fact that general practice was still trying to win its spurs as a clinical academic discipline. It was viewed with considerable suspicion by other academic disciplines, the establishment, and grant-giving bodies. He set up the University Practice at Llanedeyrn, Cardiff and he became the Honorary Director of the General Practice Teaching Unit. He undertook good research and contributed to undergraduate, vocational, and continuing education in a major way. The new Royal College of General Practitioners was an important parallel development. When the Welsh Council of the College was formed he became one of its early chairmen.

Not infrequently he had to stand up to authority and he was not afraid to put his career on the line in so doing. There came a time when the University could no longer fail to recognize the discipline, nor the man. By 1979 he had developed a national reputation and he was appointed Foundation Professor of General Practice in the now University of Wales College of Medicine. Today, that department has four professors and an international reputation in research and education.

In spite of his determination and strength of purpose, Robert Harvard Davis was a very gentle, caring, and understanding person. At six feet five inches he was known as the gentle giant. He was generous with his co-authors in research, ensuring that everyone who deserved it was given a mention. There are many today who acknowledge the help and encouragement that he gave them in furthering their careers.

As is so often the case, many generations in the future will practice without knowing of the debt of gratitude that they owe to this great man of general practice.

Derek Llewellyn and Nigel Stott

Circumcision and the Opinions of Tristram Shandy

'It is not things themselves, but opinions concerning things that disturb the minds of men.'[1]

The arguments surrounding circumcision are not new, and were satirized by the eighteenth century novelist Laurence Sterne in his eccentric masterpiece, *The Life and Opinions of Tristram Shandy, Gentleman*.[2] (1760)

Sterne's novel, a self-confessed 'cock and bull story', delights in the way that causality determines great events.

Tristram's misfortunes commence with his conception, the most celebrated episode of premature ejaculation and coitus interruptus in English literature. Following his mother's untimely exclamation: 'Pray, my dear have you not forgot to wind up the clock?', his father's 'animal spirits' are dispersed.

Bizarre circumstances surround the loss of young Tristram's foreskin:

Uncle Toby and Corporal Trim have removed the sashes and lead weights from the nursery windows to improve upon the artillery component of their scale model of the siege of Namur. The maid, Susannah, having forgotten to replace the chamber pot, lifts the window to enable Tristram to pass water into the street. In the absence of a counter weight, the window frame descends 'like lightning'. During the ensuing chaos, Mr Shandy returns with two large folios from his library. He is thought to be searching for a herbal remedy, but instead consults Spencer's *De Legibus Hebraeorum*:[3]

'If it be but right done,' said my father, turning to the Section, 'de sede vel subjecto circumcisionis ...'

'If it be but right done', quoth he ...

'Nay, if it has that convenience ...'

'Nay', said he, mentioning the name of a different great nation upon every step as he set his foot upon it — 'if the Egyptians — the Syrians — the Phoenicians — the Arabians — the Cappadocians — if the Colchi, and Troglodytes did it — if Solon and Pythagoras[4] *submitted — what is Tristram? Who am I , that I should fret or fume one moment about the matter?'*

The Troglodites say not

'But is the child,' cried my uncle Toby, 'the worse?'

'The Troglodites say not,' replied my father. 'And your theologists, Yorick tell us —'

'Theologically? said Yorick, 'or speaking after the manner of apothecaries? Statesmen? Or washerwomen?'

The Greek footnote for the washerwomen tells us that they prefer circumcision for reasons of hygiene.

These perceptions form the nub of the arguments concerning circumcision, and the importance of the operation being performed correctly. Whose theology is more valid? The opinions of doctors or female convictions about hygiene?

Sterne also understands locker-room psychology and hints at one advantage of circumcision with the sexual innuendo for which he is famous.

'I am not sure,' replied my father, 'but they tell us, brother Toby, he's the better for it.'

'Provided,' said Yorick, 'you travel him into Egypt.'

'Of that,' answered my father, he will have the advantage when he sees the Pyramids.'

A veiled reference to women's breasts.

Recent US surveys have shown that the decision to circumcise is usually taken by the mother, with hygiene as the most prominent reason. Moreover, the concept of hygiene has marked sexual overtones.

The entrance of Dr Slop introduces a sanguine note:

''Twill end in phimosis,' replied Dr Slop. 'I am no wiser than I was quoth my Uncle Toby.'

This is an early description in English of a phimosis secondary to a poorly performed circumcision.

Tristram assures us that *'I did not lose two drops of blood by it'*; but the maid Susannah, an early anti-circumcisionist, regards it as 'murder'.

Sterne is the first to document the comparison between circumcision and the amputation of puppy dogs' tails, which, together with 'snips and snails', constitute an important part of little boys in nursery rhyme lore.

'Had my father been asking after the amputation of the tail of a puppy dog, he could have not done it in a more careless air.'

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'Astrologers,' quoth my father, 'know better than us both'
The apparent haphazardness of the whole procedure is something which clearly amused Sterne:

'Never was the son of Jew, Christian, Turk, or Infidel initiated in so oblique and slovenly a manner.'

Considering the criticism that general practitioners receive for their lack of knowledge of foreskin problems, and the enigmatic and inconsistent way that consultants respond to requests for circumcision, very little has changed. Obviously, some divinity still shapes our ends.

'Our best polemic divines'
The controversial nature of circumcision is such that there is a perpetual search for definitive answers. The recent GMC guidelines have done little to alter this and Sterne's assessment is still applicable after more than two hundred and thirty years:

'The controvertists,' answered my father, 'assign two-and-twenty different reasons for it: others indeed, who have drawn their pens on the opposite side of the question, have shewn the world the futility of the greatest part of them. But then again, our best polemic divines —'

'Mr Yorick,' quoth my uncle Toby, 'do tell me what a polemic divine is?'

But their identity is unexplained and their verdict a mystery.

None the Wiser
'Now every word of this,' quoth my uncle Toby, 'is Arabic to me.'

Uncle Toby, who represents everyman, finds the whole issue confusing.

Many parents are in a similar situation, as most books on child care completely ignore the subject of circumcision. The protective effects offered by circumcision against urinary tract infection, penile cancer, and HIV are not discussed and remain unknown. Schoen[5] feels that Europe is ignoring medical evidence and needs to reconsider neonatal circumcision.

Should prospective mothers be aware of the arguments and know of the benefits and harms? Or is it better they remain, like uncle Toby, 'no wiser'?

Sterne would wish to defer to 'our best polemic divines'.

Michael Harbinson

David Kernick

A New Medical Entity — The Paradigm Escapement Syndrome

The nation has become, in part, immune to the paroxysmal wailing and gnashing of teeth that has characterized the development of the medical profession since the inception of the NHS. But this time it may be for real, as surveys consistently show high levels of stress among GPs. Following a careful study of these symptoms, I wish to announce a new medical condition — the Paradigm Escapement Syndrome.

As disciplines develop, a set of perceived beliefs are consolidated and become a paradigm — a set of shared assumptions that is strengthened by education and language and that begins to exert a deep hold on the scientific mind and world view. What follows is a strenuous and devoted attempt to force reality into the conceptual boxes that have been supplied. When abnormalities arise, they are either blocked out or accommodated, but in some cases these abnormalities are so great that fractionation is inevitable.

For example, until recently, medicine was straightforward. The GP had limited therapeutic options and the patient shut up and did as he was told. The paradigm was secure. Now medicine has become health care, an amalgam of many competing disciplines and a constellation of outcomes; the patient demands access to the once privileged body of knowledge. Under the external pressures of social, demographic, and technological change, the medical paradigm is in the process of fragmenting — changing, albeit slowly, to a new state of equilibrium.

The process I define as Paradigm Escapement — characterized by symptoms of high levels of depression, delusionment, and distress, combined with the desire for early retirement among paradigmees. There are two possible treatments for this distressing condition. The first approach is known as 'paradigm withdrawal', and I offer health economics as a suitable case to study.

Aware that their disciple is producing analytical frameworks that no-one wants or can understand, health economists elect to retreat into their laager of hypothesis generation, analysis, and interpretation, and continue to attempt to apply a spurious rationality onto an irrational, non-linear world. Clarion calls from their leaders urge a retreat to basics and a closer relationship to academic departments. A Paradigm Entrapment Syndrome evolves as they struggle to make reality fit their disciplinary matrix. Deceived by short-term reassurance, the walls remain temporarily secure.

The second treatment option is painful, and its side-effects severe, but in the longer term is more likely to ensure a full return to health. It is to accept the reality of the primary care environment; to accept that evolution from the boundaries of our paradigm is inevitable; to accept the changes that are occurring all around us, and integrate our viewpoints and perspectives with those of others.

Ultimately, the short-term pain of this treatment will be long-term gain. But what effective medicine was ever easy to swallow?

Olga Kuznetzova is Professor of Family Medicine at the Medical Academy in St Petersburg, Russia. Her report was belated, and hence omitted, from the special report from Russia in the July issue.

More from St Petersburg ...

Dealing with the political and economic changes occurring in Russia has necessitated a complete change in the way people think. This is often painful for the older generation, however for many young people these changes have brought about conditions in which to realize their creative potential.

Despite the economic complexities of our daily life in Russia, I prize the freedom of choice of contacts with foreign countries and the absence of a ban on information. Taking part in the international programme for the development of family medicine in St Petersburg between 1995 and 1997 with colleagues from the University of Iowa has changed my life radically. There was already training of general practitioners under MAPS, in a faculty and department set up for that purpose. However, the tutoring was carried out by doctors who themelves had no experience as family physicians.

Under our first USAID grant programme, a family practice centre was opened and young teachers of family medicine trained in the USA. After this training they immediately undertook patient care. This radically altered our method of teaching as, with our own outpatient base, training can relate closely to practice. This made structural changes within MAPS necessary, and a new department of family medicine was created. I was made head of this department.

Today, many young people are studying at the department. They are assimilating the new specialty with enthusiasm. We have a research programme focusing on the study of risk factors for cardiovascular diseases and the influence of preventive interventions on their distribution. Knowledge of preventive medicine in both former students and experienced doctors is poor, and this area is therefore stressed in the education programme in the department.

Another important aspect of our work is the development and adaptation of medical guidelines for general practitioners, and to this end we have begun working with British colleagues within the programme of cooperation between MAPS and the Royal College of General Practitioners.

Opportunities to participate in international programmes do not just allow our young doctors the prospect of studying all the best that exists in general practice abroad. An important feature of our cooperation with the British colleagues has been the possibility of exchange. And it is not only a professional exchange; it is an opportunity for personal contacts among young professionals who will work in the coming century. Is that not a guarantee of a more peaceful future?

Olga Kuznetzova

Tim Albert

Encouraging GPs not to write scientific papers ...

For the past six years I have been running courses that teach doctors how to write scientific papers — and get them published. From now on, I will be discriminating against GPs in the United Kingdom.

This follows a curious ruling that highlights the current absurdities of GP postgraduate training, and also has some important long-term implications.

We run our scientific papers course twice a year as a public or 'open' course at a royal medical college in London. For good training reasons we limit the number in the group to 16, and charge each participant £150. It has been approved by the Faculty of Public Health Medicine, so that most doctors can now put it towards their continuing medical education. The appropriate GP authorities have also approved the content — but on condition that I pay a £150 registration fee on the grounds that this is commercially run.

Well, up to a point. Sadly, the course attracts only one or two GPs. Paying £150 for the privilege of having them would mean that we are giving one GP a free place; the alternative would be to add £10 to the course price, which hardly seems fair to the others.

I have appealed against the decision and the appeal has been turned down: 'If a course is commercially run it is eligible for an application fee for PGEA, and the degree of profitability of that course is not something we can take into account'.

I have to, of course, so the only sensible way forward is to stop seeking PGEA approval. Since the courses are always oversubscribed it won't make any financial difference to me.

But the other part of my soul still has two concerns. First, we do need to encourage GPs to publish. If they don't then we will get a disproportionate number of publications from other groups — traditionally hospital doctors, but now increasingly nurses and other health professionals. Secondly, I fear that this is a symptom of a training establishment that risks becoming introspective and self-serving — excluding initiatives undertaken by non-members of the club, and furiously reinventing wheels that have long been turning successfully elsewhere. My suspicion is that in this context 'commercial' really means 'outsider' and had I been a GP with just a passing interest in medical writing I would have had no trouble getting approval.

Those I speak to say they know about these problems, and that change is afoot.The key question is whether change comes from the existing establishment, or whether there is genuine input from the real world outside.

Gratitude

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Whenever a given episode of care is concluded, it is the norm for a person to experience a sense of gratefulness for having been restored to his or her prior level of functioning. Because, no matter what the system in which medicine operates, the doctor is remunerated by the patient, the persistence of gratitude on the latter's part suggests that something was done above the call of duty. Although exceptional manual skill, astute diagnosis, aptly chosen therapy, and timely referral are always appreciated, it has been noted that the establishing of rapport may be the prime factor in cementing a solid physician–patient relationship.[1] Thus, explanation, reassurance, and the demonstration of empathy on the physician's part could account for the lion's share of the gratitude a patient feels.

In the majority of instances, feelings of appreciation are appropriate but, on occasion, they can be misplaced.[2] For example, the physician may have temporized to a point where matters took a sudden turn for the worse so that a situation amenable to early intervention became life-threatening. At this juncture, if all goes well, it may appear to patient and family that deliverance from dire circumstances was provided in a timely manner when, in effect, there was no need for matters to come to such a pass in the first place.

Iatrogenic complications offer an opportunity for the doctor to display astuteness in undoing what was wrought. Withdrawal of an angiotensin converting enzyme inhibitor can relieve a worrysome cough, otherwise unexplained, and place the very practitioner who prescribed it in a favourable light. The same can be true of an unnecessary intervention in a person who is asymptomatic. Coronary bypass is said to be perfomed inappropriately or for equivocal reasons in 44% of cases.[3] Since mortality and perioperative morbidity are not negligible, undergoing bypass may be likened to a brush with death, and surviving it is certain to awake feeling of gratitude.

That a physician may feel grateful towards his or her patients has been less often remarked. Such gratitude can be salutary, suggesting humility and recognition of the fact that cure is never due to a single factor. It may also represent a healthy understanding that the patient provides the doctor's livelihood. At times, the former, as the subject of an experiment or of an informed observation in the guise of a case report, can earn the latter's gratitude for contributing to career advancement.

There are occasions when a physician may believe that he or she did not manage the somatic aspects of a case with sufficient skill, while the patient valued the empathy extended and felt well cared for, expressing appreciation to this effect. The doctor's gratitude, then, comprises both an easing of anxiety concerning the possibility of litigation and, perhaps, a sense of belonging to a calling with a broad capacity for doing good. In discussing the 'connexional' (*co* = together; *nexus* = the forming of a whole) dimension of medical practice, where the barriers that people erect around themselves undergo temporary dissolution, Suchman and Matthews write: 'This moment [of connexion] may be followed by a lingering feeling of love, a sense of privilege at having been allowed into a patient's life so vividly, and a humble feeling that one is part of something bigger than oneself'.[4] They go on to speak of a need for connectedness and meaning on the part of both the patients and the doctors, emphasizing that the latter may be regarded as suffering too: 'What are our

Photo: Derek Gadd/Barnaby's Picture Library

essay

wounds? We may harbor particularly intense fears of death, feelings of powerlessness, or anxieties about the basic uncertainty of life with an accompanying need for control. Perhaps we enter medicine to be needed, seeking the attention and authority that people grant us. Whatever the nature of our wounds, we heal to be healed'.[4] This realization, though spoken of as an engendering sense of privilege, must be regarded as an expression of gratitude by the physician. It is strikingly reminiscent of Engel's idea that the patient, perhaps above all, wants to feel understood: 'Do [my doctors] sense my personhood and my individuality? Do they acknowledge my humanity? Do they care?'[5]

Physician gratitude has its down side too. For example, the meeting of needs, recognized 'in occasional moments of particular closeness during medical encounters', and a sense of joy, peacefulness, and awe can create patients' wishes for dependence and even lead to sexual attraction.[6] The — at times excessive — sense of satisfaction provided by working in the connexional dimension can cause the physician to fall in love with himself.[7]

Finally, in the same mode, it may happen that a physician momentarily feels grateful for something that is basically inimical to a patient's welfare. An instance of this might be a particularly shrewd diagnosis of a rare and incurable condition. When the diagnosis is proven correct, there may be access to professional gratification until it is recalled that the patient's death warrant has been sealed. Because the doctor–patient relationship is an ongoing one, there may even be a kind of statute of limitations on gratitude in either direction and new circumstances can cause the emotion to lapse.

To summarize, a patient's sense of indebtedness to a physician is usually appropriate and related to a display of empathy on the latter's part, although timely referral, well chosen therapy, astute diagnosis, and manual skills can all contribute to it. Inappropriate gratitude is a frequent concomitant of unnecessary treatment or of a narrow escape that could have been averted. The physician, on his or her side, is empowered by the patient,[4] gains a livelihood from the profession of medicine, and often wins academic advancement on the basis of insights gained or experiments performed while managing cases. For all of these, gratitude is owed and can be salutary, particularly where it comes to appreciating that recovery results from a joint effort, involving patients and their families as well as the medical establishment.

Joseph Herman

Sport, Medicine, and the College

Imagine the RCGP with go-faster stripes. There is now a new College Working Group on Sports and Exercise Medicine; its main purpose is to help meet the needs of College members who find that sports and exercise medicine has become an increasing part of their daily general practice workload. It is from general practice that sports medicine has grown, and early sports medicine was practised almost entirely within general practice.

Members of the College are involved in sport and exercise medicine in a number of different roles and at many levels, from the occasional jogger to the elite Olympian. Some have an informal link with local teams or sporting organizations, others are involved in exercise referral schemes. The use of exercise as a therapeutic modality for the treatment and rehabilitation of many conditions — ischaemic heart disease in particular — is an area in which GPs will have increasing involvement. In addition to the traditional doctor–patient relationship in the consulting room, GPs are often asked to take on additional roles in a more structured setting, looking after teams, or even looking after spectators.

With the growth of professionalism in sport, sporting administrators have become increasingly aware of the need to look after the health of their athletes. Many of these athletes are valuable commodities and injuries make these expensive investments more costly. In many instances, this has lead to the formalizing of relationships between the medical adviser and the team or clubs.

The increasing involvement of family doctors in professional sport has led to some real and potential difficulties. Doctors may believe that they maintain a traditional doctor–patient relationship, however the club or team may have a different view and perceive that the doctor has a contractual duty of employment. They may therefore expect the doctor to divulge confidential information to the administration. The doctor–patient relationship is the core of general practice and the duty of care lies with the patient; a source of potential conflict in the relationship between doctors and sporting organizations.

General practitioners may also be asked to become a 'crowd doctor'.[1] Following the Hillsborough disaster, the Taylor Report[2] recommended that, at sporting fixtures where the number of spectators is expected to exceed 2000, there should be a dedicated doctor whose role is to care for the medical needs of the spectators alone. It is no longer appropriate for the doctor to the team to be also doctor to the crowd. This is a key role, and one that should not be undertaken without appropriate training.

The United Kingdom Sports Institute, with its proposed satellite centres in the regions, has thrown into sharp relief the importance of good sports medicine care for the elite sports men and women involved at a national level. Many of the current sports injury physicians based at the British Olympic Medical Centre are general practice trained, as are the majority of the Governing Body Medical Officers to the Great Britain Olympic teams. General practice provides the main roots for the tree of sports medicine. Perhaps general practice training should be an essential requirement of sports medicine training, reflecting the wide diversity of primary care problems, together with specific sports-related injuries that arise when caring for a team.

Most postgraduate training in sports medicine is directed towards doctors with primary care training as their first specialty. There are distance learning courses, week-long and part-day release courses, and full time medical courses leading to a Diploma or MSc in sports medicine. The British Association of Sport and Medicine has a long history of running modular courses throughout the UK and annually hosts a conference, often in conjunction with the British Olympic Association. Sports medicine is becoming a central part of general practice continuing education. Sports medicine is already an integral part of the training of general practice registrars in some regions and there was a satellite conference on sport and exercise medicine at the 1998 RCGP Spring Symposium in Exeter. The RCGP also has a representative on the Intercollegiate Academic Board, and the Working Group strongly endorsed their role in promoting sport and exercise medicine as a specialty.

The specific objectives of the College Sport and Exercise Working Group are to create educational opportunities and promote initiatives which will help meet the needs of GPs. These will be: to advise the RCGP on sports and exercise related matters in primary health care; to encourage an evidence-based approach to the treatment of non-surgical sports injuries; to work with educational bodies to promote the importance of primary care physicians in sports medicine; and to continue to promote public exercise initiatives both from within primary care medicine and supported by government.

In the medical care of our sporting patients, and our elite athletes, general practice leads the way. We would like to remain out in front.

Domhnall MacAuley, Rod Jaques

every self-respecting practice library ...

Rembrandt by Himself
National Gallery (Sainsbury Wing) until 5 September 1999
A Brush with Nature
National Gallery (Sunley Room) until 30 August 1999

The landscape oil sketch, painted quickly in thin oils, often on paper, has been a neglected field of painting, of which the National Gallery has had few examples. 'A Brush with Nature' is an exhibition of some 70 works, largely of the 18th and 19th centuries, by many little known and some eminent painters. These works will form the core of a new permanent display. They cannot be said to be profound or 'great', but they are extremely attractive, and interesting for their treatment of often everyday scenes; a window in a slum quarter of Naples or a boat-builder's yard. They make a striking contrast to the profound exhibition in the Sainsbury Wing of Rembrandt self-portraits.

His earliest works are either experimental etchings, often whole sheets, in which individual facial expressions are analysed, or historical paintings in which the painter's likeness has been identified in one of the subsidiary figures. Then comes a series of fully worked-up oils, often in fancy dress, which remarkably had a market even at the time of their composition. Finally, after a long break we see a painter at the height of his powers depict his own gradual dissolution in some intensely moving works. The knowledge that his son and both his wives had predeceased him makes them all the more wonderful for their honesty and dignity.

The progression through these paintings is an autobiography comparable to listening to the sequence of Beethoven piano sonatas, the sense that, through a non-verbal medium, a man's life has been laid out before you. Rembrandt's dark palette is not the most fashionable at the moment (the exhibition will be seen only in London and the Hague, nowhere in the US) but any reservations will be dispelled by this magnificent exhibition.

Frank Minns

Dictionary of Health Economics
Alan Earl Slater
Oxford University Press, 1999
PB, 170pp, £19.95, 1 85775 337 2

At a time when GPs were emerging from a collection of doctors who had fallen off the hospital ladder into a framework that was to resemble a system of primary care, economists realized they had a problem. By the mid-1960s, their predictive power in economic events had become so poor that no one was taking any notice of them. An elegant solution was at hand. They would foist their metric onto other unsuspecting disciplines such as education, transport, environment, and health care.

Over the next 20 years, health economists developed their theories undisturbed in their ivory towers, developing increasingly esoteric mathematical frameworks that were largely inaccessible to all but a limited number of cognencioni. But, against a background of increasing demands on limited resources, they suddenly found themselves thrust into the limelight with their offers of technical frameworks that could facilitate the difficult choices that were becoming inevitable.

For GPs, with evidence of cost-effectiveness providing such an important input into purchasing and commissioning decisions, a knowledge of health economics is becoming of crucial importance — not only to understand the concepts and principles that the subject can offer but to prevent the wool being pulled over our eyes by an approach that does not necessarily reflect the nature and context of the environment in which we operate.

Few authors seem to have grasped the fundamental concept that the way to an introductory text is through a history of a subject — the evolving framework within which meaning is generated. Textbooks continue to compress their subject into a taxonomy as if it had arisen on a blank sheet of paper. But if a history is not forthcoming then segmenting a subject on the arbitrary basis of alphabetical order may be a second-best perspective in a post-modern world.

Here is the first health economics dictionary aimed mainly at health care professionals and workers in the field of health policy, social and business studies. Its aims are to introduce the terms used in health economics and to facilitate an understanding of the lexicon. By these performance criterion it succeeds admirably.

Inevitably, there are some important omissions for primary care. For example, a Cost Consequence Analysis stresses the importance of presenting information on both resource use and outputs in a disaggregated form so that decision-makers can apply their own values to the data, but is nowhere to be found. However, overall there is all the GP will need here and more. For example, I particularly liked Lakatosian Hard Core — 'a set of metaphysical beliefs unifying adherence to research programmes' (a useful addition to one's perjurative armamentarium).

There is a huge redundancy in the burgeoning health care literature but this dictionary has been well worth producing. As a follow-on from a primary text on health economics it will provide a useful resource for GPs who wish to be up to speed in an increasingly important subject. But note the term opportunity cost — 'the value of benefits foregone in choosing A rather than B'. At £19.95, the opportunity cost of this book is not inconsiderable.

Some Health Economic primers for GPs ... I have never been quite clear why introductory texts are written by experts in the field and not beginners who have completed their painful rights of passage. Useful introductions to the subject are all written by health economists and include:

- **Understanding Health Economics** by P McCrone (Kogan Page Publishing), and also
- **Elementary Economic Evaluation in Health Care** by T Jefferson, V Demicheli, and M Mugford (BMJ Publishing Group). Both provide a basic introduction to the subject — McCrone is possibly clearer.
- **Purchasing and Providing Cost-effective Health Care** by M Drummond and A Maynard (Churchill Livingstone Publishing). A slightly more advanced introductory text written by the war-horses of health economics.
- **Health Economics for Nurses** by S Morris (Prentice Hall Publishing). Probably the most comprehensive introduction, but there is an over-emphasis on economic theory.
- **Economics of Health Care – An Introductory Text** by A McGuire, J Henderson, and G Mooney (Routledge Publishing). An advanced introductory text from which it is possible to appreciate the more specialist literature.

It's worth a dip into **Health Economics**, the leading UK journal on the edited by Alan Maynard, to appreciate the dissonance between theory and reality. Current content abstracts can be found on MEDLINE. For a more rapid appreciation of economic evaluation and the problems of health economics, I shall promote expediency above modesty and suggest: **Economic evaluation in health — a thumbnail sketch** by D P Kernick (*BMJ* 1998; **316:** 1663-1665), not to mention **Have health economists lost their way?** by D P Kernick (BMJ 1998; **317:** 197-199).

DPK

Going For Gold
Julian Tudor Hart

David Kernick

Going for Gold has its origins in a Working Party of the Welsh Labour Party and the Socialist Health Association.

The paper begins with an analysis of the deepening crisis of the NHS in the South Wales Valleys. Although the problems are particular to the Valleys; for example, high morbidity, unemployment, and social deprivation, they are also general to the NHS (problems of staff morale and recruitment, resource needs, and so on). It ends by offering solutions to these problems which can be dismissed as based only on old-fashioned socialist collectivist nostrums, misguided idealism, and soft sentimentality. If such trite dismissal prevails, so much the worse for hope and humanity in our National Health Service.

Julian Tudor Hart first considers the uncertain future for the NHS in the Valleys based on the current commodification of medicine, and the operation of a modified market. He concludes that the history of the South Wales Valley communities, forged in the years of growth and decline in the coal mining industry, offers the chance of experimenting with a quite different approach.

The vision is breathtaking, and defies the confinement of its proposals in traditional party-political and medico-political pigeon holes. The model outlined dissolves the barriers between secondary and primary care. It describes a re-configuration of health care teams, appropriate to the coming advances in bio-sciences, to the real complexities of morbidity, and to the perceptions of ordinary people who have been conditioned to somaticize their social and personal despairs.

It straddles the political left and right. It is Old Labour in its concern for social justice, for solidarity, and for those in greatest need. It is New Labour in its audacious proposal for a Human Sciences Industrial Park — a research and education and social partnership between government, the people of the Valleys, the professions, the universities, and the major pharmaceutical and health technology and IT companies.

The survival of the NHS can no longer be secured by tinkering with the models of care which we have inherited. We are challenged here with the possibility of a major and radical experiment. The control group is all around us.

Hart is arguably one of the most brilliant and influential thinkers about medicine and health services to have emerged from 20th century British general practice. His ideas for the Welsh Valleys deserve to be put to the test. All that is required now is imagination and courage and professional and political leadership.

The Therapeutic Potential of Creative Writing — Writing Myself
Gillie Bolton
Jessica Kingsley Publishers, 1999
PB, 252pp, £15.95, 1 85302 599 2

Marshall Marinker

This is a bubbling cauldron of a book. I doubt if I have ever felt so driven to follow an author's enthusiasm to try out her ideas.

Just take a sheet of paper and a favourite pen, she says, and for six minutes write whatever comes to mind. So I did, and what happened surprised me, because I hadn't really thought much of the notion.

Gillie Bolton runs creative writing courses, and counsels and works as a therapist. She is convinced that writing is a gentle, true, and accessible way for anyone to express themselves and that this can lead on to finding new understanding through re-reading and perhaps revising the writing. She shows how the slowing down of thoughts to the pace of a pencil is an editing process that helps order ideas out of the internal chaos, but not one that stultifies subconscious experience from leaking out. Some sections of the book are about using imagination or dreams and about the way some people gain from the working discipline required to write poetry. Personal writing is always safe although it may sometimes lead to tears if painful memories crop up. The writer owns what's written and can either tear it up, keep it private, or share what started out as a private exploration with a close friend, a partner or perhaps a supportive writing group.

So this is a book about what writing can do for the writer, regardless of whether this is shared with a reader. It is definitely not about writing for publication, although some of the examples of personal poetry have eventually been published. It is also about how some established authors have used private writing to exorcise their own ghosts. There are many examples of how writing can be used to heal old hurts, from colleagues and from members of the authors' writing groups. Then later come samples and references to other writers' work about using writing as a therapy.

Much of the book is about using small groups to support and encourage such therapeutic explorations. We are shown how to get started and allow people to feel that it is not only safe but might also be fun, to let their pens to flow across the page. Examples are given of therapeutic writing groups in prisons, hospices, among demented patients and the mentally ill, for such groups can thrive in surprising settings. Gillie Bolton runs writing groups for GPs and makes the case that, instead of a prescription, doctors could offer certain of their patients a pen and a blank sheet of paper and then be willing to read whatever they might write.

Oliver Samuels

Voyages of Discovery
Natural History Museum, London

A recent conference on research training focused on the 'career ladder', up which all academic trainees are now presumed to clamber faithfully. But, as one semi-retired professor muttered in the coffee queue, whatever formal training is offered, outstanding researchers always have been (and always will be) distinguished by three characteristics: inspiration, a passion for their work, and a willingness to take risks — to which I cynically added three more: money, connections, and an intellectual edge over the rank and file.

The great scientists of the past certainly displayed these six qualities in equal measure. In 1687, botanist-physician Hans Sloane was seconded to Jamaica to attend its British-born governor. Having but one patient, he had plenty of time to pursue his interest in 'medicinal' plants — and soon discovered a dark and bitter bean highly palatable when boiled up with milk and water. On the governor's death, Sloane sailed for home bearing not only sacks of cocoa but also a set of live natural history exhibits: an iguana, a crocodile, and a seven-foot-long snake. Unfortunately, none of his charges survived the journey — the iguana inadvertently jumped overboard, the crocodile died of natural causes, and the snake escaped from its jar and was shot by one of the duchess's servants.

Eighty years later, Captain James Cook was about to embark on a voyage to confirm or exclude the existence of the rumoured fifth continent. Twenty-five-year old Joseph Banks was an outstanding botanical artist looking for a lucky break. He was also handsome, rich, well connected, and already a Fellow of the Royal Society — all of which must have endeared him to the Admiralty, who granted him permission to accompany Cook to document the new varieties of flora and fauna that were likely to exist in Terra Australis Incognita. Banks insisted on taking four servants, a secretary, two artists, an assistant botanist, two lap-dogs, and a vast amount of baggage. His entire retinue died variously of malaria, dysentery, malnutrition, and homicide, but the record of natural and ethnographic material they amassed during their three-year trip is probably unrivalled before or since. Banks returned to London in 1771 and became the talk of London society; he was later knighted and spent 41 years as President of the Royal Society.

All this is a far cry from the career path of the modern-day academic GP. Except that, if you feel the spark has gone out of your own research career, take a trip to the *Voyages of Discovery* exhibition and re-enter the bygone era when success — if you survived the experience — would have brought accolades, social prestige, and, perhaps, substantial income from marketing your discoveries.

Trish Greenhalgh

Books For The Beach!

Tim Albert
I have already taken my summer holiday — in New Jersey, where the beaches are sparse and the bookshops brimming.

To three top choices: Michael Dibdin's ***A Long Finish*** (Faber and Faber) — my introduction to the chaotic Italian sleuth Aurelio Zen. Persevere; the wonderfully grim ending makes you ache to tell others (though they would never forgive you if you did).

The Eyewitness ***Travel Guide to London*** (Dorling Kindersley) is full of details that brought the city to life, even though it was 3000 miles away. By far the most accessible of city guides.

Jon Winokur's ***Advice to Writers*** (Pantheon) will enliven the queueing time, with pearls of wit and wisdom, such as TS Eliot's 'Whatever you do, avoid piles', and James Thurber's 'Don't get it right — get it written'.

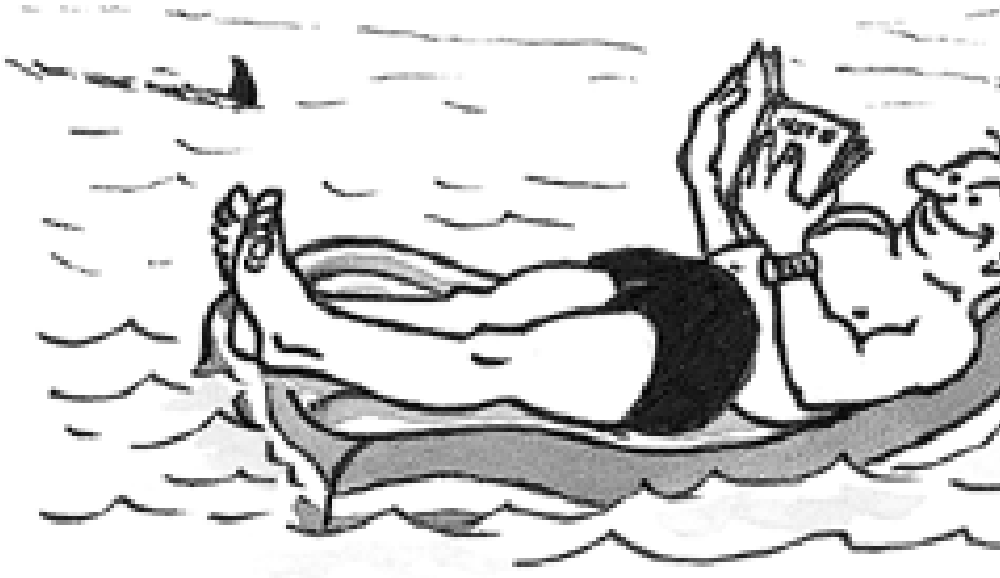
A bonus book: Jean Aitchison's ***Linguistics*** (Teach Yourself Books). It's sad really, but I did read this on holiday. It taught me how to spell Noam Chomsky, but thereafter I lost the plot.

Dorothy Logie
Sizzling on sand doesn't appeal unless my mind is simultaneously bronzed and bathed. ***Questioning the solution: the politics of primary health care and child survival*** (Healthrights, shop@itpubs.org.uk) is easy to read and questions the foundations of medical planning and global health policy. Peppered with pictures and cartoons, Werner and Sanders dissect WHO's 'Health for All' blueprint, which has never been fully implemented. With millions excluded from healthcare, are we becoming more enlightened?

Sapphire's electrifying novel, ***Push*** (Vintage/Ebury), written in the form of the diary of a black, American, illiterate 16-year-old, pregnant again with her father's baby, gives insights into why some teenagers are difficult to communicate with and why they fall pregnant. Short, absorbing, disturbing, and quite different from anything I have ever read.

Margaret Atwood's ***Alias Grace***, based on the true story of an 1840s young Canadian and supposed murderess, Grace Marks, grips from page one with an explosive mixture of sex, murder, prejudice, media manipulation, and details of asylum and penitentiary life which will make your tan tingle. Our world is definitely becoming more enlightened.

John Salinsky
I would take with me a novel, a short story, and a play. Each celebrates a very different heroine. First, the novel: Thomas Hardy's



Tess of the D'Urbervilles (Oxford World Classics).

Tess is such a lovely person, it's a shame that the men in her life (including her creator) don't treat her better. Her story will make you cry but at least she and Angel are allowed a few blissful days together in the abandoned manor house before cruel retribution catches up with them. You will also learn a lot about hand-milking cows.

My second heroine is a mouse called Josefine, the subject of Kafka's last and most mysterious short story, ***Josefine, the Songstress,*** aka ***The Mouse People***, (from *The Transformation and Other Stories*, Penguin). Josefine is a singer with charisma. Her singing (or is it only squeaking?) supports and uplifts the mouse people whose lives are anxious and precarious. But do they appreciate her? And who are the mouse people anyway? That Kafka has so many layers, he's like an onion.

Finally, let me introduce you to Viola, heroine of William Shakespeare's ***Twelfth Night*** (Penguin), and every young man's dream of the perfect girlfriend. She is warm and friendly, tender and insightful, bright as a button, and very sexy dressed up as a boy. The play is crammed to bursting with comedy, wit and wisdom and you will recognize with pleasure some of your favourite quotations: 'Then come kiss me, sweet and twenty, Youth's a stuff will not endure.'

John Gillies

Michael Ignatieff, who coined the phrase 'three-minute culture', has written a sympathetic but not hagiographic life of Isaiah Berlin, historian of ideas, who died last year. ***Isiah Berlin: A life*** (Chatto and Windus) includes a wonderful story about Churchill confusing Irving (composer of White Christmas) and Isaiah Berlin and inviting the wrong one to lunch. The reported exchanges were quite surreal. Berlin made contributions to contemporary thought on concepts of freedom, and on political and ethical issues. As all of us — individuals, economies, professions, royal colleges — fall under the thrall of global capitalism, we would do well to pay attention to his important, subversive idea of value pluralism.

I have trouble with genetics. Steve Jones's book, ***In the Blood: God, genes, destiny*** (Flamingo), an entertaining and erudite read, improved my understanding a lot. Excellent illustrations and examples, wittily written. Why does he have to advertise cars?

If you take a portable CD player on holiday, try Thomas Ades's new release, ***Asyla*** (EMI Classics). Exciting and richly textured, these pieces reflect many disparate strands of classical, jazz and rock music.

Jill Thistlethwaite

Iain Pears' ***An Instance of the Fingerpost*** (Vintage) combines history, unnatural death, religion, and a romance within a cunning literary device of presenting the tale from the viewpoint of four of the characters. Just who is telling the truth? And during the fun and games of the distorted whodunnit, the reader effortlessly learns about the machinations of the Restoration of Charles II and seventeenth century medical practice.

Then to a gentle read: turn of the century South Uist, almost as strange a place as Cromwell's Oxford. In ***A school in South Uist: Reminiscences of a Hebridean schoolmaster, 1890-1913*** (Birlinn) The Englishman Frederick Rea was the first Catholic headmaster to be appointed to this Gaelic speaking and Catholic island since the Reformation. His religion was deemed more important than the fact that he couldn't communicate with his pupils. The book is evocative of a past age, with wind tearing across the machair to the tune of the pibroch.

And if all your days on the beach resemble each other, then you will empathize with Vladimir and Estragon as they wait for Godot, in Samuel Beckett's ***Waiting for Godot*** (Faber and Faber). Or if you're trekking somewhere for days on end, think of Vladimir's words in Act 1: 'There's a man all over for you, blaming on his boots the faults of his feet.'

Alec Logan

Visions, by Michio Kaku (Oxford University Press) examines the future of mankind in the next millennium, presenting a prognosis of unflinching optimism. We're all going to live happier ever after, masters of molecular biology, boundless computer power, and quantum physics. Kaku writes clumsily, with a gushiness that makes the *Reader's Digest* seem restrained; but his book raises the eyes above your desk. Colleagues will choke on their morning coffee as you regale them with your latest assessment of superstring theory. A more elegant read is ***Tulip Fever*** by Deborah Moggach (Heinemann), a wonderful little novel, a tale of love and betrayal set in Amsterdam in the 1630s. Of course, up here in Scotland no-one in their right mind goes near a beach anyway. The weather drives us instead to the cinema — ***Star Wars: The Phantom Menace*** is, frankly, a little disappointing, though still unmissable. ***The Matrix*** is altogether more satisfying — well written, witty, and operatically violent. See it.

matters arising

RCGP Information Sheets — Recent Titles

The Information services section at the RCGP produce these sheets on various aspects of general practice. All the information sheets are copyright free and a full set can be obtained by ringing the ISS on 0171 581 3232 extension 220/230. Alternatively, you can download them directly from the College web site at *www.rcgp.org.uk/informat/rci0002.htm*

RCGP Information Sheet 4 General Practice in the UK
The history of general practice; how to become a GP; the structure of primary care in the NHS; commissioning; independent contractor status; workload; working hours; partnerships; pay and conditions.

RCGP Information Sheet 6 Commissioning
The origins of commissioning in the UK, and variations in Northern Ireland, Scotland, and Wales.

RCGP Information Sheet 8 The Structure of the National Health Service
Recent changes in the NHS and its structure in England, Scotland, Wales, and Northern Ireland.

RCGP Information Sheet 5 Health Service Expenditure
The cost of General Medical Services, consultations, and the income of GPs, together with international comparisons of expenditure.

RCGP Information Sheet 1 Profile of UK General Practitioners
Total numbers of GPs in the UK; demographic characteristics; working patterns.

RCGP Information Sheet 2 Profile of UK Practices
Partnership structure; list size; practice staff.

RCGP Information Sheet 23 Rural General Practice
Patterns of illness; rural deprivation; access to care; organization and funding; the Associate Practitioner Scheme; the Inducement Scheme; recruitment; the College Rural Practice Group; recent developments in rural practice.

Implementing the National Service Framework for Coronary Heart Disease in General Practice

Workshop Report: Saturday 26 June 1999
Royal College of General Practitioners, East Anglia Faculty

Introduction

A half-day workshop was convened in Newmarket to review the implications of the new National Service Framework (NSF) on Coronary Heart Disease (CHD) for general practice.

The National Service Framework itself was late in publication and therefore not available in time for the workshop. We proceeded on the basis of the emerging findings report and existing work on coronary heart disease conducted by the participants.

The process

- Introductions, including personal goals for the day
- Brief review of the NSF for CHD (emerging findings): illustrated 15 minute talk by Joe Neary
- Questions for consideration — introduced to participants
- Questions considered in sequence in a series of small groups, interspersed with review of the points raised in the plenary session
- During plenary, points were directly transcribed onto a PC with projected display. This process was found to give excellent involvement as well as good data capture.

The questions

- What are the main issues in the National Service Framework for CHD?
- Why are these important for general practice?
- How can they be delivered?
- Who needs to be involved?
- How would we measure success?
- What should the RCGP's role be in supporting general practitioners and PCGs?

The outcome

Action points for practices, PCGs, and the College were extracted from the data and are summarized below.

For practices

- Who are the patients with CHD in the practice? Who are the patients at risk of CHD? How do we know? Is our information kept up to date?
- What is the practice's role going to be in facilitating lifestyle changes? Is it appropriate for us to engage with this? How can we do it? Can responsibility be shared with others?
- If data is going to be shared, is patient consent needed?
- What are the practice policies in relation to medical interventions? Who should be prescribed statins? Do we know who is taking aspirin?
- Is the computer system used to best effect? Is there need for an upgrade of hardware? Of a review of the way we use it?
- Is there agreement between all the doctors and nurses working in the practice? On clinical policy? On maintaining disease and risk registers? On use of computers? How can agreement be reached?
- Should we involve patients in these decisions?

For PCGs

- Stock-take of existing capacity to identify disease and at-risk populations in general practices
- Stock-take of resources and individuals who can facilitate lifestyle changes in your locality How can we help practices to develop their skills and capacity?
- Review guidelines for medical interventions in CHD, ensuring that these are in agreement with best evidence and the final version of the NSF on CHD
- Stakeholder analysis of local health organizations, non-health public interests, commercial organizations and voluntary organizations with an interest in CHD
- Agree use of technology. Set priorities on IT development
- Agree shared standards for defining populations at risk, on thresholds for intervention, on appropriate formulary (needs to involve acute Trusts as well as hospitals)
- Decide how patients can be involved in decision making.

For the RCGP

- Where do our standards apply? Are they widely applicable in the wide diversity of practice? How do we communicate them? Comic strip guidelines and standards?
- Who do we consider in our advice? Members and non-members? Freelance as well as practice-based GPs? The professionally dispossessed? Non-medical primary care professionals?
- How are the costs of our recommendations to be met in practices and in PCGs?
- How do we reach members in their localities, faculties and in their practices? Do we have a strategy for practice based education, development and assessment?
- How responsive are our information resources to the moving tides of health policy and practice?
- How should we relate to other health organizations with an interest in quality in primary care?

Joe Neary

Sponsors: AstraZeneca pharmaceuticals

Neville Goodman

The current NHS 'modernization' includes 24-hour 'walk-in' clinics. This is all part, it seems, of the government's wish to make the NHS more responsive to what patients want. One feature stands out in many comparisons between the NHS and other health care systems: the great value of the GP as gatekeeper. This doesn't just save money. It provides a common pathway to and from the patient. Without knowing more detail of this walk-in system (are the clinics required to communicate with the GP?), I can't make an objective judgement, but (as with private medicine), I'm fundamentally against it. Unless it's to allow instant health care for shoppers whose varicose veins start aching while shopping in all-night supermarkets, I can't imagine why we need it. People shouldn't have to wait hours or days for an appointment they then think too short, so why not fund for shorter lists and more time?

To which patients is the government responding? Governments are supposed to lead, not to respond. The last government that 'led' wrecked our institutions and poisoned human relations. This government risks doing the same thing, albeit by different actions driven by different motives. Ask patients to lead and the leaders are not the patients we see in the clinics and wards.

The leaders include 'patients from hell'. This is from the (figurative) horse's mouth: Sheila McKechnie is director of the Consumers' Association; the description comes from a *Guardian* article. This patient from hell "comes to a consultant armed with a checklist". Which I don't mind. The patient knows what he or she wants, and it's delivered: that does not make them a patient from hell. Patients with lists tend also to doubt everything that's told to them: that's what damns them.

Ms McKechnie's vision of the future is more extreme than walk-in clinics. She sees patients becoming better informed, whereupon drug regulation could be "deconstructed, diagnosis automated, and doctors down-rated to 'prescribing advisers'".

I can just see future generations of schoolchildren queuing up to apply for medical school, knowing that at the end of five years there, and eight years in postgraduate training, including two or three difficult and stressful examinations, they can become Ms McKechnie's prescribing adviser. Mind you, can this really be the same Sheila McKechnie who got so upset by drug company advertising in the *BMJ* (1999; **318:** 598)? Not much hope there for 'better informed' patients if they can't even tell the difference between drug company hype and medical research reviewing. Sadly, what we'll get is patients who have more information, but who know less.

Nev.Goodman.@bris.ac.uk

Bruce Charlton

Not poetry, please …

One startling statistic I read somewhere: more people write poetry than read it. On reflection, this probably means that more people write poems than buy books of poetry, because in order to write a poem one must surely have read a few.

Another statistic — one of my own. This is the first time for over two hundred years in which there is no living English or Scottish poet of genius. Makes yer fink, dunnit? In this light, the appointment of Andrew Motion as poet laureate is appropriate — he is a highly competent and shrewd literary professional, but by no stretch of the imagination is he a poet. Motion is to poetry what Laboratoires Garnier is to science.

Hands up those who used to write poems when they were a teenager. My hand is up — love poetry. Very bad it was too, but not as bad as my sister's (e.g. 'The fire is warm, My heart is cold. There's no-one here, For me to hold.' Eat your heart out, Dr Seuss!). Indeed, I was writing poetry long before I could appreciate the difference between a poem and a non-poem, between a good poem and a bad one, or even between poems and prose. Only when I started to enjoy real poetry did I stop writing the fake stuff — it made me realize what utter bilge I was producing. Up to that point, Charlton was an undiscovered genius.

If we are honest about it, almost all the stuff that goes by the name of poetry — whether amateur or professional, published or unpublished — is of no more significance to the world at large than my pubertal drivellings. Which is to say that it serves a purely personal and subjective purpose, and has no significant value to anybody else. Write it by all means, but please don't ask me to read it.

Getting oneself known as a poet is, however, a pretty good career move. For a start, it is attractive to women — which is reason enough. Even impoverished poets who lack university sinecures are able to exert the kind of seductive fascination usually reserved for millionaires, footballers, and rock musicians. Poetry also provides an acceptable excuse for leading a feckless and bohemian lifestyle. While most of us are blamed for idleness and irresponsibility (I certainly am) this is pretty much expected of poets.

So much for bogus poets — but what is the role of real poetry? Well, it is of inestimable worth — a worth enhanced by its scarcity value. A poem encapsulates an aspect of human experience in a way that is at the same time memorable and inexhaustible. A poem is probably best when performed — either by the poet, someone else skilled, sincere and sympathetic, or by oneself aloud or in the voice inside the head.

But even the recollection of a poem (and real poems are almost characterized by their memorability) is enough to catch and amplify the momentous moments of life. Sometimes, poetry can induce an atmosphere of heightened reality which lasts hours, or even days. In other words, poetry can enhance life. Rare, idiosyncratic, and evanescent it may be, but poetry has a precious virtue which I would not wish to do without.

But please don't take my word for it — don't take anybody's word. Judge for yourself, and reject everything that you do not feel in your bones, your belly, and nerve endings.

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