The British Journal of General Practice

Viewpoint

Training GPs — a counterblast to the status quo

General practice is the last home of the generalist. You have to know something about everything. So, how do you get to know something about everything? Vocational training. This was introduced in 1978 to ensure that those going into general practice had adequate experience in various aspects of hospital medicine as well as a year as an apprentice in general practice. It worked reasonably then, because it was better than going straight into practice from house jobs.

However, there are serious shortcomings. The SHO post is still a service-dominated post where education is patchy, hours are long, and duties inappropriate. We grovel to consultants to let us have 'their jobs' when they would far rather have career doctors in the post. The GP SHO often works in the least popular job with the poorest consultant. So, after six months of substance abuse psychiatry, six months on the labour ward, six months in special care, and six months gastroenterology we are supposed to be ready for general practice. It is not good enough anymore: vocational training has got to change.

Time to slaughter a few sacred cows, then. I have two proposals.

Slaughter number 1: the humane approach

- The hospital component is too long and too irrelevant: we should have six three-month posts in appropriate specialties.
- The GP registrar year is too short, and should be extended to 18 months or two years.
- There should be an agreed regional strategy in each deanery to allocate sufficient posts to fulfil workforce planning: 40% of obs/gynae and paediatrics should be GP VTS as of right, as should 25% of psychiatry and A&E medicine posts, and 15% ENT and general medicine posts for general practice.
- Create a new type of post. At least one-quarter of posts should be for those who have finished their GP registrar year. These posts can be geared to working one day in public health, and the rest supporting PRHO and medical student practices (part-time) and helping practices that have special needs (ill-health, expanding lists, deprivation, poor performance), again part-time, for a two-year contract with educational and mentor input. Call it Senior Registrar in General Practice, if you like.

Slaughter number 2: mayhem

- Have an approach where one or more GP registrars are placed in a practice or in different practices in a rotation immediately after house jobs. Specialties could be learnt based on the educational needs of the learner.
- Keep full-time SHO posts for those who wish to have a career in those specialties.
- Teach specialties in a modular form, either in block release or one day a week. Develop skills labs to teach doctors how to learn techniques such as pelvic assessment, rectal examination, joint injections, etc. Stop using the suffering British public as clinical material on which to learn.
- Base all the assessments in general practice. Organize the majority of teaching in general practice. Have the equivalent of half a GP paid for teaching two registrars in general practice. Fund it properly.
- Think of what you want from the GPs of the future. Work out the best way of equipping them for it. Jettison the tedious and irrelevant. Ignore the 'but-who-is going-to-look-after-the-shop?' brigade.
- Tighten up summative assessment so that it is more difficult to get into general practice, and is no longer seen as a career for those who can't make it in other specialties.
- Make the MRCGP compulsory for principals in general practice, as well as active support for our Royal College (i.e. make them pay their annual subscriptions).

If we wish to be taken seriously as specialists in primary care we must stop being so servile. Stop apologizing and start to rejoice in the pleasures of general practice. Amen.

Dominic Faux

The Back Pages...

'The boy survived although both his lower legs were amputated — when Beatrice later visited him in Pristina hospital he wept and asked her how was he going to go to school now?'

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The College in Scotland

For further information regarding the RCGP in Scotland please contact:
The Royal College of General Practitioners (Scotland),
25 Queen Street,
Edinburgh EH2 1JX.
Tel: 0131 260 6800
Fax: 0131 260 6836

On 10 September 1999 a new chapter began in the life of the Royal College of General Practitioners, when Ms Susan Deacon, Minister for Health and Community Care in Scotland, opened the new RCGP (Scotland) building at 25 Queen Street, Edinburgh.

The move to this location marks a significant development in the history of the College, and will enable us to respond to the devolved system of government now operating in Scotland as a result of the creation of the Scottish Parliament in May 1999.

The Scottish Parliament offers unparalleled opportunities to work closely with Members of the Scottish Parliament (MSPs) as they develop and implement health policy. It is crucial that the views of general practice and primary care are effectively expressed and Scottish Council is moving swiftly (together with the Scottish General Practitioners Committee (SGPC)) to fulfill this role.

The new RCGP (Scotland) headquarters at 25 Queen Street, Edinburgh.

During the summer recess, officers of the Scottish Council met with the Minister for Health and Community Care. Her approach to openness and collaboration was informal and refreshing. We look forward, therefore, to a more effective way of working. We were similarly delighted with the outcome of our meeting with members of the Health and Community Care Committee. There is a need for objective and informed advice and support to the Committee members, who have a strong desire to learn from professionals working within primary care. It was recognized that the College, through a number of unique and innovative projects that have been piloted in Scotland and our ongoing commitment to the highest possible level of patient care, is one of the key organizations ideally placed to fulfil this role.

Members Working Together — the Future of the College in Scotland

This is an exciting time for the College in Scotland, as it works on behalf of its membership and the profession to take forward issues in relation to quality, education, and primary care.

In addition, members in Scotland will gain from the College:

- being at the forefront of influencing developments through the Scottish Parliament, through the devolved Scottish Health Service and through our close liaison with other primary care organizations;
- taking forward the quality/clinical effectiveness agenda in Scotland, providing useful tools to help practices and practitioners achieve excellence in patient care;
- closer association with patients, boosted by the newly established Scottish Patients Liaison Group;
- providing educational tools and opportunities to assist members in meeting the needs of revalidation;
- providing up-to-date advice and information regarding developments (medical and political) within primary care in Scotland as they happen.

Other Scottish initiatives continue, such as **hoolet**, the journal of the RCGP in Scotland, which is now available full text on-line at **www.hoolet.org.uk**

But the College is its members. We need your support in taking all of this agenda forward.

Colin Hunter
Graeme McAlister

A Different Type of Government

A new system of government has been purposely developed in order to ensure that parliamentary business is conducted in an open and transparent manner; to encourage greater public involvement; and also to make the Scottish Executive more accountable. The bulk of this parliamentary business is going to be committee-led.

The main committee with which doctors and the College will be concerned is the Health and Community Care Committee. It is anticipated that this committee will have considerable power, as they will be able to initiate cross-party legislation, in addition to the more traditional scrutinizing role of committees.

The commitment to open government is central to the operation of the Scottish Parliament and is carried through into the official reporting of parliamentary business with *verbatim* reports of meetings of the Scottish Parliament and its committees being made available. Ministerial Answers to Written Questions are similarly available.

The new Scottish Parliament takes advantage of new technology. Proceedings of the Health and Community Care Committee are available electronically at 8.00am on the day following meetings, and members of the Committee welcome (and do respond to) comments E-mailed directly to them.

Contact the Scottish Parliament at **www.scottish.parliament.uk**, and from the *Home Page* click on *Parliamentary Proceedings* and hence to the committees menu.

Retired Members' Tea Party

The sixth 'tea-party' for retired doctors was held in July, giving members an opportunity to meet the President and Chairman of Council, members of the Retired Doctors Working Group, and College Staff.

Some 85 people attended, of whom 18 were Founder Members. There was an opportunity for each member to talk about what they had been doing since retirement. Some of the activities discussed included a study of alcoholism in the profession, volunteer work in a village in India, the care for patients at home with Alzheimer's disease, and a study of the superiority of domiciliary care over institutional care.

The Chairman, Professor Mike Pringle, then outlined his aims for his three-year term of office, including revalidation, Fellowship by Assessment, Membership by Assessment, MRCGP International, the Quality Practice Award, clinical governance, and the vocational training review. This was followed by the presentation of an owl brooch to the College by Dr John Squire, a Founder Member.

In the afternoon, members and their guests were able to tour the building and view some of the recent additions to the paintings, sketches, and prints which had been presented to the College. Later, there was a video presentation from the College's archives of an interview between Past President, Dr Alastair Donald, and Founder Members Drs John Fleetwood, Nora McNally, and the late Vincent Doyle, about their involvement in establishing the Irish College. The video had been filmed in Dublin by the late Dr William Fulton.

This was a very successful event and it was suggested at the meeting that the Faculties might look into hosting a similar event at local level.

If you have any ideas you wish to put forward or would like to publish an article in the Faculty Newsletter, please write to: Mrs Mayuri Patel, Clerk to the Retired Doctors Working Group, RCGP, 14 Princes Gate, Hyde Park, London SW7 1PU; fax: 0171 589 3145; e-mail: **mpatel@rcgp.org.uk**

Autumn Webs

Where do you go and what do you want to see? Theatre booking can be a bit hit and miss. You try to book over the telephone and the person on the end of the line tells you that the seats are great. You get there and the post in front of you is the best view you've got. An expensive mistake. Go to *What's on Stage* **http://www.whatsonstage.com/**, a UK-wide theatre news and listings service. You can search the database, book on-line, and choose the best seat.

Another site for the theatre is *Theatre Net* **http:/www.theatrenet.co.uk/**. This is more London-based and features events and listings. There is free membership to this site with some ticket offers available.

If you have children and want to guide them to the right sort of sites, then you could choose the *Exploratorium* at **http://www.exploratorium.edu/**. This is an excellent resource telling the children how the world works.

What sort of service do you get if you go down the road to your local estate agent? They usually throw you the houses in the wrong category (always just out of your range).What do you do if you are moving to another area and you're not sure where to look? **http://www.home-to-home.co.uk/** is a site that provides all the updated information news and features on home buying and mortgage rates etc. It has links to the biggest house-buying sites.

http://www.value-direct.co.uk/ is a good site to consider if you are buying white goods on line. You can buy home appliances and electrical goods and it has a very good section to browse through that includes *Which?* reports to help select best buys, and links to a range of manufacturers' web sites. The only thing that lets it down is that currently there aren't any pictures of the products for sale.

Another similar site is at **http://www.we-sell-it.co.uk**. This one does have pictures and good service (fast delivery, etc.). It is an excellent site and worth trying out if you want to buy any key appliances.

http://www.railtrack.co.uk/. This site allows you to search for train routes. It gives you times and all the alternative routes you may require. It also provides other travel-related news and information. Moving around the country, I always seem to be ringing for the time of the train. I never quite believe that what has been printed will still remain accurate even a week after it has been published. This site gives the most up to date entries and keeps up with leaves on the line, or a sheep crossing! However it still won't tell you that the train will be so crowded that you won't be able to get a seat.

Amanda Kirby

Dealing with the aftermath of conflict

Sarah Pickworth, a GP from Oxfordshire, spent six weeks as a volunteer with Médecins du Monde in the Balkans. Initially, she worked in the Blace refugee camp in Macedonia, before being a member of one of the first humanitarian teams to re-enter Kosovo alongside NATO peacekeepers on 13 June 1999. This is her account of that time.

Médecins du Monde-UK *was established to contribute to the worldwide work of the international humanitarian organization, Médecins du Monde, which provides medical assistance to vulnerable populations, and treats both physical wounds and psychological traumas.*

Médecins du Monde-UK *recruits mainly health professionals as volunteers for the projects throughout the world. For more information contact Médecins du Monde-UK at 11 Sovereign Close, Sovereign Court, London E1 9HW or visit*

Blace Camp, Macedonia

When I arrived in Skopje, I met a very tired team struggling to keep morale going as news filtered across of thousands of refugees stuck behind the border while Blace camp lay empty.

Initially, there was only a trickle of refugees who needed very little medical help, but were utterly distraught from their flight from fear and terror. They told us of massacres they had witnessed, friends and family shot in front of them, and of being forced out of their homes, which were then burnt.

Then, overnight, our peace was shattered, as thousands of refugees poured over the border. I couldn't have imagined that number of people, let alone their desperation. We were overwhelmed by people so desperate for food and water that nothing would stop them. The sheer numbers of people were frightening. Our teams worked round the clock, rarely venturing off no-man's land, except to take the sickest to Blace camp below, for fear of the border guards not allowing us back on to no-man's land until all were safely through. Many of the refugees had been on the move for weeks with little to eat and were collapsing with exhaustion. People had had no access to medical care or drugs throughout the war and there were many who collapsed with grand mal seizures. There were women who had recently given birth without any medical help; one young girl had given birth on the cramped bus *en route* to the border and was only just managing to still stand up, clutching her newborn baby girl.

One of my lasting impressions of working there will be of man's inhumanity to man; Macedonian border police treating Albanians worse than animals, happy to watch those close to collapse struggle on. Working at Blace stretched everybody, it was extremely hot and dusty and resources were very limited in terms of drugs and equipment.

Photo: Boyan Topaloff

Return to Kosovo

Just as we were settling into a routine in the camp, which was by now full, the peace treaty was signed. Before we knew it we were preparing to go back to Kosovo.

Médecins Du Monde (MDM) was the first NGO to arrive back in Kosovo entering Pristina almost in front of the British troops. My team set off at a more leisurely pace with the UN convoy/traffic jam taking a record-breaking seven hours to do a journey that should normally take one hour by car. I could have cycled it faster. Once over the border people lined the roads, shouting 'UCK', 'NATO', or just 'Tony Blair'! As we entered Pristina there were still houses and mosques burning and tanks and armoured cars patrolled the streets, but the tanks were covered with red roses that people had thrown to welcome the soldiers.

The house MDM had occupied in Pristina up until the NATO strikes had been ransacked. Nothing had been left inside — not a single fitting. We had no light, no water, and most of the windows were smashed and the door locks broken. As soon as the British troops had checked the house for mines and booby traps, the first MDM team on the scene had set to work and cleared all the rubbish and excrement left by the Serbs from the floors. Very shortly we were heading out in our bulletproof jackets and helmets to do our first clinic in Gollgovic, a small town about half an hour away from Pristina. I was shocked to see the roads lined with mile after mile of Serb convoys — with jeering soldiers standing on their tanks doing 'V' signs and shouting obscenities at us.

As we approached Gollgovic the villages looked like ghost towns — burnt-out wrecks of cars and buses lined the streets standing in front of empty charred buildings, with a few cows wandering through the smashed up petrol station.

Gollgovic itself was much more lively; people were in the streets and armed UCK (KLA) soldiers were very much apparent. We set up a clinic in the front rooms of a private bungalow — the hospital was a ruin of shattered glass and probably mined. Soon we were up and running with an orderly queue (thanks to Ismet, our driver) up the garden path.

Among our first patients were three mine victims. One older man had a large gash on his face which needed stitching. He was lucky because his wounds were only superficial. A young man was rushed in on a blanket by his friends; he had lost his left lower leg and had been given first aid but he was in dreadful pain. At the same time, a boy of 13 was brought in, in a wheelbarrow. The boy had stepped on a mine while playing in a field the day before and had lost his left lower leg and his right leg was badly broken with a large gaping wound. He was so quiet

and pale but incredibly brave, and his poor mother stood beside him and wept. We did our best to stabilize them and transferred them to Pristina hospital. Sadly the young man later died. The boy survived although both his lower legs were amputated — when Beatrice later visited him in Pristina hospital he wept and asked her: how was he going to go to school now?

Each day saw changes, the city gradually came to life, and in Gollgovic we moved first into the Mother Teresa clinic before finally moving into a larger clinic, that by then was seeing up to 180 patients a day. We saw a range of medical problems, many with shrapnel wounds, people with month-old fractures healing in distorted positions, diarrhoea and upper respiratory infections in children, and older people with hypertension which, without medication, was now way out of control. Almost all the insulin-dependent diabetics had already died.

Many needed some form of counselling to help them cope with a traumatic bereavement or anxiety, or just needed a sympathetic ear. Gradually the local doctors and nurses came in to help us, and then suddenly one morning our team arrived to find their was no space for us any more — our work was done and the clinic was up and running. What a joy to be put out of work!

Visiting day

Besa, the English-Albanian interpreter, and I, were given a day off to go and see our patients in Pristina hospital. Our patient with the blast injury was still waiting for the water supply to come back to the hospital so they could operate to remove the foreign body from his eye. Sadly, we were not allowed to visit the two women we had brought in for emergency caesarian sections, neither of whom had had any antenatal care available throughout their pregnancy. But at least we were told they were doing well.

The 21-year-old woman who had given birth to 32-week twins in an isolated mountain village was still white as a sheet and we were asked by the staff to bring in a close relative to give blood if the blood test confirmed severe anaemia.

During a visit to the children's ward, a paediatric doctor took it upon himself to show us his department. We did not expect what we saw next: a group of Albanian children ranging from six months to two and a half years old. These were his 'social cases' and they were two to a cot, tied to the sides of their cots standing, if they could, in dripping nappies on sodden mattresses, just rocking the sides of the cots. They had no toys, the room was bare and the walls were white-washed. Some of the children were very delayed — there were children of almost one year not sitting yet. The children were quiet and watchful and as the doctors and nurses approached them they backed off. He explained they had been abandoned by their parents, who brought them in when unwell and then left them as they fled the country. We were told that one little boy had been found abandoned in the woods by Serbian soldiers. None of the children had identification now and they had been renamed with Serbian names.

To my utter horror, as we talked the day's events through with the team in the evening, our nurses who had worked with us in Blace told us a very different story. They had looked after distraught mothers in the Blace and Stenkovic 1 camps who, having given birth in Pristina hospital, were told they could not keep their babies. They met others who, having taken their child into hospital, found when they tried to collect them were told that they had been sent to Belgrade. We lost no time in telling UNICEF and the Red Cross of these children in the hope they would be able to go in and improve their situation, and to help them be reunited with their parents.

Helping to rebuild the health service

With Gollgovic up and running our team turned to a different area in the west around Redkov — picturesque villages ringed by high mountains. Picturesque, until you looked more closely and saw the burnt-out houses and flattened clinics. Even in villages which looked untouched, the locals would tell you horror stories of massacres. Every village had mass graves, everyone's lives were tinged with sadness.

I think I was moved most by our visits to the doctors in this area — I have nothing but admiration for them. They had been looking after people throughout the war, putting their lives constantly at risk to help others. As we left one of the clinics we had just set up together, one of the doctors pointed to a field beyond the schoolhouse/clinic and told us of his narrow escape from death — the Serbs had rounded up 6000 people from the neighbouring villages and took out 108 men, women, and children, slaughtering them in the most barbaric way in front of everyone. Later, in the dark, he and others managed to crawl away unnoticed, to safety.

It was a pleasure to be involved in helping the local doctors set up clinics by negotiating, or finding buildings where at least most of the windows were intact in the clinic rooms, doing a bit of DIY glazing, or arranging supplies of medicines or equipment. Some of this involved the enviable task of drinking considerable quantities of delicious local Turkish style coffee — right up my street! The local communities' response to their doctors' efforts to organize clinics was fantastic, and with everybody's help we had three clinics up and running in no time at all.

Sarah Pickworth

David Mazza

School Doctor

A GP married to a primary school teacher: the jewel in the crown united with the country's most precious asset. One consequence of this marriage made in New Labour heaven is my annual 'people who help us' slot with the six-year-olds at my wife's school. The fruits of our labours: the products of our health and education services, are there displayed.

"Does anybody know where their heart is?" Small hands are placed with varying degrees of confidence anywhere between the chin and the umbilicus. One child even expertly places hand on top of head, while another is adamant that his right knee is a key player in his circulatory system. I offer some gentle correction within the limits of my decaying knowledge of anatomy. Undaunted, I ask if they know how and where to feel their pulse. Only a few edged tentative fingers in a wrist-wards direction. Something has happened during the intervening year. Now 30 confident six-year-old clinicians immediately probe for the carotid pulse with such vigour that the resulting bruises may raise eyebrows in the social work department. I am left speculating: infant school science or the power of medical TV drama?

"Are there any questions?" The children see their chance. Society's fascination with and concern about the health of the nation is poured forth. There are gory tales about the birth of younger siblings and descriptions of the last time they, or any of their kin, suffered from diarrhoea and vomiting (especially vomiting). Examples of the miraculous healing powers of physicians ("The doctor felt my tummy and it stopped being sore.") are tempered by concerns about the quality of out-of-hours primary care ("I was really poorly but the doctor wouldn't come out and see me!"). The majority of the class join in a heated debate about the evils of smoking to which there is little that I need to contribute. Hayley abruptly ends this impressive discussion, "Those wee spots on your tongue — they're your brains, eh?" I am left goldfishing! Seeing me off-guard, the sharpest in the class, who has been waiting for her opportunity, asks, "Where do babies come from?" The ever vigilant teacher interjects that if my inquisitor survives long enough, all will be revealed in Primary 7!

A New Kind of Doctor: professional autonomy in a public service

Autonomy: self-regulation of a person or group; or, loosely interpreted, freedom. A precondition of freedom, said Pascal, is recognition of necessity. Unless we recognize fundamental constraints within which we must live, we can only talk about freedom, not use it. Envied by English romantics for their primitive autonomy, Bedouin Arabs were not free to eat brussel sprouts or ice-cream, or to do anything outside the desert world in which they lived.

"Until very recently, independent contractor status conscripted to small business every doctor who wanted to work autonomously in primary care."

General practice faces its sternest but most appropriate test when trying to deliver effective care to whole populations in the bottom third of our economy. Limited by its received assumptions, much of UK general practice is beginning to resemble this Bedouin metaphor. GPs, in their post-industrial deserts, are becoming socially isolated and clinically obsolete, and can hardly find worthy successors. Their working world is limited by independent contractor status.

The NHS expanded professional autonomy by eliminating trade

Before I try to demolish this supposed foundation stone for our College ideology,[1] let's recall an earlier transition. I knew Robin Pinsent personally, well enough to be sure that in 1948 he, like Will Pickles, Ekke Kuenssberg, and most other founding parents of our College, differed from 85% of their GP colleagues by actively supporting the NHS in the turbulent six months preceding implementation of the Act. When national BMA leaders likened Nye Bevan to Adolf Hitler, and predicted a future in which committees rather than surgeons would decide when and whether to operate for appendicitis, they deceived themselves, but almost nobody else. Robin had confidence in more fundamental principals. His priority was patients' needs, not medical earnings, and he understood the difference. So much so, that he refused ever to collect BMA-approved fees for private certificates, and publicly derided colleagues who continued to tap this lucrative but demeaning source of tax-free petty income.

According to English pre-NHS wisdom, private practice set standards for public service, because this alone would ever be sufficiently resourced. The NHS, offering free care for the previously fee-paying middle class, would therefore decapitate general practice.[2] In fact, the NHS released a wave of reforming energy at all levels, including the birth of our College. It permanently dethroned private practice from moral or clinical authority and swung substantial investment into secondary care for the first time since Queen Victoria. To its great credit, the College never looked back to imagined 'good old days' of private practice. Right up to the divisive contract of 1990, it looked mainly to NHS urban group practice to provide wider and deeper social foundations for innovation.

The NHS virtually eliminated trade at primary care level, and GPs thereby gained greater scope to work effectively for all of the people. Their anticipated loss of autonomy never occurred, because they measured this, not as freedom to do whatever you wanted, but as power to think and act effectively for their patients.

We stand on the brink of a salaried service

Until very recently, independent contractor status conscripted every doctor who wanted to work autonomously in primary care to small business. Small businessmen naturally seek profitable sites, with optimal balance between earnings and workload. This formula guarantees that areas of highest mortality, morbidity, and GP workload always have the least choice of staff.[3] Countries that traditionally exported doctors — first Scotland, then Ireland, and later the countries of South Asia — filled medical sweatshops that English and Welsh doctors could avoid. Many of these, notably the South Wales valleys, have depended for the past 30 years on GPs trained in South Asia for 50–80% of their staff. Used first as dead-end junior surgical staff to maintain our consultants in the manner to which they were accustomed, they were then dropped into the GP dustbin, to find some niche in a profession where black faces were unwanted.[4]

We now face the consequences of 30 years' unprincipled opportunism. The hard working sons and daughters of these Asian GPs now compete successfully for consultant posts; they want something better than cornershops. So the deep end of general practice is everywhere in crisis, with health authorities desperate to find another generation of staff.[5]

Through deregulating legislation, rushed through in its dying months by the Conservative government, roughly 15% of advertised posts in general practice are now salaried. Most of these contracts are held by Community Trusts, a few by health authorities. There is no national contract, although the BMA wants one.[6] A few of these posts are being used imaginatively, but they seem to be transient props for the old system rather than seeds for anything new. This ignores an opportunity for new advances as profound as the NHS was in 1948, both for us and for our patients. This possibility of advance arises from a new stage in the same process of transition from private trade to public service. Independent contractor status is a tenuously surviving legacy of private practice. With salaried service, GPs can finally get out of business and into social biology.

Depersonalized treadmills?

Piecemeal salarization of general practice will probably continue, with little professional opposition so long as it doesn't threaten foxhunting areas.

Governments and civil servants naturally prefer a tidy salaried command structure. They would probably have improved in this direction long ago, had they not faced implacable professional hostility, and saved vast sums of money by GPs' willingness to accept responsibility for virtually all investment in primary care until 1967, and most of it until 1990.

Opponents of salaried service have rightly said that, by itself, salaried service does nothing to improve quality of care. It entails high risks of bureaucratic stagnation, depersonalization, and loss of continuity. In many countries this is so evident that its opponents have virtually ignored successful salaried services in several countries comparable with the UK. Nor do they seem to consider mounting evidence that independent contractor status has generally failed to maintain continuity, as it has shifted from single-handed to group practice,[7,8] although personal continuity was supposed to be its main justification.

Salaried service as a treadmill for doctors and a clinical slum for patients is all too familiar, wherever public service has to develop as the poor and despised relation of affluent private practice. Without mass pressure first to restore and then to promote priority for redistributive, tax-based public services, that would be its natural outcome in our market society.

The positive potentialities of salaried service depend on active struggle. This time around, advance must be initiated *by* health professionals, not in spite of them. That means that at least a critical mass of innovative GPs (whom I would estimate as roughly one-third to one-half of all GPs) must be won to a positive view of this alternative.

Only about 20% of GPs seem to rule out salaries on principle,[9] but with few exceptions, GPs who have created excellent group practices and vocational training schemes and are now trying to make the rhetoric of a primary care-led NHS into reality through commissioning Primary Care Groups, remain hostile to all immediate proposals for salaried service. They see nothing feasible within this vision which they couldn't achieve themselves, without giving up their personal ownership and control of the heart of NHS primary care.

The easiest answer to this is that such progressive partnerships are as exceptional now as they always were. Although about one-third may be seriously trying, far fewer have evidence that they are succeeding. Independent contractor status has no mechanism for extending to all practices the good work of an exemplary few. As we all know, most group practices are lucky if all partners are on speaking terms, organize regular meetings where the work of the whole team is critically discussed by the whole team, or have any agreed clinical or population policies.

A more telling but less acceptable answer is that personal ownership of large chunks of the NHS has become intolerable for most staff who are excluded from this power. This ensures that creativity is mostly restricted to these personal owners. This is as true of GPs, with their *de jure* ownership, as it is of hospital consultants, with *de facto* ownership.

Visible failure is a precondition to fundamental reform

But the decisive answer is that salaried service can only begin where independent contractor service has already visibly failed, where new staff can no longer be recruited in the old way, and independent contractor status is no longer a viable option. If supplementary salaried staff imitate the present job definition of GPs the downward slide in morale will continue, with less continuing care, more crisis intervention, more emergency admissions, more self-referrals to accident and emergency departments, and higher costs for irrational prescribing.

"Independent contractor status has no mechanism for extending to all practices the good work of an exemplary few."

As an effective alternative, salaried staff must work in a new way, no longer based on the assumption that GPs are responsible in the first instance for the entire range of work which hospital specialists cannot do better, or which they consider beneath their notice. Who does what must become based on evidence from analysis of the actual work of primary care and the skills needed to perform it, not on arbitrary hierarchies of power.

Take, as an example, the current problems of a Valleys Health Authority, facing escalating demands for INR anticoagulant control. Atrial fibrillation has a population prevalence of about 4%. Primary prevention of stroke by continuous anticoagulants is effective (seven patients need to be treated for five years to prevent one cardiac or cerebrovascular event, compared with 18 for antihypertensive treatment of elderly men).[10] About 90% of those at risk want treatment and are thought by their GPs to be able to cope if they have some help at home.[11,12] The Authority rightly believes it has a duty to make this advance available to all who can benefit, but its hospitals can't cope even with present demand for INR. So they are negotiating with independently contracted GPs to do them.

Will this reduce demand? Probably not much. Predictably, GPs who take this on may take a few cases out of hospital follow-up, but they will also greatly expand coverage of the population. Like other chronic medical needs, the Rule of Halves (at least) has applied hitherto, so the NHS cannot move forward without expanding sideways.[13]

"Personal ownership of large chunks of the NHS has become intolerable for most staff who are excluded from this power..."

This new work for GPs will take time. Independent contractor workload has risen throughout this decade.[14] Where can this new time come from? If GPs employ someone else to do INRs, why should they pocket the difference between hourly earnings of phlebotomists and those of doctors, and who will be responsible for training and quality control? More likely, they will give up other tasks not yet rewarded by fees, though no less important. Home visiting rates have

"Why (cannot) rich Britain in 1999 afford the same social generosity (of) poor Britain in 1948?"

fallen by 25% over a period in which the number of pensioners has risen by 7%.[15] This has included home visits for terminal care. Stick and carrot control of independent contractors is no way to ensure comprehensive, effective, and efficient primary care. The tasks of both hospital and primary care long ago became too complex to be owned and controlled by one group of professionals, answerable only to their own uncritical peers, and subordinating other health workers in their authority.[16] Consultants formally conceded this in 1948, because public investment in hospitals was on a scale they could hardly deny, though they have still clung to informal power. With virtually no investment in primary care, GPs could and did resist, but now no longer. We must have more people. Machine production needs even fewer people, health services and education needs ever more people. A sane society would find means to encourage such a transfer of labour.

For Lloyd George's government, the great advantage of independent contractor status was that, in the name of autonomy, GPs voluntarily accepted a pecuniary interest in mean and unimaginative provision of care, and inflated claims for what one man could accomplish.

This has been steadily eroded by increasing state investment in primary care, direct or indirect, as government slowly began to understand that you can't build effective or efficient hospital care without a foundation of effective and efficient primary care. For industrial and post-industrial areas at least, independent contractor status is losing its grip both on government and on professionals.

Or chariots of fire?

Salaried service is both inevitable and a necessary, but not sufficient, precondition for serious advance in quality of care for the mass of the people. There's going to be a battle, between social forces using salaried service principally to rationalize further retreat from the original aims of the NHS to provide free comprehensive care for the entire population, funded from taxation, and forces using it to reapply these principles in the entirely new situation we are now in.

What's new about it? Three things. First, advanced economies — the so-called post-industrial economies — are shifting from production of material commodities to production of knowledge. Appropriation of wealth from production of knowledge depends on legal and cultural submission to the concept of private intellectual property. This will be fiercely contested, as was the concept of private property in land, that even in Europe has taken well over 1000 years, and in the rest of the world remains hopefully incomplete. Resistance to unregulated markets in intellectual property could enlist a much wider social majority than was ever available for socialization of the means of material production. If we want truly fundamental research, publicly funded through independent universities, we have to succeed. We certainly can do so, if we learn to make new social alliances.

Secondly, both the public and health professionals are beginning to understand the limits of consumerism, and the profound significance of developing patients as co-producers of health gain as a social product, rather than consumers of care as a personal acquisition.[17]

Thirdly, on a basis of regionally organized primary care, information technology creates the possibility that cumulative records of the process of care can provide a database for mass participation in research. Based on what we have learned, largely through College initiatives, about the nature of continuing care as a life story, these records can accurately refect real lives and thus have wider uses than the episodic fragments available to hospital care. Using such cumulative records, the experimental nature of all consultations can be used positively to produce new knowledge, rather than concealed to preserve professional authority. The NHS is the biggest single employer in Europe, a major producer of wealth, though not in commodity form. Associated with research-based biotechnology, it could become a very much bigger employer and wealth producer.[18] Though some of this new wealth would have initially to be traded as commodities for profit, it seems unlikely that such primitive social arrangements can be permanent; but that's another story.

There will be a battle. So far, the more patrician leaders of our profession have, predictibly, chosen to submit to established power, pleading for a special relationship as their reward, for justifying to the mass of the people why rich Britain in 1994 could not afford the same social generosity as poor Britain gave so readily in 1948.[19] But GPs are not patricians. Faced with the consequences of Sir Maurice Shock and all the other health care rationers' capitulation on their behalf, GPs and their own leaders have refused to abandon their role as advocates for their patients.[20] Having bravely refused to marginalize their patients suffering erectile failure, they might even dare to ask why a relatively simple variant of nitroglycerin, whose particular action on penile blood flow was discovered by accident and has already sold more than any other medication in North American history, has to cost the NHS £5 per tablet. Perhaps we are seeing the beginning of the end of appeasement and social paralysis.

Autonomy is about power. The power we need is the power to apply medical science effectively to the real problems of the people, with the people. Locked in the past, we can't be effective, and our autonomy becomes illusory. To have autonomy in a necessarily more regulated future, we must fight for it, as advocates for our patients, with the public as our allies, not only we, but all skilled workers, have the right and duty to control not the aims of our work, but the ways those aims are achieved. We need to work with our patients in our own way, because that way will certainly be most socially efficient. Whether established power then regards us as enemies depends not on our wisdom, but theirs.

We are many, they are few. But that depends upon who become recognized, and who become excluded, as 'we'. The times are changing.

Julian Tudor Hart

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in brief...

Autumn, thanks to Rupert Murdoch, is now the season, not of mists, mellow fruitfulness, and the quince, but of Champions League football, rather too many rugby matches, **The Sopranos** (Channel 4, beyond compare), and, for the leaden of heart, pre-season excitement as postgraduate programmes thump on to general practice doormats. Dogs bark and children scream.

But relief is at hand. **The Man Who Ate Everything** by Jeffrey Steingarten (Hodder Headline, 1999, PB, 384pp, £6.99, 0 7472 6097 4) is a glorious series of essays about food. Steingarten, a Harvard lawyer turned restaurant reviewer for *Vogue* writes in the finest tradition of MLK Fisher and Elizabeth David. At turns obsessional (*Primal Bread* — 40 pages on the creation of naturally leavened bread), snobbish (*The Waiting Game* — 'you cannot learn anything by smelling or squeezing the cork'), and brilliantly informative — on perfect *choucroute garnie a l'Alsacienne* and on Wagyu beef — 'from an ancient strain of Japanese black cattle ... raised on a diet of beer and sake-soaked grain, pampered throughout their lives with massage and acupuncture.'

More importantly, he cannot abide North American health fascism — the sort of stupidity that leads the pleasant town of Sausalito near San Francisco to declaim on public notices that it is a 'cholesterol-free zone'. In *Why aren't the French dropping like flies?* Steingarten reminds us that France, with its inimitable high-cheese, high-wine, high-goose-fat diet enjoys better cardiovascular health than any other developed nation save Japan. An irresistable read.

Alec Logan

A Professional Odyssey in General Practice
Brian H Connor
McGraw-Hill (Australia), 1998
HB, 95pp, 0 074706 10 1 [Australia only]

General Practice: The Uncertain Art
John Stevens
McGraw-Hill (Australia), 1999
PB, 149pp, 0 07470725 6 [Australia only]

In a world that seems to become more and more dominated by urban dwellers, it is comforting that some medical publishers recognize the importance of health care in non-metropolitan areas. Brian Connor's book, *A Professional Odyssey in General Practice*, is intended to provide reading material necessary for 21 seminars for prospective rural Australian general practitioners. Each chapter addresses a theme for individual or group discussion. Topics include continuity of care, time management, professional development, ethics, morality, money, and the law.

Some of the issues the book raises are described in the context of Australia, but are nevertheless important for UK readers. Analysis of a national health care system in a country with autonomous states like Australia might well inform a discussion about the significance of devolution and regional government in the UK. Doctors may choose rural practice to enhance family life and allow their children to be brought up in the countryside only to find that the integrity of family life is threatened because their children leave home for educational reasons.

The stated aim of the book is to stimulate young doctors to discuss the various issues. However, as a reader, I found myself following the author's own professional development. Anyone who has tried to write knows that it is enormously educational to organize and describe one's thoughts. As I read the book, I could not help but feel that the book's greatest strength is in the insights it gives us into the author's own life. Much of it is autobiographical. What he really seems to be describing is the impact upon himself of changing technology, patterns of disease, organization of health care, patients' expectations, and, most of all, his role-models, mentors, and experience.

His commitment to helping younger doctors to cope with change is laudable and obvious and the book lists many topics for discussion. However, it might have been better simply to provide the structure for the seminars and to encourage participants to do more of the 'spade work'. I am not a newly qualified doctor and may be the wrong person to judge, but some of the text seems platitudinous. For example: 'Once you have sorted out your time management strategies so that your practice and life are organized as efficiently as possible, then you need to consider how to use this time most appropriately.'

There is a great deal of excellent resource material for vocational training in the UK but very little literature on rural general practice. Nevertheless it is unlikely that Course Organisers will choose to commit themselves to a series of 21 seminars based upon this book.

John Stevens, the author of *General Practice: the Uncertain Art*, was born and educated in England, emigrating to Australia in 1964. He practised in rural Tasmania for thirty years, during which time he was an active member of the Royal Australian College of General Practice. This anthology of regular, monthly articles he wrote for *Australian Family Physician* reflects his personal view of the life of an Australian GP. I enjoyed reading it.

He describes the pleasure and pain of living and working in the same community and the difficulties involved in maintaining a balance between personal concern and professional detachment when caring for friends. Many of his insights will strike a chord with family doctors in the UK and other parts of the world, not just Australia.

The articles are fun to read. He has a ready wit and an ability to describe his common sense approach to medical practice. Experienced doctors know that, when their patients are stressed or distressed, there are occasions when tactful plain speaking is more effective than prescription of psychotropic drugs or referral to a psychiatrist, psychologist, or counsellor. For example he 'tore one heck of a strip off' a teenager who remained listless and unsettled after he had almost electrocuted himself. The treatment worked perfectly. The boy returned to school and happily got on with his life again. His humanity and kindness are obvious, but he is realistic about his occasional intolerance. He is also clear about the importance of applying a sound knowledge of anatomy, physiology, and pathology. As well as being sympathetic and understanding the interesting nuances of human behaviour, a good doctor makes accurate diagnoses and prescribes treatment that works.

It is a pity that the articles do not carry the dates when they were written or published. He advises a newcomer to general practice that "you will be surprised that measles occurs in the newborn and recurs thereafter at monthly intervals during the first five years of life. It is accompanied by no systemic disturbance whatever and vanishes ten minutes after the consultation". This is clearly out of date and wrong. We now know that it is meningitis, not measles.

He reminds us that our patients often seem

to have less confidence in their GP than they have in articles in women's magazines or the medical opinions of their neighbour's or hairdresser's. This, for me, reflects real life. So does some of his other home-spun wisdom: see depressed patients in the afternoon, not in the morning. You can learn more about a patient from an experienced receptionist than from an hour-long interview.

Although John Stevens has now retired and his book describes a world of general practice that may soon seem very dated, there is a lot in it for GPs who want to enjoy their job. It is a good and easy read. I recommend it.

Jim Cox

Asthma in Practice
Mark Levy, Sean Hilton
Fourth edition
RCGP Publications, 1999
PB, 112pp, £14.85 (non-members); £16.50 (others); 0 85084 243 3

Given that asthma is the commonest chronic disease of childhood and one of the most common conditions in general practice, in these days of clinical governance its good management is highly prized by Primary Care Trusts.

Levy and Hilton's fourth edition was therefore already destined to be a best seller for any practice seeking to obtain a quality practice award. However, instead of buying a copy for your practice library and leaving your practice nurse to put its systems and ideas into practice, read it and remind yourself that one of the successes of British general practice is its continuity of care, allowing access to complete records and, rather than considering each respiratory consultation in isolation, raise your awareness to the possibility of asthma.

If you are already asthma aware and have identified your asthmatic patients who have presented atypically, or with normal peak expiratory flow readings, or early in childhood, or, conversely, in later life with occult airways disease, this book will remind you to reappraise the diagnosis in some of the children or reassess the current level of asthma control and adequacy of treatment. It will also reinforce the need to follow up your asthmatic patients after hospital discharge and ensure their early review after initial treatment of acute episodes in the community.

The chapter on 'Uncontrolled and Acute Severe Asthma' lays emphasis on the need to record PEF, pulse, and respiratory rate, and (even if we do not feel it is appropriate to produce a self-management plan) to ensure that patients are aware of how and when to contact their doctor should they deteriorate.

Following my own extensive involvement in the recent Scottish Confidential Inquiry into Asthma Deaths, I can confirm the almost universal lack of any objective measurements even in these fatalities and would insist that all patients are contacted or seen within 12-24 hours of an acute consultation and, like the authors, would follow them up until the exacerbation had resolved.

In any case, the authors have already convinced me to buy a pulse oximeter and convert from a compressor to oxygen-driven nebuliser.

The chapters on Diagnosis and Investigation and on Management of Chronic Asthma use case histories as effective learning tools and remind us of how vital it is to opportunistically review our asthmatics, even in the busiest of surgeries. Useful guidance is also provided on initiating treatment aggressively, sub-sequently reducing medication appropriately using the concepts of 'good' and 'acceptable' control.

Your practice nurse will welcome the chapters on 'Education and Self Management', 'Inhaler Devices' (including very relevant advice about the imminent switch from CFC to HFA inhalers), and the practical suggestions in 'Organisation of Asthma Care'. In particular, the need for all members of the primary care team to be vigilant and involved in identifying the patient who makes an early request for a bronchodilator, and for receptionists to be aware of at-risk patents and those who do need medical care that day.

The Clinical Governance agenda ensures that the Research and Audit chapter has never been more relevant and should help and encourage the most sceptical to look at simple process and outcome measures and perhaps also to realize that asthma in the general practice setting offers a large study population of an everyday clinical problem which you can research and improve yourself.

This book provides all the essential references and advice to allow you to make the simplest of starts and its excellent appendices supply useful addresses along with an example framework of equipment and advice for those just setting up an asthma clinic.

My only plea would be for the authors to produce a definitive set of clinic data recording sheets for universal distribution by the College itself.

Cliff Godley

ContraPack
Family Planning Association, £59.50
To order: tel 01865 719413

Given recent anxiety surrounding increasing teenage sexual activity and pregnancy rates, this little case and its contents present a timely reminder of the available contraceptive choices. Parents of young children will find it reminiscent of a similar item, containing well-known building bricks. If family planning advice is at times aimed at little more than children, its implications are nothing less than profoundly serious.

Of course there is much debate concerning the perceived direct link between increasing sexual activity and increasing contraceptive availability. Most professionals will agree that sexual activity still, more than often, precedes contraception and the social pressures within this progression will continue to provide debate. However, many clients will present requiring family planning advice in a more reasoned setting.

ContraPack is produced by the Family Planning Association in conjunction with an extensive panel of experts and is aimed at 'doctors and nurses who work in general practice'. Its dividers reveal small compartments containing a full range of contraceptive methods, the FPA's latest information leaflets, guidance notes written by Anne MacPherson on the pack itself, and two publications entitled *FPA Contraceptive Handbook* and *RCGP Handbook of Sexual Health in Primary Care*. Both publications are easily readable, relevant, and highly recommended.

In fact, likely purchasers should also include family planning clinics that will find ContraPack an educational tool equally as useful for doctors and nurses in training as for patient discussion and choice.

Peripatetic health professionals such as school nurses and community health education workers may also find a place for ContraPack.

Should every practice own ContraPack? With increasing training requirements and specialization in family planning, the average GP may be unable to provide all the available contraceptive methods. ContraPack serves as a tidy reminder of existing choices, leading to specialist referral if indicated.

The future for practice-based education? AsthmaPack, DiabetiPack, RheumaPack ...

Sheila Dobbie

digest

The Eye in General Practice
R D Finlay and P A G Payne
Tenth edition
Butterworth-Heinemann, 1997
PB, 216pp, £27.50, 0 75063691 2

For a textbook to go into its tenth edition says an encouraging 'something' about the usefulness of its contents. *The Eye in General Practice* has reached this happy stage of evolution and I dare say that one or other of its editions has a place on many a GP's bookshelf. More to the point, on the top edge of these shelved volumes, not much dust will have settled and the owners will have well-charged batteries in their ophthalmoscopes.

It is indeed a very useful book for GPs. Most of us have worried a good deal over the years about the difficulties of ophthalmology because, such is the crowded state of the undergraduate curriculum, we qualify and register without the benefit of in-depth ophthalmic knowledge and, even more so, without much experience of ocular disease.

Finlay and Payne have provided, in a well-written and illustrated thin volume, just what we need for a pithy summary of the most commonly encountered eye conditions. In addition to the usual layout of 'from-front-to-back' (eyelids to visual cortex) they give a summary of eye problems in systemic disease, and an outline of the special investigations we read about in letters from eye clinics — ultrasound scans, fluorescein angiograms, etc — and the benefits available to the unfortunates who are registered blind or partially sighted.

The book is a favourite of medical students and registrars in my practice, their interest triggered by my enthusiasm for a handy volume that I predict will appear in many future editions to come.

John Rawlinson

An Introduction to Qualitative Methods for Health Professionals
edited by Yvonne Carter, Sara Shaw, Cathryn Thomas
RCGP Publications, London, 1999
PB, 138pp, £16.20 (0-85084-246-8)

This booklet, which comprises an authoritative and well-written introduction and 15 key articles (grouped into five helpful sections) will be a very welcome addition to the shelves of any qualitative researcher involved in designing or running research methods workshops within primary care — or, indeed, in health services research more generally. The articles reproduced here include virtually all of my personal favourites and will certainly save time and trouble with regard to providing reading lists and acquiring copies of papers (with all the attendant problems surrounding copyright).

The booklet was designed originally to accompany workshops, but provides a comprehensive introduction for the health professional embarking upon qualitative research. Those of us who have been involved in such courses will be only too aware of the tensions and compromises involved in seeking, within the short workshop format, to equip new researchers with what are essentially complex skills. In addition, qualitative research rests on a set of theoretical and methodological assumptions which are likely to challenge practitioners' prior knowledge or preconceptions of the research process, which are likely to have been influenced by the positivist paradigm.

It is to the credit of this booklet that it does not shy away from these difficult issues. Harding and Gantley[1]. have themselves criticized the tendency to offer a 'cookbook' approach to teaching and learning qualitative research skills through an emphasis on the different methods of data collection, to the virtual neglect of theoretical issues. They have avoided this trap by locating the various methods for generating data within a broader discussion about what qualitative research is and what sort of questions it can address. I particularly liked Chapter 2, 'Methods of Data Collection', both for its comparative focus in encouraging the researcher to reflect on the implications of different methods and for its inclusion of observational methods, the importance of which is frequently overlooked.

The section on sampling is very brief and the accompanying exercise relies on consulting texts rather than seeking to apply the principles of different sampling strategies to a research situation. A hypothetical research question with a practice population as the sampling frame could readily provide such hands-on sampling experience.

While I can see that the approaches to data analysis outlined in Chapter 4 would work very well as four parallel workshops, I do wonder whether their appearance here — with very little discussion as to their points of similarity and divergence — might be confusing and rather off-putting for the novice researcher. Of course, in a workshop format there would be the opportunity for the workshop participants to feed back to the wider groups and to compare analyses produced from the same dataset, using different approaches. Some examples of analyses could have been illuminating here.

It is obviously not possible within the scope of

Further reading on qualitative research . . .

General

Dowell J, Huby G, Smith C (eds). *Scottish Consensus Statement on Qualitative Research in Primary Health Care*. Dundee: Tayside Centre for General Practice, 1995.

Griffiths F. Qualitative research: the research questions it can help answer, the methods it uses, the assumptions behind the research questions and what influences the direction of research. *Fam Pract* 1996; **13(suppl 1):** S27-S30.

Marshall C, Rossman GB. *Designing Qualitative Research*. Second edition. London: Sage, 1995.

Mason J. *Qualitative Researching*. London: Sage, 1996.

Sampling

Kuzel AJ. Sampling in qualitative inquiry. In: Crabtree BF, Miller WL (eds). *Doing Qualitative Research.* Newbury Park, CA: Sage, 1992: 31-34.

Mays N, Pope C. Rigour and qualitative research. *BMJ* 1995; **311:** 109-112.

Chapter 5 in Mason J op.cit.

Methods of Data Collection

Interviewing

Barbour RS, Featherstone V *et al*. Acquiring qualitative skills for primary care research: review and reflections on a three-stage workshop. Part 1: using interviews to generate data. *Fam Pract* (in press).

Collins P. Negotiating selves: reflections on 'unstructured' interviewing. *Sociological Research Online* 1998; **l3(3):** http://www.socresonline.org.uk/socresonline/3/3/2.html

Focus Groups

Barbour RS, Kitzinger J (eds). *Developing Focus Group Research: Politics, Theory and Practice.* London: Sage, 1999.

Morgan DL, Krueger RA. *Focus Group Kit* (Vols.1-6). London: Sage, 1997.

Qualitative Health Research 1995; **5(4)**. Special Issue on Focus Groups.

a short introductory text to do justice to all the ongoing debates within qualitative research. Nevertheless, I would have liked to have seen some discussion of the difficulties in applying 'grounded theory' — which is often used, argue Bryman and Burgess (1994),[2] as little more than 'an approving bumper sticker' (see Melia, 1998[3] for a refreshingly pragmatic approach). A similar quibble relates to appeals to triangulation, without acknowledging that this is frequently more problematic in practice (see Mason, 1996;[4] Barbour, 1998[5]).

Inevitably, there are a few references which I would like to add to the collection reproduced or cited here (see Further Reading).

In summary, this booklet is so good that I do have one niggling concern that health professionals may use it in isolation to guide them through their introduction to qualitative research. Certainly, I can think of no superior guide book, but I would be concerned lest they miss out on the potential which workshops afford of comparing notes with other new researchers and experienced colleagues.

Rose Barbour

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3. Melia KM. Producing 'plausible stories': interviewing student nurses. In: Miller G, Dingwall R (eds). *Context and Method in Qualitative Research*. London: Sage, 1998: 26-36.
4. Mason J. *Qualitative Researching*. London: Sage, 1996.
5. Barbour RS. Mixing qualitative methods: quality assurance or qualitative quagmire? *Qual Health Research* 1998; **8(3):** 352-361.

Data Analysis:

Barbour RS *et al*. Acquiring qualitative skills for primary care research: review and reflections on a three-stage workshop. Part 2: Analysing interview data. *Fam Pract* (in press).

Coffey A, Atkinson P. *Making Sense of Qualitative Data*. London: Sage, 1996.

Fielding N. Qualitative data analysis with a computer: recent developments. *Social Research Update* 1996; **1** http://www.soc.surrey.ac.uk/sru/SRU1.html

Melia KM. Producing 'plausible stories': interviewing student nurses. In: Miller G, Dingwall R (eds). *Context and Method in Qualitative Research*. London: Sage, 1998: 26-36.

Stanley L,Temple B. *Doing the business: using qualitative software packages in the analysis of qualitative datasets*. In: Burgess RG (ed). *Computing and Qualitative Research*. Greenwich, CT: JAI Press, 1995.

A Good Salve for an Old Sore
A Celebration of English Herbal Culture
John Rylands Library
University of Manchester, Deansgate
Until 8 October

If you are passing through Manchester in the next week, then the John Rylands Library, 150 Deansgate, contains a gem not to be missed.

In 'A Good Salve for an Old Sore — a Celebration of English Herbal Culture', the history and usage of herbs is chronicled through a collection of artefacts and texts covering the last millennium. The humble herb is celebrated in medicine, poetry, prose, and the culinary arts. For those whose noses haven't succumbed to rhinitis, there are lift and sniff demonstrations around the gallery.

Highlights include a fine collection of illustrated manuscripts, many on loan from nearby Chetham's Library (one of Britain's oldest). Authors, including Boorde and Culpepper, detail prescriptions and recipes from the sixteenth, seventeenth, and eighteenth centuries.

Many earlier texts were written for general consumption, physicians and apothecaries being rare outside towns; country people depended on the lady of the manor and her copy of *A Booke of the Properties of Herbes Which is Called an Herball*. In 1618, its centenary year, the London College of Physicians published the first pharmacopoeia, signalling subsequent professional ownership of herbs — but few of these exhibits would meet the evidence base required by NICE.

The John Rylands Library (not to be confused with the University establishment located on the campus) is itself worth a visit, being a fine example of Gothic architecture which will celebrate its centenary on 1 January 2000. Soaring in Cumbrian stone, it has attractive wooden panelling, early art nouveau metalwork, and is 10 minutes' walk from central Manchester stations and shops. Entrance is free, including the herbal exhibition, with guided tours for £1 at midday on Wednesdays. The exhibition will continue until 20 October and the library is open from 10.00am to 5.00pm weekdays and Saturday mornings.

Jim Ford

Nothing But A Flem ...

The Van Dyck Exhibition
The Royal Academy, London
Until 10 December

The Light of Nature
British Museum, London
Until 28 November

From 25 September you can visit three Van Dyck exhibitions in London: at the Royal Academy and the British Museum, drawn from around the world, and at the Wallace Collection, a small display centred on the collection's own holdings. Given the relentless line of the press reviews, that Van Dyck is some kind of spin doctor *de ses jours* — albeit for a doctrine as antiquated as the divine right of kings — this prominence is unsurprising. He is, however, a great painter, and he deserves to be seen without some rather specious modern relevance being attached to him.

The paintings at the Royal Academy are a mixed bag: the religious subjects are almost without exception utterly second-rate, whereas the portraits are absolutely sensational. There is a clear contrast in the way Van Dyck was inspired to show real individuals, and his failure to engage with 'generic' subjects such as apostles or the Holy Family. The subject matter of the portraits, the great men of early seventeenth century Europe and their families, above all the court of Charles I, and the virtuosity of their depiction, is captivating. The pictures of children are particularly notable for their sympathy and realism, none more charming than the sketch of the Princesses Elizabeth and Anne from the National Gallery of Scotland.

The British Museum offers a rather different side of Van Dyck: landscape drawings and watercolours, set beside the work of his contemporaries. Well captioned (unlike the complete absence of information beyond the title and ownership of the painting at the RA), these remind you of the extraordinary age in which Van Dyck painted. There are works by Rembrandt, Poussin, and Lorrain for example; this contextualization is very important, and I would recommend going to the BM first. With these contemporaries in mind, the RA exhibition will be that much more fulfilling.

Frank Minns

uk council, september 1999

Good Medical Practice for General Practitioners and Revalidation

The General Medical Council has decided that Revalidation will occur. It will set the general framework, the timescale, and the criteria by which any proposed system will be assessed. Any system of Revalidation must satisfy the GMC before being implemented. The College's Working Group on Revalidation, chaired by Mike Pringle, has developed initial proposals for revalidation for clinical general practice. Revalidation must be against explicit criteria that are understood by every GP. The report *Good Medical Practice for General Practitioners*, written by a Working Group convened by the RCGP and led by Professor Martin Roland, looks at all the areas in the GMC's document *Good Medical Practice*, offers interpretations of those areas in the context of general practice and for each area describes the criteria for an 'excellent' GP and an 'unacceptable' GP. Any GP who consistently or frequently meets any of the criteria for an unacceptable GP will be at risk of failing revalidation.

A meeting was held on 9 September to discuss *Good Medical Practice for General Practitioners* and the Revalidation Working Group's first proposals for revalidation in general practice. The meeting was attended by representatives from the College, the General Practitioners Committee, the National Association of Non-Principals, the Overseas Doctors Association, JCPTGP, COGPED, RCGP Patients' Liaison Group, and the General Medical Council. Council welcomed both reports but raised concerns around resource implications. The reports will go out for consultation to the profession in October.

NHS Direct and Walk-in Centres

Mike Pringle introduced his revised paper on the significant changes to the configuration of primary care services following the development of NHS Direct and Walk-in Centres. It was recognized that NHS Direct may offer patients a source of information and advice that they would not otherwise have and that if patients are helped to use the full range of NHS services more effectively, including self-care and pharmacy advice, then this development can be welcomed. However, there are concerns that it may fuel demands, rather than address needs. NHS Direct may be an additional service (not a substitution) and, indeed, may impact considerably on accident and emergency and general practice workloads. Concerns were expressed over difficulties about giving advice over the telephone. It was recognized that some patients need access to urgent facilities but that there are long-standing arrangements in general practice and accident and emergency to provide this service. As walk-in centres will be nurse-led, and nurses are unable to prescribe, a large number of cases may be referred to general practitioners. The main concern of Council is the effect that walk-in centres will have on continuity of care. Council welcomed the evaluation of NHS Direct but felt that a more rigorous evaluation was necessary. Both initiatives must be subjected to full, impartial, external evaluation over a sustained period of time.

Racial Discrimination in General Practice

Council welcomed a report from Has Joshi and Mike Pringle setting out the issues raised by the McPherson report in relation to institutional racism. The Council report sets out recommendations for action that the College should take to highlight and fight injustices suffered as a result of belonging to any minority group. In the past, there has been evidence that doctors born overseas and trained overseas have a lower pass rate in the MRCGP Examination. The College has authorized a study to investigate the scope for equal opportunities and ethnicity in the oral component of the examination and the results will be available shortly. It was recognized that some of the worst racial discrimination towards doctors is from patients and the PLG will be asked to look at ways in which key issues of equality can be addressed with patients. It was recommended that the College monitors equality of access to its Fellowships and Awards. The report will be redrafted in light of the Council discussion and used in appropriate forums. The recommendations will be taken forward by Maureen Baker. Progress will be monitored and reported back to Council in six months.

Vocational Training for General Practice

Council considered a motion from the East Anglia Faculty urging the College to produce a detailed review of the desired objectives, content, and assessment of vocational training for general practice. This concern arises from the changing needs of general practice, changing circumstances in acute hospitals, and increasing demands on GP registrars. The Vocational Training Working Group will carry out a comprehensive review, to include looking at the way SHO posts are used for vocational training. It was felt that the College should ensure that the membership is aware of their concerns

regarding vocational training and the work which the College is carrying out.

Commission on Primary Care Conference
The President reported to Council on the Prince of Wales' visit to the College to attend the Commission on Primary Care Conference on 16 September 1999. His Royal Highness addressed the Conference and commended the Publication of the Prince of Wales Fellows 'Making a World of Difference'.

Terms of Office
This Council was my last as Honorary Secretary; Maureen Baker will be elected to succeed me at the November Meeting.

Scott Brown is nearing the end of his term as a Vice-Chairman of Council and Mayur Lakhani has been identified as his successor.

George Shirriffs, Chairman of the Education Network and Lindsay Smith, Chairman of the Quality and Clinical Network will complete their terms of office in November. Has Joshi has been identified as the Chairman of Education and Joe Neary as the Chairman of Clinical and Special Projects.

Ballot for GP Registrar Observer on Council
Dr David Lewis has completed his two-year term as one of the two GP Registrar Observers on Council. If you know of any GP Registrar who may be interested in standing for election, please request further information and a nomination form from Dawn Jenkinson, Central Secretariat ext 246. The closing date for nominations is Friday 8 October.

The Annual General Meeting
Council approved the Agenda for the 1999 Annual General Meeting, to be held on Friday 19 November at the Royal Geographical Society, Exhibition Road, London. The Agenda will contain the names (with Faculties) of the members being elected to Fellowship at the Meeting. You should receive your Agenda in October.

Next Meeting of Council
The First Meeting of the 1999–2000 Council will take place at Princes Gate on Saturday 20 November 1999. Mike Pringle thanked all those who were attending their last Meeting of Council for all their work on behalf of the College and Council.

Bill Reith

Neville Goodman

Niche Marketing

It's called niche marketing. Medical journals are no different from glossy magazines and Sunday newspapers: hold them up by the centre spine and leaflets cascade onto the floor. The leaflets advertise goods and services irresistible to the person — correction: to the *type* of person — who subscribes or buys that publication.

So what type of people are doctors? They buy Rovers or Saabs. They subscribe to book clubs. They are in desperate need of insurance and of blokes with turned-up coat collars who chase up patients failing to pay their private fees. They don't buy collections of porcelain thimbles and decorated plates of gypsy flower sellers (unless they also buy the *Mail on Sunday*).

In some ways I am not like other doctors. Whichever categories I fit from the previous paragraph, I note from the *BMJ*'s inserts that doctors are supposed to like only classical music. This confirms a strong impression from colleagues. Until recently, when the corps of anaesthesia examiners became rather large, our group would often take an evening's entertainment. Generally opera, and high opera at that. It wasn't that I disliked their company; I just didn't share their taste. After my continuing absence was noticed and, feeling sorry for me that I was left out, someone suggested I should choose the next social event. Well, Siouxsie and the Banshees were on at the Hammersmith Odeon — perhaps … No: certainly not.

Unsurprisingly, medical journals also contain leaflets advertising other medical journals. Not direct competitors of course, but journals you might want in addition to the one you already receive. A leaflet for *Journal Watch* fell out of the *New England Journal of Medicine*. This is a twice-monthly audio cassette review (credited at 2 CME points per hour) of more than 50 medical journals. Helpfully bulleted was the advice that you could listen in your car, at the gym, during mealtimes, between patients, or simply during spare moments. Listening during mealtimes would avoid having to speak to the family, but what was meant by the remaining bullet point: listen 'during your daily routines'? Concurrent use of the electric toothbrush could cause problems, if only of audibility. What other daily routines could they possibly mean? Do doctors in the USA really go to the lavatory complete with a Walkman informing them of the latest advances?

If ever there was a missing niche, surely it's in the smallest room. Why not print medical journals directly onto toilet paper?

Nev.W.Goodman@bris.ac.uk

our contributors

Rose Barbour is Senior Lecturer in the university department of General Practice in Glasgow

Jim Cox, among many accomplishments, edited the seminal *Rural Healthcare* (Radcliffe Medical Press, 1998), with Iain Mungall

Sheila Dobbie is a GP and a trainer in family planning medicine. She works in Wishaw, Lanarkshire — a correspondent to the *Journal* points out that Wishaw, far from being a quaint fishing village by the Clyde, is, in fact, a 'an ex-mining village in Strathclyde that has no fish near it whatsoever'. Many thanks to our ever-alert readership

Dominic Faux is a GP in the Black Country, and a lecturer in primary care at the University of Wolverhampton

Jim Ford used to be a GP, but now communes with NHS Executive chaps in Leeds and Whitehall

Cliff Godley is a GP in Strathaven, Lanarkshire (again), and a renowned polymath. He has published extensively on asthma and primary care. He proved recently that illegal parking in Edinburgh risks not only parking tickets, but psittacosis

Julian Tudor Hart must be reeling from the effects of eulogy fatigue. He famously propounded the Inverse Care Law

Colin Hunter has invigorated the College in Scotland by his chairmanship of Scottish Council. He is a GP in Aberdeen, and a surprisingly good tenor

Amanda Kirby graces occasional Friday mornings on BBC Radio 5 Live, and is fetchingly described by Nicki Campbell as 'young and trendy'.

David Mazza is a GP in Livingstone, West Lothian

Graham McAlister is the newly appointed Policy/Information Officer of the RCGP in Scotland

Sarah Pickworth is a GP in Oxfordshire

John Rawlinson was for many years a GP in Amersham, Buckinghamshire, and, in retirement, pens pithy book reviews

Bill Reith, the Cardinal Richelieu of Aberdonian general practice, shortly completes his term as Honorary Secretary of RCGP UK Council. New challenges doubtless beckon ...

James Willis, a GP in Alton, Hampshire, is the Mr Kipling of our profession — he writes exceedingly good books, another of which is in the pipeline.

All our contributors can be contacted via the Journal office

James Willis

Going through the roof

I was commenting last week to a local pharmacist on the cost of modern drugs (through our combined efforts we had just avoided a mix-up that would have resulted in the duplicate prescription of fifty pounds-worth of Risperidone) and he said, in effect, that we ain't seen nothin' yet. The generics are about to go up enormously, he said, with the introduction of patient packs. Our prescribing costs would go through the roof. And no doubt the government would blame us.

I must say it has never been clear to me what the problem was that the new patient packs are designed to solve. That they would be wasteful of packaging materials and more expensive was obvious from the start. You think that the committees that decide these things probably know what they are doing, but the truth appears to be that they are required to switch off their common sense.

The day before this exchange I had been at the brilliant 'NICE, CHIMP, and the NHS reforms' symposium at the Royal College of Physicians in London. In the last of the 12 addresses the Professor of Clinical Pharmacology at Oxford, David Grahame-Smith, told us about the remit of the Committee of Safety of Medicines, on which he had served, in order to throw light on the magnitude of the task faced by NICE. The CSM considers just two questions, he said, "Is it safe?" and "Does it work?" Nothing else. Not even, "Is it better?". NICE's avoidance, until very recently, of any mention of cost in the matters it was going to consider was ominous, since that was what everybody was worried about.

This was an extraordinary insight into how government committees operate. It is so automatic for us to take all aspects of a question into consideration that it simply doesn't occur to us that the official mind doesn't do the same thing, and better. But it doesn't. I saw this for myself when I served on the Caldicott Committee into the confidentiality of personal information, whose comparatively broad remit was, even so, rigidly-defined.

Without the benefit of the six-month sabbatical I have just enjoyed I don't suppose many of you will rush out and read Steven Mithen's book, *The Prehistory of the Mind*, so I will tell you something that it says; about the difference between us and Neanderthal man. It is very interesting because Neanderthal man (oh, OK, and Neanderthal woman) had a bigger brain than we do, and probably lived in at least as large social groups as our direct ancestors. So what was it that got them stuck in their rut, these super-chimps, making their one design of flint spear-heads, albeit by an incredibly sophisticated napping technique that even the most dedicated modern enthusiasts can only occasionally reproduce, for two hundred thousand solid years? I don't know whether this thought boggled their minds but it certainly boggles mine.

Well, Steven Mithen suggests, very convincingly, that the developmental leap that enabled us to jump this rut and streak forward into the vast giddy complexity we now call life, was that the separate domains of intelligence in the brain *joined up*. We developed something he calls cognitive fluidity. The social skills, already very advanced in Neanderthals, could suddenly be applied to hunting, tool-making skills to social functioning, and so on and so on, in an infinite complexity of interactions and enrichments.

So there is a sense in which government committees, with their carefully demarcated domains of intelligence, are like Neanderthal man, and humble little GPs like me, with my mind so cognitively fluid that I can hardly sleep wondering how we are going to resolve all the problems, is like modern man.

All in all, this seems to be a very odd time to be considering depriving doctors of free will.