# The British Journal of General Practice

## Viewpoint

**All Change**

Change is uncomfortable. Changing quickly is more uncomfortable still.

General practitioners are not entirely bad at it. We are much better than many other health care professionals. In the past five years we have adapted to audit, to clinical governance, to further computerisation, to wholesale reform of primary care (annually), to new complaints procedures; and we are fêted by GMC as we move remorselessly towards revalidation. We are masters of hoop identification, and our prowess at jumping through them is positively Olympian. Which, in a smug, slowly changing world, would be enough.

The world, however, is not like that any more.

Government throws new hoops into the ring with a conjurer's ease.[1] Our patients, expectations driven upwards exponentially, demand standards of service that combine the very best of telephone banking practice, Edwardian nannying, and an everyday grasp of molecular physics. Throw in a contractural obligation for infallability that is proto-Papal, and we wonder whether a career in accountancy might not have been a more sensible option. As Mike Pringle, Chair of Council, said recently, life as a rap artist would have been simpler and more lucrative. (He didn't actually, but one can dream ...) Less flippantly, today we are finally able to treat cardiac insufficiency effectively, and tomorrow the human genome, all six billion base pairs of it, will be accessible from our desktop computers.

Are we up to dealing with change on such a scale? Or is it the Fast Packet to the Antipodes for the lot of us?

Two new series starting in this issue of the *Journal* may help to clarify matters. First, Trish Greenhalgh, in *Theories of Change*, explores the theoretical basis for different approaches to change, offering help for practitioners in identifying what may work, and explaining why particular approaches do or do not work in particular circumstances. She suggests that change may not be as daunting as we suppose; indeed, that the challenge of change can invigorate us.

Then there is Paul Hodgkin, supplying the first in a series of 12 *Postcards from the 21st Century*. The terminology that will have unreconstructed colleagues reach for the sick-bag — Roll Up! and prepare for Data Smog, Informational Tornadoes, and New Conceptual Maps. But the series is not just about breathless Gee Whizzery. It's about stepping back a little and taking the amazing, exciting, relentless pressure of change in our stride so that we can develop a clearer idea of what the new primary care might look like. What, for example, does the 'McDonaldisation of out-of-hours care' mean? What are the rules that govern information and what sort of medicine are they creating? How can we re-capitalise the cottage industry of general practice? How can we get the computer systems we deserve?

We live in paradoxical times. Biomedical science explains humanity to a point where 'microscopic' seems laughably big. Today's junior cardiologists discuss patients as if they were subjects in large multicentred trials, and proceed logically, and algorithmically, but not always relevantly, or humanely. Tomorrow's junior geneticists will inform us of alphabetical anomolies in our patients' genomes that we really should follow up most carefully, with all due respect paid to interested life assurance companies. Anatomists, then microbiologists, and now geneticists carefully explain humanity down to its very building blocks — reductionism, 'the dominant force in Western medicine for the past 400 years' carried to its natural conclusion.[2]

Primary care physicians (aka GPs, or whatever fashionable nomenclature dictates) will still be required, to translate, and to heal. We shall remain our patients' advocates. And with better skills for coping with change and a wider vision of what we can be, we may be able to enjoy the rollercoaster that is upon us. We'll still be moaning about our terms of service; we'll still struggle to keep pace with galloping science; and if we're clever we'll avoid territory beyond our competence.[3] As long as we learn to change, as medicine changes. As does life.

**Alec Logan**

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2. Kumar S. Resisting revolution: generalism and the new genetics. *Lancet* 1999; **354:** 1992-1993.
3. Munro A. Reformation. *Br J Gen Pract* 1999; **49:** 594-595.

# The Back Pages...

'May God forgive me for my part in ruining the lives of some of these vulnerable patients ...'

**Anthony Pelosi,** on *Chronic Fatigue and its syndromes*, page 82

Meanwhile,
trendy taxonomies...

**... data smog, information tornado, experiential learning cycles, andragogy, oases of systematic care, transformational learning, decision density ...**

**Paul Hodgkin** and **Trish Greenhalgh**, preparing us for a new Millennium, pages 76-79.

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news

## Mental Health Skills for General Practitioners

The National Service Framework on Mental Health highlights the key role of primary care in managing common mental health problems. Two of the seven standards cover the need for prompt identification, good assessment, and effective treatment whenever patients present with mental health needs. There is also a requirement for appropriate referral when needed, and also regular consideration of the needs of carers. Throughout the framework there is reference to the need for access to psychological services.

Each of the areas described above have training implications, and the same familiar themes have emerged from several surveys of the mental health training needs of GPs. Those who were keen to improve their mental health skills requested training in 'talking skills' (counselling skills, cognitive therapy skills, and stress management skills that can be used in day-to-day consultations). They also wanted to learn how to cope with 'difficult' patients, such as somatising or 'heartsink' patients, as well as how to manage psychiatric emergencies or help substance abusers. In response to this demand (and the low level of current provision in these topics), the RCGP Mental Health Education Unit (represented by Dr André Tylee) and Dr Tim Thornton (Regional Health Educational Fellow for Northern and Yorkshire Region) have set up a series of Mental Health Masterclasses at the RCGP on areas such as how to help somatising patients, counselling skills, how to cope with 'heartsink' patients, and cognitive therapy skills.

The first masterclass, on How to Help Somatising Patients, was held in November, with 20 GPs and a paediatrician in attendance. Small group work revealed that none of the participants had any difficulty in describing their patients, who consulted virtually on a weekly basis with unexplained somatic symptoms, yet were unable to accept that no physical problem existed.

Most of the scenarios described were of GPs who felt at an impasse, and the groups came up with a range of helpful strategies. Professor Sir David Goldberg, who has specialised in seeing these patients in psychiatric settings, provided a wide range of strategies, and insight into how some somatisers can be helped to reattribute their symptoms and some cannot; in the latter case different strategies are needed. He provided evidence that his training package, devised with Dr Linda Gask, has helped to reduce costs in these patients and to reduce concurrent depressive symptoms. Linda Gask's latest teaching tape was used to rehearse a whole series of 'microskills', to help patients who somatise to begin to reframe their illness experience. Participants worked in threes consisting of 'doctor', 'patient', and 'observer' in rotation, to practice skills that can be used in day-to-day consultations. The practicalities of putting these theories to work in one's own practice, the need for the whole team to work together, and the importance of this work being valued by partners or colleagues not wishing to be actively involved in this area were discussed.

**Jennifer Goulding**

*Future Masterclasses are being organised on Counselling, 'Heartsink' Patients, and Cognitive Therapy. For further details please contact the RCGP Courses Unit on 0171 823 9703.*

## New Chairs appointed to College Education and Clinical Networks

The Royal College of General Practitioners (RCGP) has appointed new Chairs to its Education and Clinical Networks. Dr Has Joshi FRCGP and Dr Joe Neary MRCGP take over areas that cover the core work of the RCGP.

Dr Joshi is a full time partner in a training practice of seven doctors in Pontypool in Wales. A course organiser for over 10 years, he has been responsible for assessing and accrediting prospective trainers and re-approving established trainers and their practice. Dr Joshi will be overseeing Accredited Professional Development (APD), one of the Education Network's current project activities.

Dr Joe Neary has advised on Department of Health national guidance for developing clinical governance in primary care and has developed and implemented innovative approaches to providing clinical services within his own practice in Wisbech, Cambridge. A variety of disease management and health promotion clinics, run by nursing staff, has enabled higher development of doctor-led services in the practice, including anticoagulation monitoring and drug dependency support.

**St Paul RCGP Quality Unit**

St Paul, the medico-legal defence organisation, has joined with the RCGP to set up a unit devoted to promoting high standards in general practice. The St Paul RCGP Quality Unit will develop quality markers, advise on issues such as clinical governance, and review learning needs. Following the many NHS changes that have taken place throughout the United Kingdom, the Unit will provide a welcome support to GPs. It will offer a unique service to those with questions about quality issues, including primary care groups, the National Institute for Clinical Excellence (NICE), and revalidation. It will be based at the RCGP and opens on January 1 2000. The Unit will be run by a general practitioner and one full-time member of staff.

**RCGP Inner City Task Force: e-mail Forum**

Following a successful conference this summer, the Task Force agreed to set up a discussion forum which would be open to all involved in primary care in urban deprived areas. It is being hosted by a member of the Task Force, Dr Helen Lester, who can be reached by sending an e-mail to **H.E.Lester@bham.ac.uk**

Through conversations with like-minded people you can find support for your own initiatives. In addition, the ICTF will collate information about lay involvement in PCG strategies in urban deprived areas, provide contacts and expertise, and give formal ICTF approval to quality projects.

More information about the Inner City Task Force can be obtained from Fiona van Zwanenberg, Administrator, Clinical and Special Projects, at Princes Gate.

**Out of Hours Access to GPs and clinics**

A survey conducted by the Department of Health to collect information on out-of-hours access to GP surgeries and clinics was recently published. The survey was carried out during April and May of last year, to provide additional information to the 'National Survey of NHS Patients: General Practice 1998', which was published earlier in October. Information was collected from a representative sample of 12 health authorities on GPs' times of availability and the availability of clinics provided at GP practices. This was supplemented with information on the avalability of services provided at community-based clinics. Together, the surveys provide a picture of access to primary care services outside office hours in England.

The main findings are that nearly all practices (98%, covering 97% of patients) offered some access to GPs before 9.00am or just after 5.00pm at least one weekday per week. Just over a quarter of practices (27%, covering 38% of patients) offered access to GPs before 9.00am and after 5.00pm on every weekday.

Eleven per cent of patients were able to consult their GP about non-emergency matters at the weekend. Patients in single-handed practices had less access to GPs outside office hours (i.e. 9–5 Monday to Friday) than did patients in multihanded practices.

There was widespread provision of contraceptive services outside office hours, mainly in community clinics after 5.00pm. Other than for contraceptive services, very few community-based clinics were provided outside office hours.

In March 1999, GP practice leaflets were collected from a representative sample of 12 health authorities. The results are based on practice leaflets for 61% of practices within the 12 sampled health authorities.

In April 1999, all providers of community clinic based services services commissioned by the same 12 health authorities were asked for details of clinic sessions provided outside office hours. The results are based on 100% of community based providers within the 12 sampled health authorities.

Copies of the report outlining the results of both surveys, *Access to GPs and Clinic Services outside office hours in England 1999*, are available from the NHS Executive.

*The winner of the RCGP* Members' Reference Book *Prize Draw Competition was Dr David M Smith MRCGP of Sutton Coldfield. Dr Smith has won a holiday for two in Nairobi, Kenya, at a luxury golf and country club resort for six days, with £500 spending money. Warms one's cockles, it really does.*

# Snake Wars — Episode One

**One snake or two?**[1]

The symbol of the American Medical Association is the single-staff, single-snake Aesclepian staff. The symbol of the American Army Medical Corps and the American Public Health Services is the two-snake, two-pronged staff of Hermes, the caduceus. American physicians wish to see the Aesclepian staff replace the caduceus, as the 'caduceus … was, and still should be, an emblem of all [Hermes'] numerous duties, which [do] not include medicine'. The 'true sign of health care [is] the staff of Aesclepius'.[2]

Aesclepius was god of medicine, the physician healer and some say the physician hero, whereas Hermes was god of many things, including commerce, travellers, dreams, magic, sleep, protector of thieves and outlaws, and interpreter of messages between the gods and the people and the people and gods.' The medical profession, it is argued, should not be associated 'with the likes of Hermes and his less than desirable exploits'[2] and the Aesclepian staff, representing as it does the 'ideals of medicine'[1] should be universally adopted. It is suggested that the slender and elegant winged caduceus has been adopted in favour of the chunky Aesclepian staff for aesthetic reasons. The British were misled by Henry VIII's physician, Sir William Butts, who believed the caduceus to be the Aesclepian staff.[3] A silver caduceus is still carried by the president of the Royal College of Physicians on ceremonial occasions.

**Snakes in antiquity**

However, snakes, staffs, or snakes with staffs, be it one or two, appear in archaeology, mythology, and literature in the ancient civilisations of Greece, China, and Egypt. The snake, able to shed its skin, is associated with healing, renewal, regeneration, and fertility, as well as death and destruction.[4] The rod is a symbol of authority, and the staff or 'wand' of the herald Hermes, brought out when it seemed as if it was time to stop fighting and start talking, should not have its authority dismissed solely on the grounds of being less chunky than the Aesclepian staff.

**Sacred cows**

Hermes should not be castigated for representing both good and bad, for this was the nature of Greek gods. They epitomised dichotomy and multitasking, and what they gave they also took away. Athene was goddess of arts and peace, but was also a warrior goddess; while often depicted with a war helmet and spear, she chose the wise owl for her emblem. And why should outlaws and others at the margins of society not be represented by Hermes, son of Zeus the King god, protector of the weak and hurler of thunderbolts? The marginalised could certainly do with a few well-timed bolts of lightning being delivered on their behalf.

As for Hermes' 'less than desirable exploits',[2] they do include snatching the infant Aesclepius from his dead mother's womb (she was murdered on the instructions of her lover, Apollo, father of Aesclepius) and acting as herald to Hades, god of the underworld, to 'summon the dying gently and eloquently'.[5] Apollo was god of healing. Hermes slaughtered his sacred cows, and turned them into a lyre. Asked by his father Zeus about his career plans he said, 'I will … never tell lies, though I cannot promise always to tell the whole truth'.[5]

**Wounding healer**

The snake was guardian of the tree of life, for, 'only an animal as dreadful as the snake could adequately protect the tree of life'.[6] Whinging over the number of snakes per emblem manages simultaneously to misunderstand the symbolism of the snake in antiquity, and to divert us from the wonderful image of the snake, terrible wounding killer, and renewing healer.

Personally, I prefer to cherish my interpretative, hermaneutic role[7] rather than be the physician hero, especially when it comes to slaughtering sacred cows.[8]

**Ruth Bastable**

**Acknowledgement**
Thanks to Jan Hutt, Librarian., QMW

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# Raggi balls, poverty, and health in Bangalore — Project *Jeevika*

They are about the size of the haggis that supermarkets sell for a week or two before Burns' Night, but they look like balls of uncooked minced beef. Sitting on the floor of a dilapidated schoolroom, I was being offered one of these for lunch and I felt a little less than enthusiastic. I need not have worried. Raggi balls are made of ground millet and cooked rice, and moistened with a thin vegetable stew and eaten with the fingers; they tasted good. They are the staple food and part of the pay of the bonded labourers of South India, and no-one grows fat on them.

With three colleagues from India and one from Nepal, we were visiting a project that was attempting to release children from bonded labour and rehabilitate them back into school. It was an orientation visit prior to the South Asian Dialogue on Poverty and Health, held in November 1999, sponsored by the World Health Organization and organised by the Community Health Cell of Bangalore. Nothing could have illustrated more powerfully the links between poverty and ill-health. Poor families struggling to make ends meet are suddenly confronted with the expense of illness or a funeral, and are forced to take a loan, usually from their landlord. An adult or child bond their labour to pay back the debt and end up paying back many times the monetary equivalent of the loan by the time the bond has expired. If the father of a family is bonded and becomes ill or dies, a child may be forced to take his place and, regrettably, many of these children have already dropped out of school because, being of lower caste, they are frequently beaten by their higher caste teachers. Poverty, caste, bonded labour and ill-health combine in a powerfully vicious cycle.

Over the succeeding four days we spent many hours exploring the nature of this vicious cycle and how it might be broken. There were a few delegates from the WHO and a few, like me, from the International Poverty and Health Network. However, most were health and poverty activists from the countries of South Asia and they were angry. They were angry with the destructive interventions of the World Bank, the erratic activities of donor agencies, the inertia and impotence of their own governments, and with the World Trade Organization, which was perceived to be manipulating the global economy to continue the long and dishonourable tradition of protecting the interests of the rich countries at the expense of the poor. A fifth of global arms exports go to India and Pakistan and there are powerful vested interests opposing peace in South Asia.

The mutually reinforcing links between poverty and ill-health are well known. Global society knows what needs to be done and has known for many years. It appears that what we are seeing is a deliberate failure of political will. Health is political: what then is the role of the doctor?

**Iona Heath**

# Change and the individual 1: Adult learning theory

Theories, i.e. explanatory frameworks with which we conceptualise and make sense of reality, are at the heart of clinical practice, planning, and research. They powerfully influence how evidence is collected, analysed, understood, and used.[1] Yet the literature on the management of change in health care, replete as it is with potted advice such as 'Ten tips for successful implementation', is often frustratingly lacking in sound theoretical principles.

'Tips' aside, most of us would like to be able to explain why individuals, groups, organisations, and social systems change — and why they are so often stubbornly resistant to change. There is no single, unifying theory that explains all aspects of change. Indeed, the multiplicity of conceptual approaches to the subject has itself been a source of considerable confusion in the recent health care literature. For this series, I have selected (arbitrarily, some may argue) the six theories that have had most influence over my own understanding of the change process as applied to health care and health services research.

Adult learning theory is one such explanatory framework. Adult (or experiential) learning can be defined as occurring when '… individuals engage in sustained, systematic learning in order to effect changes in their attitudes, knowledge, skills or belief systems'.[2] In other words, adults choose to learn because they want to change.

**The roots of adult learning theory**

Adult learning theory goes back at least 50 years to the work of child psychologist Jean Piaget, sociologist Kurt Lewin, and educationist John Dewey — recently summarised by David Kolb.[3] Piaget hypothesised that, in the learning stage of late adolescence (which he called 'formal operations' and which we might describe as 'becoming an adult learner'), the young adult becomes able to integrate new experiences into existing conceptual models, modify these models in the light of experience, and test the new models against external reality.

The experiential learning cycle (Figure 1), which most people attribute to Kolb but which Kolb himself credits to Lewin,[3] likewise emphasises the role of active experience in shaping the concepts and generalisations that constitute understanding. Lewin borrowed the notion of feedback from electrical engineering to describe how the learner uses a social learning and problem-solving process to generate information that he or she can use to assess deviations from desired goals. Lewin believed that the failure of both individuals and organisations to learn and change effectively was attributable to a lack of adequate feedback processes, resulting in an imbalance between observation and action.

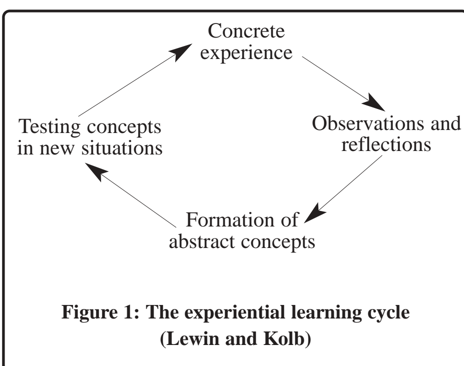


**Figure 1: The experiential learning cycle (Lewin and Kolb)**

Dewey's model, also described by Kolb, is similar to Lewin's, but places more emphasis on ideas as an impetus for learning. Dewey depicts (Figure 2) a progressive spiral in which judgements based on concrete observations lead the learner, via new ideas, closer to an ultimate purpose or goal.

Experiential learning theories (of which there are now several) differ epistemologically from both instructivist theories (which depict learning in terms of the accumulation of facts, like storing money in a bank, and which assume that learning can be assessed by the reproduction of these facts) and behaviourist theories (which depict learning in terms of performance outputs, like teaching a dog to beg for a reward, and which deny — or at least, refuse to analyse — any key role of consciousness in the learning process). First, experiential learning theories assume that facts are not fixed and immutable elements of thought but are constantly formed and re-formed through reflection and experience. Secondly, experiential approaches view learning as a continuous process in which every new experience builds on, and integrates with, the accumulated experiences that have gone before. Thus, says Kolb, no two thoughts are ever the same, since experience always intervenes.[3] Third, these theories place a central importance on social discourse as a means of consolidating or changing understanding. As Friere put it: 'Knowledge emerges only through invention and reinvention, through the restless, impatient, continuing, hopeful inquiry men pursue in the world, with the world, and with each other'.[4]

These principles underpin three important fields of activity relevant to managing change: andragogy, self-directed learning, and transformational learning.

**Andragogy**

Andragogy is the art and science of helping adults learn. Its founder, Malcolm Knowles, argued that:

- adults need to be involved in the planning and evaluation of their education,
- adults need a motive to learn,
- there is a need to explain why things are being taught,
- experience (including mistakes) provides the basis for learning activities, and
- learning should be problem-centred rather than content-oriented.[5]

Andragogy has powerfully influenced the design of continuing medical education programmes in recent years, shifting the emphasis from 'bums on seats' in lecture theatres to work-based initiatives, such as education through audit, portfolio-based learning, and professional and practice development plans.[6,7]

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## Self-directed learning

Carl Rogers was a psychotherapist who believed that the most critical feature of adult education was the freedom of the learner to pursue his or her self-discovered learning activities. The educational experience, he claimed, should be largely unstructured and occur when the learner decides they are ready. Rogers concluded that learning occurs quickly and effectively when:

- the individual initiates the learning and can control its pace and content, and
- the material does not pose a threat to the self, i.e. it concords with existing knowledge, belief systems, and values.[8]

According to Rogers, the teacher should act as a facilitator, not an instructor. The teacher's responsibilities include setting a positive climate for learning, clarifying the purpose of the learner(s), organising and making available learning resources, balancing intellectual and emotional components of learning (for example, showing empathy and sharing the joy of discovery, and offering support especially when the new material poses a threat to the self), and sharing feelings and thoughts with learners.[8]

There is now an expanding educational literature on self-directed learning, reviewed by Stephen Brookfield,[9] which focuses on the process by which adults take control of their own learning, and in particular how they set their own learning goals, locate appropriate resources, decide which learning methods to use, and evaluate their progress. Unanswered questions, says Brookfield, include the cross-cultural dimension (is self-directedness a universal characteristic of successful adult learners, or just of white middle class ones?), and gender issues (does the independent, self-directed learner reflect patriarchal values of division, separation, and competition?).

## Critical reflection and transformational learning

Adult learners are a mixed bunch, aged from 16 to 106 and from any social class, gender, ethnic background, and professional group. They bring a wealth of life experiences to the learning situation. The active process of education occurs against, and is influenced by, other dynamic processes — the passage of time (adolescence, youth, maturity, ageing), personal and professional milestones (leaving home, choosing a career, finding a partner, and so on), and cultural and political identity (for example, race, gender, and class).[10]

Adults frequently choose to learn in response to (or in anticipation of) a major life event. The process by which the learner comes to be consciously aware of, for example, 'me as a fairly successful, middle-aged, childless black woman facing redundancy' has a profound influence on the educational process. Mezirow's work on disempowered groups, including women on return-to-work courses, led him to develop the notion of transformational learning, i.e. the process by which adults come to recognise and re-frame their personal and professional roles and relationships.[11]

## Conclusion: learning and change

Adult learning is all to do with change, since adults learn in order to change. They learn best when they have identified a need to learn, when they engage in interaction with other learners, and when they have repeated opportunities to apply theory and information to practical situations in their own lives. Adult learning theory has important implications for effecting change both at an individual level (see case study below) and in relation to group and organisational learning, which will be covered in future articles in this series.

**Trish Greenhalgh**

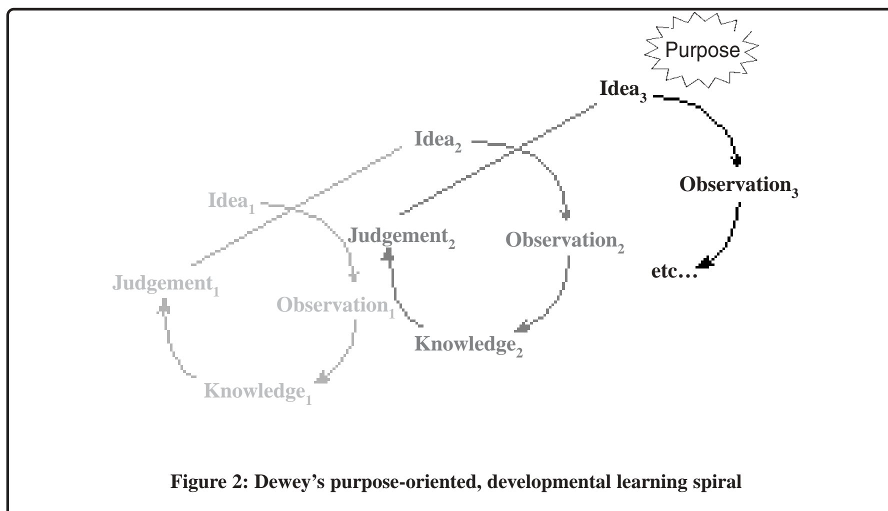


**Figure 2: Dewey's purpose-oriented, developmental learning spiral**

### Case study: Applying adult learning theory to the management of change in health care

Brynton Health Centre is a four-partner general practice in south-west England. The practice was computerised in 1997 and could now potentially submit most of its item of service claims electronically and contribute to needs assessment data on disease patterns at PCG level. At least one partner is keen for the practice to go completely paperless, and for electronic databases such as MEDLINE to be available on the practice intranet.

The senior partner, Dr Wesley Capel, is 62 and intends to continue working full time until 70. He has a computer terminal in his room but has never even turned it on. He still hand-writes prescriptions. Attempts by the three other partners to encourage Dr Capel to use the computer have included numerous offers to 'go through the basics', an on-site training day (which Dr Capel left after half an hour 'to see to an emergency'), and buying him a self-study guide. At a practice meeting recently, one of the partners called Dr Capel a 'selfish dinosaur', claiming that his reactionary attitude was costing the practice money and compromising patient care.

The important point to grasp here is not simply that Dr Capel does not want to learn, but that he is choosing not to learn because he does not want to change. He has no motive to learn, and the 'carrot' so far offered — that his colleagues will like him better if he embraces technology — is a weak one. The computer, especially with its explicit link to proactive care, population-based needs assessment, and the basing of clinical decisions on external research evidence, probably represents a major threat to his professional beliefs and values.

Drawing on the models of adult learning described in the text, a number of strategies are likely to have some chance of success. The first is to address Dr Capel's motivation. He needs either a tastier carrot or a bigger stick. A serious complaint following an illegible prescription, or the threat of a financial penalty for not submitting automated returns, might serve as the latter. Ideally, Dr Capel should encounter a problem he wishes to solve, for which the solution would include learning to use the computer. Second, a personalised programme of learning must be designed, delivered and evaluated by Dr Capel himself. He will need the opportunity to explore the new technology in a safe, supportive and relaxed environment, not with one of his junior staff breathing down his neck. He must be able to make mistakes without losing face. Finally, given the lack of conceptual overlap between new and existing knowledge, his partners should recognise that his progress will inevitably be slow.

As Figure 2 suggests, once Dr Capel has assimilated his first lesson, he may modify his goals. In acquiring the skills to generate prescriptions from the computer, he may partially overcome his fear of technology and find that with very little additional effort he could automate other tedious and time-consuming tasks. His ultimate success will depend on many factors, including the ability of his partners to persuade him of the benefits of change and to facilitate, rather than impose, the learning he subsequently seeks.

# 1 Postcards from a New Century

## Navigating the new primary care — A Pilot

*Professionalism is the exercise*
*of discretion on behalf of another,*
*in a situation of uncertainty*

Mintzberg[1]

The practice of medicine is being transformed by a powerful set of interlocking trends: evidence-based medicine, clinical governance, consumerism, litigation, resource limitation, devolved budgets, and the ending of the profession's monopoly of medical knowledge. The medicine that is emerging is more accountable and systematic.

It is also a medicine that does not prize judgement, that by its nature devalues the professional's exercise of discretion in the face of uncertainty. Yet we know from everyday experience that decisions well reached despite uncertainty are often the highest service we can perform for patients. To make sense of this intensifying paradox we need new maps. The heart of the problem is embedded in the interplay of evidence and clinical freedom (Figure 1).

Where the evidence is strong the new orthodoxies seek to constrain clinician behaviour and rightly celebrate the health gains for patients and populations. Where the evidence is weak a sense of medicine's failure pervades.

This trade-off between clinical freedom and evidence is fine for single diseases, but GPs are generalists. Can we apply this graph to the whole range of problems we have to cope with? Expanding the picture to include all conditions is the equivalent to spinning the curve around on its vertical axis. The three dimensional picture that emerges shows a clinical landscape where evidence is not uniformly distributed (Figure 2). For sure, the scene is dotted by deep wells where enough evidence has accrued to demand a systemised approach. Beyond these oases of evidence lies the larger terrain of practice, where little evidence exists and professionals really show their true worth as they exercise judgement in the face of uncertainty and time scarcity.

This map of the new primary care is helpful in several ways. It is clear, for example, that the evidence-based regions centre on specific conditions or routines, such as CHD, diabetes, or 'flu vaccination programmes. As such, they are disease-centered rather than patient-centred.

Since these regions are by definition the only evidence-based areas of practice, they will inevitably be the focus of much activity and measurement. Here be HImPs, clinical governance, and outcome measures. By contrast, the broad sweep of work out on the plains, where undifferentiated illness and psycho-social issues roam, risks being seriously undervalued.

Creating a well-run oasis of systematic care takes particular skills and resources. Delivering good diabetic care, running a programme of 'flu vaccinations, or hitting cytology targets, all are hard to achieve via opportunistic interactions carried out in the midst of acute care. In fact, high quality oases are usually populated by nurses equipped with efficient administrative routines, and stray GPs who wander in from the plains all too often just cause havoc.

This landscape also makes less sense for patients than providers: why come to a special clinic, run by a nurse, when I could just talk to the GP about my diabetes? And why can't I talk about my baby's cough when I bring her to the Well Baby clinic?

The aim of National Service Frameworks is to fill each oasis with objectives, milestones, and coherent programs. Given that the basic problem of providing systematic care is not, in principle, so difficult, it is entirely possible that PCGs will succeed in constructing high quality watering holes that will be a pleasure to visit. By the same token the routinised nature of the problem means that others will also be happy to provide ready-made solutions. Outreach from trusts or inreach from pharmaceutical firms, will develop standard packages of care that practices or PCGs can buy in and which are certified to deliver particular standards of care.

This landscape looks different to each of the players. Patients with chronic disease are likely to get better care, but at the cost of extra attendances and the risk of some fragmentation.

For nurses, their working week is likely to be increasingly punctuated by the vertical columns of specialised disease services. Such evidence-based specialism cuts across nursing's traditional rhetoric of holistic, patient-centred care and may meet resistance. On the other hand, such care will be the motor to deliver the population-based agendas of HImPs and clinical governance. The status of practice nurses is therefore likely to rise.

GPs may be ambivalent about the increasingly perforated nature of their landscape. On the one hand, they will know that a lot of systematic work around chronic diseases is already taken care of when the patient walks in, leaving them free to concentrate on less-structured problems. On the other hand, they may be tempted to continue to provide some of this care


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Schenk D. *Data Smog: surviving the information glut*. London: Abacus, 1997.


futurology 1

opportunistically during acute consultations.

Such interventions are often appreciated by patients but can be difficult to integrate into more systematic, nurse-led approaches.

PCG Boards (and others concerned with ensuring that practices deliver cost-effective, transparent care) will have a strong interest in developing these systematised areas of practice. Cross-practice standardisation together with outsourcing are likely to be important in their repertoire of solutions. It will also be essential to avoid fragmentation by having a strongly patient-centred approach.

**Data smog and informational tornadoes**

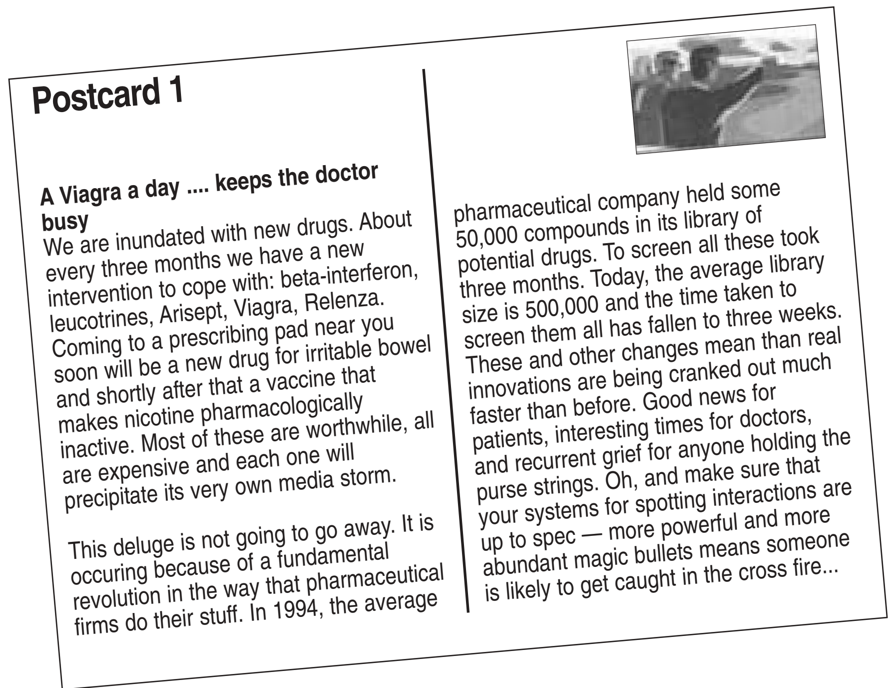
Clinical practice is also increasingly drenched in data. Often inconclusive, sometimes conflicting, always demanding to be collected or analysed, such data smog rarely leads to predictable change. It begins in an avalanche of paper, e-mails, journals, and undigested reports, and ends with unsubstantiated information derived from the Internet. Through the smog we glimpse multiple shifting mirages, each insistent that they may be the most important breakthrough since lunchtime.

We feel uneasy about simply ignoring data smog because, as the decision density in consultations rises, we know we need to know more about more. The solution lies in new tools to organise information: up-to-date directories of all local health-related organisations, direct booking of outpatient appointments, the ability to print patient-specific information sheets at the same time as we print the prescription, smart agents to track articles of interest.

At extremes, we get informational tornadoes: areas of sudden and extreme uncertainty that tear across the landscape. Recent examples include BSE, GM foods, new evidence that turns current practice on its head, therapeutic advances such as Viagra, gene screening, rationing storms, and sudden withdrawal of prescription drugs. Even where they do not touch medicine directly, such storms add to the unpleasant sense of hyper-vigilance that is becoming endemic to clinical organisations.

Accurate maps improve navigation and reduce uncertainty. The interplay of evidence-based practice and professional discretion structures many of the phenomena that are emerging in clinical organisations. Knowing where you are in the topography may help to make sense of rapidly changing systems, practices, and roles.

**Paul Hodgkin**



**Postcard 1**

**A Viagra a day .... keeps the doctor busy**

We are inundated with new drugs. About every three months we have a new intervention to cope with: beta-interferon, leucotrines, Arisept, Viagra, Relenza. Coming to a prescribing pad near you soon will be a new drug for irritable bowel and shortly after that a vaccine that makes nicotine pharmacologically inactive. Most of these are worthwhile, all are expensive and each one will precipitate its very own media storm.

This deluge is not going to go away. It is occuring because of a fundamental revolution in the way that pharmaceutical firms do their stuff. In 1994, the average pharmaceutical company held some 50,000 compounds in its library of potential drugs. To screen all these took three months. Today, the average library size is 500,000 and the time taken to screen them all has fallen to three weeks. These and other changes mean than real innovations are being cranked out much faster than before. Good news for patients, interesting times for doctors, and recurrent grief for anyone holding the purse strings. Oh, and make sure that your systems for spotting interactions are up to spec — more powerful and more abundant magic bullets means someone is likely to get caught in the cross fire...

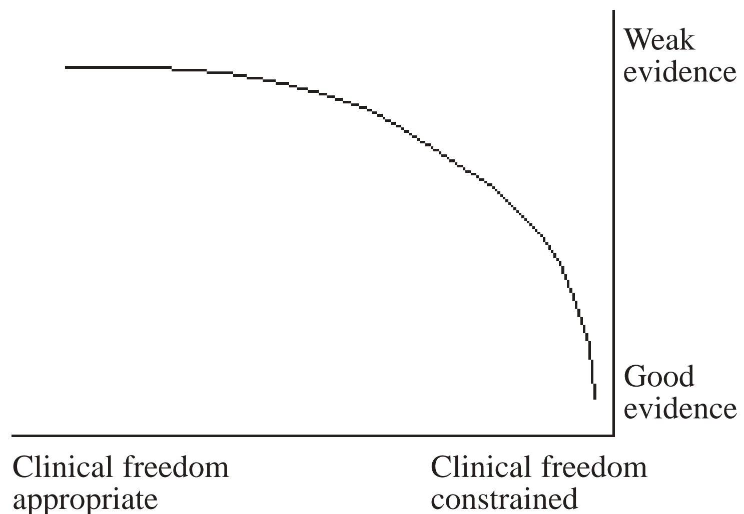



**Figure 1.** Evidence and clinical freedom.

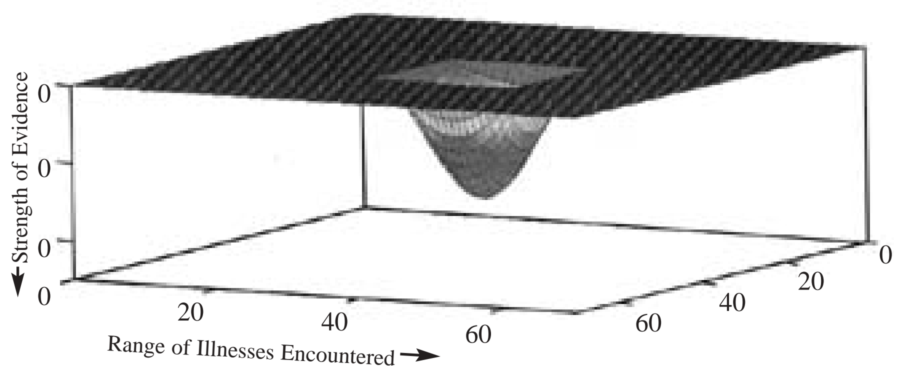



**Figure 2.** Clinical practice and evidence-based routines.

# 'Keep Taking the Words'
# Therapeutic writing in general practice

**Acknowledgements**
*We would like to thank David Hannay, the GPs and patients who took part in the Therapeutic Writing in Primary Care Project, Marilyn Lidster, Iola Nelson, Susanna Gladwin, Helen Joesbury, Jane Searle, Stephen Rowland and*

*A wise man ought to realise that health is his most valuable possession and learn how to treat his own illnesses by his own judgement.*
Hippocrates[1]

**David, the GP:**
Sometimes, a patient can have a profound effect on you. He was such a one.

He came in despair. Not that you could tell. Quiet, gentle, articulate, just chatting. And then you could see and feel the hopelessness. We had met before and talked of his work. Residential headmaster: children with challenging behaviour. He loved it — his life — dedicated. Then, allegations of financial misdeeds — suspension from duty.

Help me, he was saying, not speaking.

Of course, that's my job. But how?

Have you thought about writing? I said.

Why did I ask that? Discussions with Gillie, yes, but why then? He had so much to say, no time to say it, yet I thought he would burst if he did not. Might this give him time and space?

No, I haven't, he said, but I like the idea. And so he wrote. Copiously. A diary that he shared with me, and I was privileged. Activities; thoughts; desires; focusing on priorities; trying to find a new route: incidentally helping my medical model approach to him. Physical symptoms. Mental state. Almost as if I could see inside his head.

Guilty, said a committee, when he had hoped for vindication. Appeal. Guilty, said another committee. More despair. Appeal tribunal. Delay. But by the time of the hearing he'd ridden through on his words. Cathartic, he said.

New jobs, new life, new focus, new worries. Then, his name cleared. Yet he felt no spite. It didn't matter anymore. He'd won anyway.

Still he writes. Keep taking the words. Perhaps I should prescribe them for myself. But I haven't the time. And anyway I'm a doctor, so I don't need them ... do I?

**Peter, the patient:**
I could not see. Twenty-eight years meeting other people's needs. Advice, education, counsel, time, energy, and self — how draining that tap labelled 'self' can be. Blindly, I ran into that wall — a solid, very high wall of emotional bricks.

Others — clients and professionals alike — I had helped over the wall. My own wall was impenetrable. David gave me the route. Gillie gave me the permission.

It had been a long time since I sought permission. People came to me for routes. Professionals with human needs wrapped in erudite language. Client parents with little language but anguished pleas. Client children with no language, just screaming affirmation and aggression that they needed help.

David is correct: my mind would have burst. My brain hurt and needed a release. Writing gave me the route. With the counsel of David and Gillie came the affirmed permission. The writing allowed me to unpack my mind and relieve that pressure.

No deep psychotherapy, no chemical therapy. My pencil and my pad were the tools to navigate that emotional wall.

With the permission for the time to myself, my pen explored deep avenues, clearing the brain, providing some interesting excursions. As Wordsworth would have said: 'transport of delight'.

As a professional working with disturbed clients I could not see the route or give myself the permission to navigate that wall. Why are professionals so blind?

I am reassured by my new work that I can still offer something to damaged children. This reassurance was discovered through writing and is still supported through writing.

**Gillie, the research fellow — on therapeutic writing:**
Confucius is reputed to have said: 'If I give my student one corner of a subject and he cannot find the other three corners for himself, I do not repeat the lesson'. David and I offered Peter one corner of the solution to his distress. He eagerly groped for the others.

David Gelipter and Peter Nelson were involved in a small pilot study to assess the feasibility of Therapeutic Writing in Primary Care (RCGP funded). Six GPs were involved overall; they identified appropriate depressed or anxious patients and suggested therapeutic writing over a two-month trial period, giving them a simple explanatory leaflet.[2-4] At a training session with myself and the GPs, certain elements were stressed, such as the need to be sensitive to potential problems, including literacy, disability, and lack of confidence; the privacy of the writing; the writer's ownership of it, and their right to choose with whom to share it (if anyone). The doctors were asked only to select patients with whom they already had a good and trusting relationship. Patients continued any other treatment already begun, throughout the writing intervention.

Peter presented initially with depression and physical symptoms of stress, having been unfairly dismissed from work as the live-in head teacher of a special school for severely disturbed and damaged adolescents. He

began writing his diary at David's suggestion, and wrote well over 200 closely typed diary pages about his symptoms, his distress both at work and the circumstances surrounding his leaving. He wrote angry letters (not intended to be sent) to people at work, and a questioning one to his late father; he also wrote their fictional replies to him (also a personally illuminating process).

In therapeutic writing, the patient is involved centrally in a process under their own control; it is free, available to anyone with basic writing skills, and can enable the patient to take a high degree of responsibility for their own management of anxiety and depression at their own pace. Normally, such symptoms would be treated with costly psychotropic drugs or time-consuming counselling. Therapeutic writing can be a partnership between doctor and patient; Peter shared his writing with David, offering him greater insight than a normal consultation could allow. Peter could spend as long as he needed, exploring his difficulties and anxieties in writing, longer than he could have in a consultation. Because writing is private until a decision is made to share it, it also encouraged Peter to explore areas he found too painful, embarrassing, or possibly inappropriate to speak of in a consultation. As he has written in a private communication: 'I doubt that I would have let anybody near enough to me to get a sensible understanding, let alone make an accurate diagnosis. Writing allowed me to be more open and honest with myself.'

One of the other GPs in the Therapeutic Writing in Primary Care Project commented: 'patients can write all the things they want to say, whereas in talking they have to choose'; and 'you can't mishear what's written'.[2] However, many patients found that close friends or relatives were the appropriate people with whom to share their writing.

The writing of other patients in the study varied from 'not much' to 'lots, it all came flooding out'. Most wrote about the past, some about dreams, and several wrote letters. Most of these were not to be sent, like Peter's, one however was by a young girl writing to her parents; the first drafts being very angry, but in the final version she found she could say things she could not say in speech, such as 'I love you'.[2]

Peter spent time and money choosing the right writing materials; after an initial writing period he took his new folder, pad, and pen out to a country area several miles from his home. All the patients were encouraged to approach writing in this thoughtful way. Peter found he wrote completely differently when away from the computer in his 'den' — lyrical autobiographical pieces about his past,[2] which were deeply satisfying to him. These connected him up with a carefree pre-schoolteacher — Peter.

Another GP in the study appreciated that writing discouraged somatisation: '"dis-ease" is when a patient is not at ease with their body. Patients present with many psychological problems, which should not be medicalised. But they feel they need to present with medical symptoms, and feel embarrassed to show emotions. This is a way of opening this area out.' Another added: 'it is a bridge for people who find it difficult to get in touch with their feelings'.[2]

**Other research and experience**

There are other studies of the value of therapeutic writing in healthcare, in which different models have been explored. In the Sheffield Therapeutic Writing in Palliative Care Project a specialist offered therapeutic writing to patients[3,5] and nurses have been trained to use it.[3] I am now supervising a poet working with patients in practices in a Poetry Society-funded project and there have been many other projects and experiences.[6,7]

Therapeutic writing has a growing randomised control trial (RCT) base proving its effectiveness in helping the symptoms of anxiety and depression. Pennebaker *et al*, have undertaken numerous trials.[8] Recently, Smyth *et al* have reported their RCT with asthma or rheumatoid arthritis sufferers.[9] Patients were assigned to write either about the most stressful event of their lives, or about emotionally neutral topics (the control intervention). In an editorial to the issue of the *Journal of the American Medical Association* which reported this trial, David Spiegel said: "Were the authors to have provided similar outcome evidence about a new drug, it likely would be in widespread use within a short time. Why? We would think we understood the 'mechanism' (whether we did or not) and there would be a mediating industry to promote its use. Manufacturers of paper and pencils are not likely to push journalling as a treatment."[10]

David and Peter's experience, and the study in which they were involved, is embedded in a fast-developing corpus.[11-14]

**Conclusion**

David said: 'perhaps I should prescribe the words for myself. But I haven't the time. And anyway I am a doctor so I don't need them ... do I?' He has since joined a GP reflective writing group,[15] having realised the importance of not only of treating the whole patient, but also of the doctor bringing his whole person to the practice of medicine.[16] Therapeutic writing by the patient, when offered by such a practitioner, can support the patient in taking a central role in diagnosing and treating some of their own psychological problems.

**Gillie Bolton**
**David Gelipter**
**Peter Nelson**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digest

## in brief...

**Ken Adam**
**Serpentine Gallery**
Kensington Gardens
London W2 3XA
(020 298 1514)
Until 9 January, admission free

Ronald Reagan, on becoming President, had but one urge — to visit the Pentagon's 'War Room', the vast concrete bunker where, in Stanley Kubrick's film *Dr Strangelove*, Cold War *realpolitik* finally achieved Armageddon.

Poor Ronnie — the War Room, brilliantly realized, was just a film set, no more real than the sets of countless James Bond movies, not to mention *The Madness of King George* and *Chitty Chitty Bang Bang*.

All stemmed from the work of Ken Adam, an artist who raised set and production design to unparalleled heights, and who earns the first retrospective devoted to film production design in a UK fine arts gallery. The War Room is memorably recreated, and for those of us seeking a good excuse to be late for meetings at Princes Gate the curators have engineered a pleasing cinema where clips from *Moonraker*, complete with mammoth set design, run on a continuous loop.

Very well worth visiting *en passage* to Princes Gate, though you'll have to hurry

***Alec Logan***

**Chronic fatigue and its syndromes**
**Simon Wessely, Matthew Hotopf and Michael Sharpe**
Oxford University Press 1998.
HB, 416pp, $79.50, 0 19262181 5

I first came across patients with severe and unexplained fatigue states in 1981 when I was a keen and, I thought, ever so knowledgeable registrar in neurology. These patients would get a huge battery of tests — from lumbar puncture, through visual evoked responses, to muscle biopsy — which were always normal. They would then be given the diagnosis of 'myalgic encephalomyelitis' ('ME'), a disease that only our group knew about and understood. They were told that not one of the couple of hundred patients we had seen with this illness had ever got better but research advances in neuro-virology may lead to a cure. For reasons that we never really thought about many of these patients hated their previous doctors, especially their general practitioners. However, they were grateful to us and this felt extremely satisfying.

It is now obvious that before embarking on these investigations we should have spoken to our patients using the skills we were all taught at medical school. Our social history was farcical — usually along the lines of 'Smokes 10/day; occasional alcohol; currently unemployed'. We never did a mental state examination because to do so was somehow considered an insult to patients. We should also have been in the library finding out how other doctors from other specialities had tackled similar clinical problems.

It was all a complete mess and may God forgive me for my part in ruining the lives of some of these vulnerable patients. Things are in an even greater mess now. Journalists have sensed a good story and, with a few honourable exceptions, they are either in the insulting 'yuppie 'flu' camp or they believe that patients are being deliberately maltreated by an uncaring medical establishment. This media interest is fuelling self-diagnosis in people with a host of unrelated illnesses and problems. Even worse, parents are now diagnosing ME in their children.

*Panorama* (BBC Television, 8 November 1999) recently allowed its journalists to dive into the debate without any attempt at balanced reporting. They implied that nothing could be done to help ill children with severe and chronic fatigue. The parents of their featured patients had trooped around the country until they found a paediatrician who would agree with their own diagnosis of ME. Some child psychiatrists were at least prepared to try a rehabilitation programme. They should have accepted that this was doomed to failure since they had lost the trust of these parents and, inevitably, of the ill children. They set themselves up as easy meat for their critics by unwisely resorting to compulsory court orders. Unfortunately, the *Panorama* programme makers appeared unconcerned that doctors find it difficult to abandon an ill child to a potential lifetime of disability when this is due in part to a self-fulfilling prophecy of a poor prognosis.

General practitioners have a duty to protect their patients from simple-minded approaches to these heterogeneous and sometimes complex problems. In refining their own approach they can do no better than read *Chronic fatigue and its syndromes* by Wessely, Hotopf and Sharpe. This contains a wide-ranging discussion of the latest aetiological research into symptoms and syndromes of fatigue. It summarises outcome studies and offers approaches to investigation and treatment that could form a template for the management of these problems in primary and secondary care. However, it does not stop there. It tackles all of the medical hubris, subspecialist ignorance, journalistic excesses, and patient misunderstandings that have contributed to such a raw deal for some people with severe fatigue in recent years. It is also firmly rooted in a fascinating historical perspective that demonstrates repetition of errors at various times in the past century.

All doctors, and especially general practitioners, will continue to have difficulties in dealing with chronic fatigue states over the coming years. I firmly recommend to them this book, which is highly readable despite its intense detail. It should be read by the other health professionals who are involved in the management of chronic fatigue states, including physiotherapists, occupational therapists, psychologists, and complementary practitioners. I will also take it upon myself to send a copy to the producers of *Panorama* with a request that they pass it around their journalist friends.

**Partnerships in Practice: the GP's guide to getting it right first time**
**Petre Jones**
Radcliffe Medical Press, Oxford 1999.
PB, 53pp, £16.99, 1 85775359 3

***Anthony Pelosi***

Searching for a partnership is difficult. Many people offer advice, but few can provide objective evidence supporting particular approaches. When the chips are down, one's instincts guide decisions. If this was sufficient then partnerships would always function well, few

acrimonious disputes would develop, and general practice would be thriving. If this sounds like your practice then you do not need this book — you should write your own to tell everyone else how to do better!

Most of us do not work in ideal surroundings because something is not right in the organisation we are working in and responsible for. GP registrars need guidance in appraising prospective partnerships, as does any GP looking for a new partnership.

Dr Jones developed a module in the Newham Vocational Training Scheme that addresses this need for advice about partnerships. This book grew from the course notes and workshop discussions. The style reflects this: there are tables, case studies, and diagrams to help come to decisions about various desirable qualities each student values. There is clearly no single correct answer.

The following topics are covered: core values and practice ideals; the partnership dynamic; owning or leasing premises; financial issues; how hard do you want to work?; and working policies. The interpersonal areas are well presented and worked through, whereas the business side needs greater depth in a book of this type.

This slim volume might be used by trainers and course organisers to direct some tutorials, but the wise student will need more because of the lack of references.

One must be properly prepared to appraise prospective partnerships. The following will serve well:

- Henry R Patterson. *Tutorials in management in general practice. Churchill Livingstone* (ISBN 44305485), £22.50,
- Phillipa Moreton. *The very stuff of general practice.* Radcliffe Medical Press (ISBN 1 85775 390 9), £35, and
- Ruth Chambers. *Survival skills for GPs. Radcliffe Medical Press* (ISBN 1 85775 334 8), £30.

The British Medical Association runs New GP Principals Courses throughout the year which provide in-depth coverage of the business side of practice; check your local office for dates and locations.

In summary, Petre Jones's book is a quick read surveying the partnership landscape, but one needs other resources for the detailed view. In the end, though, it comes down your instinct — the most important thing in a successful partnership is liking you partners and no-one can you teach you that.

***David Lewis***

**Patients and Doctors: Life-changing Stories from Primary Care**
**edited by J Borkan, S Reis, D Steinmetz, and J H Medalie**
University of Wisconsin Press, 1999
HB, 221pp, £18.50, 0 29916340 7

This lovely insightful book should be read by every student and practising doctor, physician and consultant. It's not just that it contains wisdom, but that it offers a route for deep life- and career-affirming reflection.

There is certainly wisdom. Jack Medalie says on page 50: 'The motto "There is always another patient waiting to teach me something new" may be a cure to many of the blues of our profession and our own personal dilemmas and anxieties. Acquiring the skills to do this may allow the doctor–patient therapeutic relationship to reach a far deeper level of understanding with better outcomes for both the patient and physician.'

Clinicians' stories of their own doctor–patient interactions — of all sorts, and from all over the world (including Britain) — are at the heart of the book. They are very funny, tragic, full of blunders, uncertainties, joys, secrets, and soul-searching. The unifying theme is that the doctors feel they have learned from the situations and from writing about them.

The stories are short, which is a good thing in the few ditch-water dull ones — a mere recounting of case studies of the kind encounted every day. Each section has an introduction, some of which are just magic: full of insight and humour.

Borkan and Miller on page 11 say how 'many hold their failures inside, allowing them to smoulder and decay; others step into self-destructive habits; others tell stories.' I would add: others write stories. A pen and paper are the kindest and most illuminative route to practice development. Don't just tell your puzzling, worrying, horrifying, amazing practice story over coffee, don't sit on it in silence: write it, share it, learn from it, enable others to learn from it too.

This really is a good and enlightening read, despite the unfortunate pass-the-sick-bag title and cover. The last word belongs to Borkan and Miller on page 13:

'We hope this book will touch your heart and head: surprising you, engaging you emotionally, and stimulating you intellectually. Regardless of whether you are comforted or disturbed by what you read, we hope the stories will challenge you morally and intellectually, leaving you more aware and less certain.'

***Gillie Bolton***

*First Cut*
**Jonathan Kaplan**
in **Love Stories: Granta 68**
*Granta*, Cambridge 1999
PB £8.99

The quarterly *Granta* is widely regarded as one of the very best of literary magazines. This latest edition keeps up that high standard, and is particularly notable for Jonathan Kaplan's vivid account of his early medical career in South Africa.

*First Cut* contains a wonderfully visceral account of a young surgeon's first contact with major trauma. I've never read such a poetic description of abdominal surgery: 'A faint odour, fresh yet slightly sour, rises from the exposed tissue.' I missed the 'neatly layered bowel pulsating in slow waves like wind over a cornfield' when grimly hanging onto a retractor myself. *First Cut* makes me wish I'd taken more notice.

Kaplan is equally good at describing the farce of a senior anatomist 'hold(ing) tea parties in his office for groups of old ladies, trying to coax them into leaving their bodies to science' and the horror of racially segregated mortuaries. The climax of this short (9000 word) essay details the horrifying effect of army service under apartheid on a colleague of Kaplan's. The final warning not to 'believe that bullshit I used to give you about being able to keep your humanity by being a doctor' is truly chilling. Kaplan goes on: 'It isn't true. There are situations where that option simply doesn't exist.' *First Cut* should make us thankful that most of us practice medicine in less morally extreme conditions.

*Granta* 68 contains many other riches. Peter Ho Davies's account of a drug addict mother trying to keep custody of her child and Daniel Meadows's fascinating photographs of ageing subjects over 25 years stood out for me. *Love Stories* could hardly be bettered. Recommended for anyone with even a passing interest in humanity.

***Wayne Lewis***

## uk council, rcgp agm, december 1999

As is customary for the first meeting of Council following the AGM, all the Honorary Officers of Council, the Chairmen of Committees and the Chairmen of Networks for the year ahead were appointed. A full list of all members of Council including the Honorary Officers is available from the Clerk to Council, Dawn Jenkinson (0171 581 3232 ext 246 or e-mail *djenkinson @rcgp.org.uk*).

**Declarations of Interest**
Council, propelled by discussion at the Academy of Medical Royal Colleges and the work of the Nolan Commitee, has decided to introduce a compulsory register of interests for all Council members. Arrangements, guidance, and other details will be worked on together with the question of access to the register and how it is maintained. A report comes back to Council this month.

**College Strategy 1998–2001**
Council has adopted a strategy prepared by Chairman of Council, Mike Pringle, for his three-year term of office, now entering Year Two. Key objectives remain:

1. to facilitate the improvement of quality of care in British general practice,
2. to support general practitioners in demonstrating the quality of care they deliver, and
3. to improve the standing and influence of general practice and the College within and outside the profession.

**Primary Care Workforce**
Council discussed a comprehensive paper produced by Tony Mathie examining trends in and pressures on the primary care workforce. The factors identified which influence the size of and trends in the workforce include:

- pre- and post- vocational training,
- the components of training,
- entry to and drop out rates from general practice,
- career patterns of GPs and how they might be affected by devolution in the UK,
- the effects of immigration and national immigration policies,
- the changing gender balance in the workforce, and
- the non-medical workforce.

Analysis of these factors suggests that for every 100 GPs leaving the workforce, there needs to be about 150 registrars to undertake the same amount of work. This is against a background of a downturn in recruitment to general practice.

Council agreed that work identified to take forward the conclusions in the paper should be considered. The points raised in the debate will be taken into a further version of the paper which will then be published in the 'blue and white' series.

Council also decided to establish a joint working group with the GPC on workforce issues. The GPC has had a Workforce Committee for several years and the College has a Career Support forum which considers some workforce issues. The rationale behind a joint group is:

- to pool the resources and expertise in the College and the GPC,
- to have a single forum to discuss mutual interests and to engender mutual support, and
- to avoid duplication and hold parallel meetings on similar issues

**Revalidation and Good Medical Practice for General Practitioners**
The College, together with the GPC, have agreed that two important documents will soon be distributed to all GPs in the United Kingdom. We very much need to hear members' comments, as these issues are vital to the future development of the profession.

First, the draft version of *Good Medical Practice for General Practitioners* will be published to all GPs. Second, the first report of the Revalidation Working Party is being circulated for comments. Members will receive a fax-back sheet for comments; these should be received by the College at Princes Gate by 31 March 2000 at the latest.

***Supporting Doctors, Protecting Patients***
Council had a very full debate on this consultation paper issued by the Department Health in England on Friday 12 November. The College has already issued two press statements in response.

In summary, the paper, which is confined to the English Health Service but envisages similar provisions in other UK countries, proposes:

- to help doctors whose performance gives cause for concern,
- to reform disciplinary procedures with different routes for tackling personal misconduct, failure to fulfil contractual obligations or clinical performance,
- to introduce compulsory participation in clinical audit for all GPs as part of clinical governance,
- to introduce appraisal for doctors working in the NHS with the RCGP and the GPC being invited to work with the Government in developing the appraisal framework,
- to provide for referral to an Assessment and Support Centre (or, if more serious, the GMC) where there is concern. The centres will be run jointly by the NHS and the medical profession,
- to co-ordinate the separate processes of external peer review and accreditation with NHS quality arrangements.

Council was keen to ensure that the positive aims of the proposals are supported and seen

**The Spring Meeting**
Council agreed to adjust the use of the Spring meeting to include once again a general meeting business session. This would allow members to be elected to Fellowship (which has to be done at a general meeting) and to give them the option of being admitted either at the AGM or at the Spring Meeting. The programme for the Spring Symposium in 2000 (in Crieff, Scotland) is now very well advanced and so any changes would be effective

**Update reports**
Council received update reports on NHS Direct and Walk-in Centres, MRCGP, and Summative Assessment and Services over the Millennium. On the last of these, the College, in conjunction with the National Association of GP Co-operatives, hopes to monitor use of selected GP co-operatives telephone services over the Millennium period so as to act as an early warning system. This will be a simple and effective way of getting a handle on overall call numbers and to identify patterns of calls, such as the possibility of a high incidence of food poisoning or 'flu over the holiday period. The information gathered will be passed to the Department of Health's Millennium Executive Team. This is partly in reaction to the bad press last year when there was perceived break-downs in primary care provision in some areas of the country, although subsequently most problems were attributed to logistical reasons, such as problems with telephone exchanges. Steps have been taken to avoid a re-occurrence of those problems.

to be supported. Those aims include:

- protecting patients,
- meeting, maintaining, and improving standards of service and care, and
- identifying poor performance concerns early on and addressing them quickly.

However, Council expressed its very considerable concerns that, although the analysis of the problems identified was correct, the measures proposed to meet those concerns were inappropriate. Members were keen to work with patient groups wherever possible to give weight to its response and convey to the Government that their views command wider support.

The College will issues further press statements and will have further debate this month before responding in full before the closing date of 25 February 2000. The College is very keen that members' views are heard and considered.

**National Service Frameworks (NSFs) and NICE Guidelines**
Members will be aware that the Department of Health has commissioned four NSFs on coronary heart disease, mental health, care of the older person, and diabetes mellitus. Also, the NICE has three work programmes: to evaluate new technologies and drugs; to produce guidelines setting out best practice; and to recommend audit tools.

Council identified a need for the College to analyse the impact of these for general practitioners and will, where appropriate, produce summaries for members.

**Future of Independent Contractor Status**
Together with the Chairman of Council, The Honorary Secretary submitted a paper to Council that reviewed Independent Contractor Status.

The paper reviewed a model outlining the four essential attributes of primary care as:

- first contact care,
- longitudinal care,
- comprehensiveness, and
- co-ordination of services.

Our analysis was that, despite some disadvantages, independent contractor status most readily delivers the key attributes of primary care and is an efficient and cost-effective model. Those key attributes could however also be largely delivered by salaried doctors who are practice-based. We also felt that changes in access to primary care should be monitored from the viewpoint of their impact on the key attributes of primary care.

**Next Meeting of Council**
Princes Gate, 28 January 2000, at 9.00am.

**Maureen Baker**

## our contributors

**Maureen Baker** is the new Honorary Secretary to RCGP UK Council, and is busy cultivating her predecessor's nimble prose style

**Ruth Bastable** is a GP in Cambridgeshire

**Gillie Bolton** is an extensively tatooed research fellow in medical humanities at the Institute for General Practice & Primary Care, Sheffield.

**Liam Farrell**, internationally distinguished medical columnist (it says here), presently tours churches in Newry and Mourne disguised as a Wise Man. He is upstaged by his six year old daughter

**David Gelipter** is a GP in suburban Sheffield and yet another part-time lecturer at the Institute of General Practice, University of Sheffield. Like many contributors to the *Journal* he is an enthusiastic Morris dancer

**Trish Greenhalgh** is a Chair waiting to happen

In another forty years or so **Iona Heath** will be hailed as the Mother Superior of British General Practice. Until then she'll be hard at it, at Caversham Group Practice, in north London

**Paul Hodgkin** is co-director of the Centre for Innovation in Primary Care, Sheffield (**www.innovate.org.uk**)

**Wayne Lewis** practises in Abergavenny, Monmouthshire, and has never worked in Sheffield. Forthcoming work for the *Journal* encompasses Salman Rushdie and Woody Allen, though not in the same article

**Peter Nelson** plans to cut the guy ropes holding up the Millennium Dome. Previously he has been a teacher

**Tony Pelosi** is a consultant psychiatrist at Hairmyres Hospital, East Kilbride, near Glasgow. He has published extensively, and tellingly, on fatigue disorders.

*All our contributors can be contacted via the Journal office*

## Liam Farrell

**Star Trekking**

I've been writing columns for nearly six years now, and it's perversely like having sex; there is a modicum of satisfaction to be had, though it's usually my own.

But writing a novel, I feel, is beyond me, partly because of the daunting scale (this article is 600 words, a novel is on average 100 000), partly because of the inadequate financial recompense (as Samuel Johnson said, 'only a fool writes for anything but money', and partly because of the difficulty of developing characters, creating real people that a reader might care about.

It is no coincidence that so many of the great writers have been doctors, from Celine to Turgenev, Chekhov to Munthe. We share a privileged yet objective viewpoint; we are in situations but not of them; we are flies on the wall, eyes in the sky. But the novelist must create his own characters and direct behaviour accordingly. In contrast, our 'characters' have invented themselves and so will do nothing we tell them.

I was therefore very pleased to see our iconoclastic Scottish sister journal, *Hoolet*, paying tribute to the career of the most illustrious and widely travelled fictional physician of all, Dr Benedict 'Bones' McCoy of the Federation Starship Enterprise.

Bones has all kinds of useful gadgets available to him, most notably a pen-like machine which enables him to quickly assess vital signs or, alternatively, to instantly confirm death, hence the unforgettable quote, 'He's dead, Jim'. But despite such incredible progress in medical science, and despite having such astounding technology at the tip of his fingers, Bones's main role is an emotional creature, an empathic counterpoint to Spock's cold inexorable inhuman. A true scientist who doesn't screw around with alternative therapies, he is nevertheless the ultimate proof that doctors can never be replaced by the implacable objectivity of computers; our human frailty is ironically our greatest strength: we understand human weakness because we are human and weak.

Seemingly contradictory was the sequel, *Star Trek: Voyager*, where the medical officer is a computer-generated hologram, but, over the series, the computer begins to develop feelings and intuition of its own. It comes to realise that such non-exact, non-scientific qualities are mandatory qualities in a physician, and exquisitely complementary to evidence-based medicine.

The true appeal and the real reason for the success of Star Trek was that we actually cared about Kirk and Spock and Bones. At the start of the film *Star Trek 4* the trio are sitting shooting the breeze beside a camp fire in the Montana Woods, as far from slaughtering aliens (or making love to them) as it is possible to be, but we are still interested in them and what happens to them; we don't need weirdly-shaped aliens and futuristic technology — we just need people. People are what make things relevant.

A bleak Connemara mountain fastness only becomes truly remote when a little white-washed cottage is seen to huddle under its protective shoulder. A quantum leap in medical science only becomes relevant to us when it eventually trickles down to help one of our patients. The moon becomes comprehensibly alien only with a dwarf-like Neil Armstrong standing on it waving a flag; only then can we see its true scale. The Grand Canyon on its own is nice, but only becomes meaningful and spectacular when there is a human perpective, e.g. my Uncle Woody and my Aunty Mamie standing in the foreground waving 'Hi' to all the folks back home; my Uncle Woody and Aunty Mamie were enormous and spectacular and unforgettable and monumental in their own right.

We don't need exotic locations and magnificent scenery — we just need people.