The British Journal of General Practice

viewpoint

Turning up the heat on doctors' performance

Doctors don't like to be criticised, particularly when it is politicians who are questioning our clinical standards of care. Clinical governance, NHS re-appraisal, and revalidation are starting to feel like big sticks hanging over our heads. The recent media interest and public concern at high profile examples of the failure of doctors to keep their own ship in order has not helped our cause. The writing is on the wall — poor performance is not acceptable and something will be done to eliminate it.

The really frustrating thing is that, as a working GP, I know that the criticism has a certain ring of truth about it. I am not lazy or incompetent but I recognise that the quality of care that I provide for some of my patients is far from perfect. I know that I could improve on the way that I manage some of my hypertensive and diabetic patients but I never quite seem to get around to it. It's not that I can't be bothered or that I'm ignorant. It is simply a question of priorities. There are so many competing demands on my time and energy that I don't always give the quality of my clinical performance the attention that I know in my heart it deserves.

The public release of the performance data, in the form of standardised comparative reports on quality of care, will ensure that my excuses sound increasingly hollow in the future. If I don't give top priority to an indicator that measures the quality of the care that I provide, but other doctors do, then my practice will be exposed. Most professionals like to excel, they don't like to be shown up. Of course there are significant problems with the use of performance indicators, ranging from technical issues such as case-mix and risk adjustment to well recognised 'gaming' of the results.[1] We can complain as much as we like about these problems but, at the end of the day, most doctors are competitive animals and I suspect that we will respond.

The UK government sees public disclosure of information about quality of care as one of the central planks of health policy,[2] not so much an opportunity to inform users and promote choice but a vehicle to ensure accountability for minimal standards and continuous improvements in professional practice. The recently published hospital performance data for England and Wales[3] was a start and it is only a matter of time before those working in primary care start to feel the heat of public (and political) attention. The use of performance indicators by the current government is one of many examples of their desire to 'micro-manage' the public sector. Apparent performance, as measured by the indicators, will almost certainly be one of the carrots (for 'good performers') or sticks (for 'poor performers') that will influence the distribution of the recently announced additional funding for the health service.

The rationale for public disclosure is simple. The collection and analysis of audit data is an important part of most quality improvement processes. However, simply providing data is not enough — mechanisms are required to focus attention on the data and to remind (or, if necessary, shame) professionals to make use of it. In the past, educational initiatives aimed at facilitating intrinsic professional motivation have been used. Public release of comparative information is an external motivator that turns up the heat to the point that we can no longer ignore relative underperformance.

The central question that remains unanswered is: how much heat is needed before doctors start to respond to comparative performance data? Where should that heat be applied — to PCGs, practices, or individual GPs? Not much heat was applied to the hospital outcomes data and the public and media response was, as a result, remarkably muted. The government has made it clear that they intend to keep turning up the heat until we react. Will we respond in a competitive fashion in order to reduce unfavourable comparisons or will the heat result in significant numbers of doctors wanting to get out of the kitchen?

Martin Marshall

References

1. Davies HTO, Lampel J. Trust in performance indicators? *Quality in Health Care* 1998; **7:** 159-162.
2. Marshall MN, Shekelle PG, Leatherman S, Brook RH. Public disclosure of performance data: learning from the US experience. *Quality in Health Care* 2000; **9:** 53-57.
3. NHS Executive. *Quality and Performance in the NHS: High level performance indicators and clinical indicators*. London: The Stationery Office, 1999. (http://www.doh.gov.uk/indicat/nhshlpi.htm)

The Back Pages...

'That evidence-based medicine is itself not evidence-based is of course a commonplace; we simply do not know whether the numerous ways in which it may do harm will eventually outweigh its obvious benefits.'

James Willis on *NICE, CHI and the NHS Reforms*
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news

A national UK audit into epilepsy-related deaths

Five Royal Colleges, including the Royal College of General Practitioners, have been asked to undertake a National Sentinel Audit of Epilepsy Deaths. The audit is coordinated by the charity Epilepsy Bereaved, supported by the International League Against Epilepsy, and funded by the Department of Health through the National Institute for Clinical Excellence. The Scottish Executive, the Welsh Assembly, and the Northern Ireland Department of Health, Social Services and Public Safety have granted additional funding to ensure a UK-wide audit.

Epilepsy is the most common serious neurological condition. Although the prognosis is good for most patients with epilepsy it is now acknowledged that epilepsy carries an increased risk of death above and beyond that of the underlying disease.[1]

In 1998, national mortality statistics recorded 963 deaths registered as epilepsy. Patients of all ages with epilepsy have an increased mortality risk of approximately two to three times that of the general population.[2] Some of these deaths may be owing to a complication of a seizure (e.g. head injury, drowning), convulsive status epilepticus or a related underlying condition, including a neurodegenerative disorder or severe cerebral palsy.

The majority of these deaths, some 500 a year, cannot adequately be explained. It is to this group that the syndrome of Sudden Unexpected Death in EPilepsy (SUDEP) has been attached. The syndrome is poorly understood, particularly in children[3] and many different mechanisms are likely to be responsible, including fatal cardiac dysrhythmia (possibly representing an automatic seizure) or a severe prolonged disturbance of brain-stem function by epileptic discharges (possibly resulting in a respiratory or cardiac arrest). Young people and those with chronic or severe epilepsy are at particular risk. Comparison has been made between SUDEP and sudden infant death (SID) as SUDEP deaths are often at night and are wholly unexpected.

The phenomenon of SUDEP is not sufficiently recognised by health professionals or those involved in the investigation of a sudden death. False attributions, such as status epilepticus or asphyxia, may be cited as causal factors of death.[4] Further, a GP with an average list size who may be prescribing medication for some 10 epilepsy patients at any one time may have little or no experience of SUDEP. It is not surprising that when a SUDEP death does happen in a practice that it can be traumatic for the GP as well as the relatives.

It is important to investigate this phenomenon in more detail in order to identify potentially preventable causes. By finding out more about epilepsy-related death we hope to identify ways of addressing epilepsy care and so reduce mortality. This information should then facilitate a more appropriate and realistic counselling of families when discussing SUDEP.

The primary objective of this audit will be to investigate the standards of determining epilepsy-related deaths as well as evaluating the standards of services provided before the person's death. Data will be collected on the ante-mortem access and quality of care of both primary care and secondary care services (including anti-epileptic drug treatment), and the post-mortem examination and certification of deaths where epilepsy is mentioned on the death certificate. Audit tools have been developed for primary and secondary care and a panel of general practitioners and others with an interest in epilepsy is agreeing standards.

A sample of cases of epilepsy-related deaths occurring between 1 September 1999 and 31 August 2000 will be audited. The primary ascertainment mechanism for the project is through Coroners and the Office of National Statistics. The Audit Officer of the Royal College of Pathologists, who acts as Audit Facilitator and Project Manager, will collate data. A secondary ascertainment mechanism is through Epilepsy Bereaved. If a relative contacts the charity and wishes to flag up a case to the audit, Epilepsy Bereaved can pass on the case details to the Audit Facilitator.

The audit tools will be used by a team of clinical audit officers to audit medical records and post-mortem reports. Trusts and primary care groups have been contacted to inform them of the audit and to seek their cooperation. Individual GPs may be contacted for their cooperation in this way, should one of their patients die from epilepsy. GPs will also be asked to complete a short questionnaire on how epilepsy patients are managed in their practice. Once the data has been collected all linkage information identifying the patient and professionals involved in their care will be destroyed.

The data will be analysed to see how practice is implemented in individual cases. However, at no stage in the audit will it be possible to know the identities of either the person who has died, their family or the professional involved in their care. A report will be made to departments supporting this audit containing recommendations on how epilepsy services could be improved. In addition to a published report, regional events will take place to share findings and give health professionals the opportunity to contribute to the debate.

Henry Smithson

References

1. Hall WW, Martin EW, Smithson WH. Epilepsy - a general practice problem. [RCGP Clinical Series.] London: RCGP, 1997.
2. Cockerell OC, Johnson AL, Sander JWAS, *et al*. Mortality from epilepsy: results from a population-based study. *Lancet* 1994; **344:** 918-921.
3. Appleton RE. Sudden Unexpected Death in epilepsy in children. *Seizure* 1997; **6:** 175-177.
4. Coyle HP, *et al*. Coroners' autopsy reporting of sudden unexplained death in epilepsy (SUDEP) in the UK. *Seizure* 1994; **3:** 347-354.

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Home efficiency scheme — for warmer, healthier homes

On average, 30 000 more people die in a British winter (December to March) than over the rest of the year. This does not happen in colder countries such as those in Scandinavia. It is likely that several thousands of these deaths are associated with cold conditions in homes. Ninety per cent of excess deaths are among the over-60s; the main causes are heart attacks, strokes, respiratory illnesses, and accidents — all of which can be exacerbated by the cold.

Research indicates that cold homes are a major domestic health hazard. Living in a cold and damp home increases the risk of ill health, especially to older people, children, the chronically sick, and the disabled. In 1996, it was estimated that at least 4.3 million households in England were unable to keep their homes adequately warm.

A recent inter-departmental review concluded that energy efficiency improvements offer a long-term solution to the problem of fuel poverty. This is why the Government is introducing the New Home Energy Efficiency Scheme (New HEES).

From June this year, New HEES will provide grants of up to £2000 for heating and insulation improvements for the homes of those most vulnerable to cold-related ill health. The scheme will focus on:

- older people (over 60s) on a low income,
- families with children under 16 and on a low income,
- the disabled and the chronically sick, and
- households in the private rented and owner-occupied sectors (where the problem of fuel poverty is greatest).

The package of measures provided will be tailored to the property type and the needs of the household. They are designed to substantially reduce the cost of heating the homes by up to £1000 per annum.

With a budget of £260 million for England for the first two years, New HEES is expected to help some 460 000 households. Similar programmes in Wales and Scotland will bring the total budget available to £300 million. However, those people in the greatest need are also the most difficult to reach. Older people in particular may be reluctant to hold up their hand and ask for help. This is where the Government needs the help of frontline workers — nurses, GPs, and other health professionals — to help identify vulnerable households and refer them for assistance. Those who have day-to-day contact with vulnerable households in need can use New HEES to make a real difference.

For more information please telephone: 0800 952 0600. For information on similar schemes in Wales and Scotland phone 0800 072 0150.

Mitesh Dhanak

WONCA statements ....

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The Wonca Region Europe ESGP/FM Conference in Vienna, Austria 2–6 July 2000

The Executive of the European Society of General Practice/Family Medicine (WONCA-Europe/ESGP-FM) and the Austrian Society of General Practice (ÖGAM) have issued a position statement with regards to the conference in Vienna.

In addition to this, it was seen appropriate to emphasise, in the context of the conference, the values and attitudes in general practice/family medicine and the role of the family doctor, when confronted with ethical dilemmas. Prior to the recent political changes in Austria, the conference organisers had already included programme topics related to this issue in the first day of the conference .

It has been decided to confirm the conference programme in the light of the recent political developments in Austria, and to address the important role of general practice/family medicine in safeguarding human values under political pressures. Details of the main issues addressed that day will also be summarised in a press release.

In our view, this is the most powerful way of supporting general practice/family medicine in Austria as they cope with their situation, and at the same time it presents an important frame of reference for the discipline throughout Europe in the face of comparable challenges.
We encourage large numbers of general practitioners/family physicians from Europe and elsewhere in the world to join us in Vienna and make the conference a success.

On behalf on the executive,

Professor Chris van Weel

President of the ESGP/FM

European Society of General Practice/Family Medicine (WONCA-Europe/ESGP-FM) and Österreichische Gesellschaft Für Allgemeinmedizin (ÖGAM)

WONCA-EUROPE/ESGP-FM and ÖGAM feel the need to make the following statement in the light of recent political developments in Austria, and state explicitly what under other circumstances might have been left implicit:

General practitioners/family physicians, as all medical practitioners, are strongly committed to the provision of medical care for all human beings, regardless of their origin, race, cultural background, beliefs or religion. We strongly reject, and take position against, any political attempts to violate basic human values.

We invite all general practitioners/family physicians for their support, and to join us at the conference in Vienna, July 2–6 2000. This would be the best way to underline the core values in general practice/family medicine.

To be protected against political interference, no government backing has been sought for, nor have politicians been invited to the conference.

Spring Symposium 2000 — Crieff

Tina Ambury's famous baby has already become an RCGP institution. Dr Ambury is a part-time GP and medical journalist
Niall Cameron is a Govan GP and the deputy editor of **hoolet**, the incomparable organ of the RCGP in Scotland
John Gillies practises in Selkirk
Deirdre 'Tosca' **Hutton** is vice-chairman of the National Consumer Council
Max Inwood practises in Edinburgh, when not on manoeuvres with the Royal Naval Reserve
Dorothy Logie writes persuasively on Third World debt
Chris van Weel is professor of general practice at the University of Nijmegen in the Netherlands. Nijmegen's central importance in the career of Louis XIV is worthy of study
Patricia Wilkie chairs the Patient Liaison Group of the RCGP

Chris van Weel
The Spring Symposium offers — particularly for a visitor from overseas — an opportunity to catch-up on the current preoccupations of British general practice. Care for individual patients is the common ground of general practice, even when practised in different countries and under different systems. As a discipline we expect to find the effects of our efforts reflected in the health status of individuals, and this individual orientation makes it difficult to keep a broader perspective.

Phil Hanlon's presentation (*Why Health?*) and Sir Kenneth Calman's 'Pickles' on *Aspects of Risks* were apparently unrelated, but developed an impressive string to put the broader perspective of health on the general practice agenda. Despite better general practice care there is an increase in socio-economic differences in the health status of the population; the health status of modern society is surrounded by unprecedented and often scaremongering media-coverage. On the basis of their detailed information a forum for professional reflection developed on the way general practice should cope with these realities.

General practice has made impressive progress in the improvement of quality of care in the past decade. The Spring Symposium signalled the need to link this potential to other factors that determine the health of the population, and the discussions generated may be of great value to the College in providing leadership in this area.

Tina Ambury
Highlights? What highlights?!

- James Willis holding up a borrowed lap top showing an intrigued audience stunning photos of the eclipse over the Blue Mosque in Istanbul.
- Phil Hanlon telling us that 'It all matters!' when it comes to tackling health inequalities, in his own inimitable style and using the College mace as a make-believe telephone.

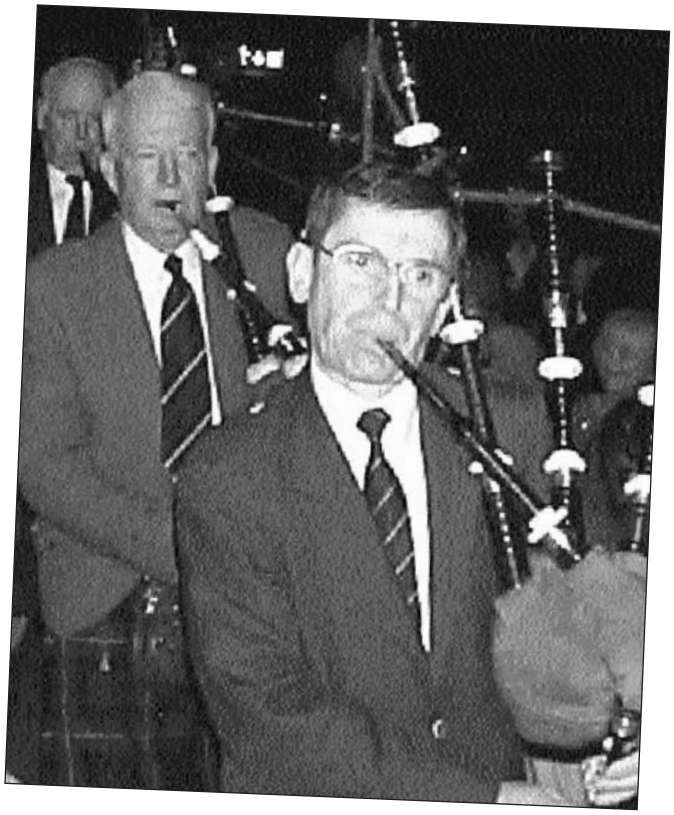
Maybe wee Ken Calman's 'chest moment', with the exceedingly tall Lesley Riddoch was not seen by all, but it shall tickle my memory for a very long time.

Dorothy Logie
'There is unease about the future but the job still drives you forward'. These words, captured in a brief biography of Alistair Grassie, a GP on the Isle of Arran, accompanied a remarkable photographic exhibition encapsulating the moods, hopes, and fears of 47 of Scotland's 200 lone practitioners who work in remote Highland communities and on islands. It was a breath of fresh air to discover Rosie Donovan's wonderful black and white wilderness photographs, squeezed among the drug firm stalls. Each single-handed GP, very much an individualist, wedded to his or her community, each defining some essential aspect of what 'real' general practice used to be, and indeed still is, in these communities; but also iterating concerns that were anxiously echoed in the wider meeting. In ten years time, will general practice, as we know it, continue to exist?

'In a community like this you have to forsake the ideal medical practice,' said John Buchan, Isle of Stronsoy, off Orkney, 'in order to retain faith with your patients'.

In other words, use EBM prudently, put risk management firmly put its place, and tread cautiously on the quick sands of managed care. Diversity can be strength. Mr Blair, please don't try to clone us.

Deirdre Hutton
The final session on Saturday at the RCGP Spring Symposium, far from being the graveyard shift, turned out to be a really lively session. Discussion was stimulated by Avril's story — the experience of a sixteen-year-old facing leukaemia — and the



The three pipers at the Grand Banquet. Photo by Graeme McAlister.

decisions and risks that had to be coped with by her and her parents.

Some useful pointers emerged:

- Families are critical in helping the patient make decisions and cope with the process of being ill, but those families also need support and doctors have to try to engage with the whole family experience.
- Patients are often angry about being ill and doctors need help both with understanding the causes of patient anger and in finding ways of coping with it.
- GPs can have a crucial role as intermediaries between patients and consultants, but they need to be helped in this by a better quality of feedback information from hospitals and consultants.
- Patients differ in their capacity to accept and deal with information about the progress of their illness, courses of treatment, and possible outcomes. There is a need to develop a tool to help doctors understand the appropriate phasing of information for each patient.
- In assessing risk, patients and doctors may have different views about what each would see as a benefit of a particular course of action and doctors must try to understand what constitutes a benefit from the patient's perspective.
- Patients are becoming better informed because of access to tools such as the Internet. Doctors should not be threatened by this but use it to create real partnership between themselves and their patients.

John Gillies
The themes of uncertainty and risk ran through this meeting. How should patients and GPs handle and quantify risk? Can we afford to live longer? Why does more evidence and information lead to more uncertainty? Is medical satire (e.g. *Struck off and Die*) insulting to patients or a necessary coping strategy for doctors?

At a meeting awash with talent, there were two highlights for me. Paul Hodgkin's creative exploration of the exponentially growing effects of the Web suggested that we and our patients will have few fixed points of reference in the future unless we altruistically create them (e.g. Linux and the Cochrane collaboration.) Rosie Donovan's exhibition of elegiac pictures and stories of single-handed GPs in remote Scotland suggests the opposite view. Values and personal relationships will still matter.

(If you want to see the Rosie Donovan exhibition in your area, contact her via **rosiedonovan@yahoo.com**)

Max Inwood
It was, as Winnie the Pooh would say, A Very Good Night. The Grand Banquet was a dazzling cornucopia of food and sparkling entertainment. I try to remember some of the jokes and sketches and who said what but they all seem to merge into one. Perhaps it was the wine.

And wasn't the whole conference a bit like that? A weekend of high quality education. A hotel full of freethinkers prepared to debate the higher things in medicine rather than the cheapest statin.

Jewels do stick in the mind. We had poetry from Dylan Thomas and Kipling, paintings by Picasso and Turner with quotations from Machiavelli and Kant. Presentations by Hanlon and Buckley were my favourites. We had a brace of Knights, a pair of OBEs, a puff of pipers, more professors than you could count, and a bevy of beautiful dancers to close the conference.

It was, as Pooh would say, A Very Good Weekend.

Patricia Wilkie
Springtime in Scotland and snow falls only occasionally. Nuggets sparkle ...

Phil Hanlon, Professor of Public Health at Glasgow, discussed less obvious influences upon health, such as the role of hope, and of hierarchies. The weak and the despairing do less well.

What messages were there, as I saw it, for daily interaction between GPs and patients?

Many speakers discussed the need to move towards a more patient-centred approach in working with patients. Many GPs still find it difficult to conduct patient-centred consultations, a difficult task for all members of the primary care team in the time available; especially in the challenging field of assessing and explaining risk

Sir Kenneth Calman highlighted the complexities in risk information, including the scientific and lay perceptions of risk comparisons and risk familiarity. What of the language of risk? Does 'safe' mean negligible or zero risk? When are risks 'avoidable', 'justifiable', or 'serious'? The terms 'high', 'low', 'moderate', and 'minimal' mean different things to different people, at different times. Perhaps patients and their representatives and doctors need to work together to develop a mutually understood and acceptable language of risk.

Presenters and contributors referred to the difficulty of working with uncertainty and a fear of being devalued, disrespected, or perhaps even sued if you show or share this lack of certainty with a patient. In earlier times doctors either pretended to understand how things worked, or ignored the problem, or simply made up stories to fill the gap. If doctors acknowledge uncertainty and share this with their patients they would absolve themselves from the responsibility of promising more than individual doctors or medicine can deliver. It would also reduce the feelings of psychological abandonment that we as patients can experience when we sense that doctors are hiding behind a curtain of silence or evasion, and would encourage shared decision-making with patients.

The session on patients' perceptions of risk was special, but not because it made us much more aware of the decisions, questions, and anguish faced by Avril, who was diagnosed with leukaemia some 12 years ago, nor by her mother. Mac Armstrong was the other patient who described not so much perception of risk but what it felt like to be a patient. The session became an opportunity for the contributors who have recently been patients, or who are the parent or carer of a patient, to describe their emotions of being patronised, of losing dignity, of not understanding, of being frightened and of feeling alone and uninformed. While it was a pity to lose a good discussion on patient perception of risk I wonder whether there should always be a session for GPs as patients. A session at the Dublin WONCA last year was similarly cathartic.

Good medicine is holistic, advising patients where necessary to get a balance in their lives. What a pleasure it was to see a group of GPs enthusiastic about their profession and their work communicating so magically through music and poetry. I am just sorry that the musical tour through Scotland had not been a plenary session heard by all. All of the musical and poetry contributors, pipers, jazz musicians, and singers were stars. But those who did not hear the chairman of Scottish Council's rendering of *Mary of Argyll* missed a magical performance — a real treat.

Niall Cameron
I doubt that many delegates to the Spring Meeting realised that, until fairly recently Crieff Hydro, was not renowned as one of Scotland's hot spots. Rather, it was a temperance hotel frequented by dour Presbyterian ministers who, with honourable exception, avoid Bacchanalian revelry. Saturday night at the Spring Meeting would have been viewed with holy disapproval.

A bustling drinks reception preceded a banquet where the level of conversation and laughter resounding around the hall provided ample testimony to success.

Hazy recollection reminds me of the dry wit of Duff Hardie; and of *Private Eye*'s Phil Hammond, who achieved the rare feat of being both serious and funny; and the outrageous George Duffus, the only financial adviser who has ever given me a laugh, whose Dundonian interpretation of *Hamlet* is shortly to be filmed by Kenneth Branagh. Or so it should be. Roll on Belfast, 2001!

Change and the organisation 2: Strategy

References
1. Mintzberg H. *Strategy safari: a guided tour through the wilds of strategic management*. New York: McGraw-Hill, 1996.
2. Eccles T. *Succeeding with change: implementing action-driven strategies*. London: McGraw-Hill, 1994.
3. Tarplett P, McMahon L. *Managing organisational change - a management workbook*. London: Office of Public Management, 1999.
4. Greenhalgh T. Change and the organisation 1: Culture and context. *Br J Gen Pract* 2000; **50:** 340-341.
5. Waterman RH, Peters TJ, Phillips JR. The 7S framework. In: Quinn JB, Mintzberg H, James RM (eds). *The strategy process*. New York: Prentice Hall, 2000.
6. Senge P. *The fifth discipline*. New York: Doubleday, 1990.
7. Greenhalgh T. Change and the individual 1: Adult learning theory. *Br J Gen Pract* 2000; **50:** 76-77.
8. Carter Y, Shaw S. *Assessment schedule: accreditation of primary care research and development in general practice*. London: Royal College of General Practitioners, 1999.
9. Lewin K. *Field theory in social science*. London: Tavistock, 1952.

Acknowledgement
I am grateful to Fraser Macfarlane and Alec Logan for helpful comments on earlier drafts of this paper.

What is strategy?
Strategy is about having a vision and putting things in place to help you achieve it. There are literally dozens of different theoretical approaches to the study of organisational strategy,[1] but most of them boil down to five essential steps:

1. analyse where you are,
2. define where you want to go,
3. identify the steps needed to get there,
4. follow those steps, and
5. measure your progress.

Strategic analysis: understanding the external environment
The case study (see box) describes three young GPs who are considering becoming a research practice. Clearly, such a decision should not be made solely on the basis of enthusiasm, but on an analysis of the external forces that might support — or mitigate against — the desired change. One tool for analysing external forces is the PEST analysis (political/legal, economic, sociocultural, and technological).

Political and legal forces in this case include the fact that, under clinical governance, GPs are now contractually obliged to understand and apply research evidence. The forthcoming revalidation system for GPs will require evidence of systematic professional and practice development based around patients' needs. Furthermore, research activity is gradually becoming a defining feature of a 'quality' general practice. Economic forces include the major investment occurring in primary care research at national level, protected 'set-up' funding available for infrastructure development, and the potential for additional funding from research grants.

Sociocultural influences on the strategic decision to become a research practice include the fact that an increasing proportion of patient care occurs in the community, and hence it makes sense for biomedical research to occur here. Furthermore, the experiences, needs, and priorities of primary care populations are relatively under-researched, and practice-based research would align well with the prevailing philosophies of both 'evidence-based care' and 'patient-centred medicine'. Technologically, powerful IT systems are becoming affordable and prices for GP practices increasingly subsidised. Collection of clinical data in electronic format may soon become a required activity for primary care groups. Practice IT systems are becoming increasingly user-friendly.

Strategic choice: deciding where you want to go
The PEST analysis above suggests that the external environment is favourable to developing practice-based research. But the strategic choice of whether and when to embark on this particular change also depends on a number of internal factors, that crucially include questions about organisational structure (are we, or could we be, set up to do this?) and systems (what goes in, what happens to it, and what comes out?). In the management sense of the term, structure includes a host of individual, departmental, and organisational roles and relationships, expressed variously as responsibilities (who does what), accountabilities (who is answerable to whom), task descriptions, work flows, administrative processes, reward criteria, promotion procedures, departmental boundaries and separations, and co-ordination mechanisms.[2]

The systems approach to organisations describes them in terms of inputs (staff competencies and physical resources), processes (what goes on, and how), outputs (goods and services produced), and outcomes (ultimate achievements that hopefully correspond to the organisation's explicit goals).[3] In the case study, for example, the ultimate desired *outcome* is surely improved population health and better quality patient care. This will stem from the practice's *output* of high quality, important, ethically sound, and culturally sensitive research. The *processes* needed to achieve this output include new internal systems for producing, prioritising, refining, and testing research hypotheses, focused project management, reliable data collection and analysis, protection of confidentiality, informed consent from patients, an efficient process for writing up and disseminating findings, and a high degree of peer support from more experienced colleagues. The *inputs* will include new staff with the relevant skills and experience, training for existing staff, links with the local university and the wider research community, funding, and protected time away from clinical work.[4]

Additional aspects of an organisation's capability for a particular change include its philosophy and purpose (what are we here for?), its culture (how are things done around here?), and the acceptability of the proposed change to staff and clients.

Two popular tools for weighing up the pros and cons of strategic choices, and identifying barriers to change, are the SWOT analysis (Table 1) and the stakeholder analysis (Table 2).

Table 1: 'SWOT' analysis of the practice in relation to research activity (see case study).

Strengths All partners and the practice nurse are enthusiastic and committed. Reception staff are intelligent and able to learn new skills.	**Weaknesses** No-one in the practice has any academic training. Space is very limited.
Opportunities Dedicated funding for research infrastructure. Professional and staff development. Input of own ideas into research studies.	**Threats** Conflicting demands on partners' time, especially heavy service commitments. Stringent process for research accreditation by RCGP — may require considerable investment of time and money.

Strategic management: getting there from here

You may know where you want to go, and you may even have a time frame with milestones for getting there. But how do you go about it — and where should you begin? Organisational change is not a linear process, and there is, therefore, no single, unproblematic and undisputed starting point. I personally find the 7S diagram — developed by a team of management consultants at McKinsey's and shown in Figure 1[5] — a helpful *aide mémoire* for the addressing the different key dimensions of strategic management. Strategy — the overall vision and the plan for change — is conventionally shown at the top of the diagram, closely linked with structure and systems in what the authors called the 'cold triangle'.

The extent to which a new strategy can be implemented solely via top-down changes to structures and systems remains hotly debated in the management literature. In his excellent book, *The Fifth Discipline*, Peter Senge gives examples of how a group of intelligent people, all highly motivated and acting rationally, consistently perform poorly in tasks when their information systems and job responsibilities are badly structured, while well-designed structures and systems bring out the best in individuals and teams.[6]

The 'warm square' in Figure 1 shows some softer dimensions — the 'who' and 'why' of the organisation rather than the 'what' and 'where'. The case study illustrates how a conscious focus on the 'warm square' can prepare the ground for the more visible and measurable changes that might occur in structure and systems.

One of the most widely cited authors on strategic change is Kurt Lewin (the same social scientist, incidentally, who set the foundations of adult learning theory[7]). Lewin suggested that the change agent should identify both pushing forces (for change) and restraining forces (against change) and work to increase the former and decrease the latter. He also believed that reducing or diverting restraining forces would generally be vastly more effective than increasing pushing forces.[9]

Conclusion

As Mintzburg has emphasised, it is probably unhelpful to have too rigid a view of organisational strategy. Depending on the situation, you may legitimately view strategic change as an evolutionary process, an organisational learning experience, an exercise in interpersonal politics, or an 'adapt or die' response to a changing external environment.[1] Far more important than the primacy of any particular model is the fact that you have, and regularly revisit, a vision for your organisation's future and a realistic plan for achieving it that can be monitored, negotiated, and evaluated.

Trish Greenhalgh

Case study: The Corner Surgery becomes a research practice

Joe, Freda, and Imtiaz took over a run-down inner-city practice five years ago. Having worked hard to complete structural work to the premises, improve the manual records, install computers, build a multiprofessional practice team, establish audit and quality control for clinical services, and set up a patients' committee for feedback, the partners decide to work towards becoming a research practice.

Using published guidance from the Royal College of General Practitioners,[8] Imtiaz, who has agreed to take the lead, is pleased to discover a step-wise framework for introducing the relevant structures and processes. His three immediate priorities are (a) to build a research culture and 'get everyone on board', (b) to improve the quality and consistency of the clinical data held electronically, and (c) to provide a systematic programme of training in research appreciation and data-handling for the partners and staff.

Using the 7S diagram, Imtiaz locates the main obstacles to change in the 'warm square'. There is a distinct lack of shared values (over half the staff have no concept of research and they neither understand nor adhere to its underpinning values), appropriately trained staff, and skills. Management style may need to shift from hierarchical and doctor-dominated to egalitarian and multidisciplinary.

Imtiaz notes Lewin's force field analysis model and, with the help of the practice manager, identifies some key restraining factors — notably the overwhelming pressure on administrative space and the universal feeling among the receptionists that 'we've only just got this place straight after five years of hassle'. He decides that the place to start is not by rewriting job descriptions or sending reluctant staff on courses, but to begin an informal, internal 'marketing' programme about what practice-based research is and the benefits it may offer. Once there is wider ownership of the vision, Imtiaz feels that the changes in structure and systems needed to support research in the practice will be relatively straightforward.

Table 2: Stakeholder analysis for The Corner Surgery's aim to gain accreditation as a research practice (see case study).

Stakeholder	***Present stake***	***Costs***	***Benefits***	***'Wrecking power'***
Partners and nurse practitioner	Enthusiasm for the idea	Time and effort in developing the practice to meet accreditation criteria. Possible personal financial.	Enhanced reputation as a 'quality' practice. Refreshment, stimulation, professional development.	Some players' enthusiasm for research may wane, causing dissent and resentment.
Practice manager	Nil	Major responsibility for reorganising administrative systems.	Acquisition of new skills; variety of work.	Negative attitude. May not co-operate with required changes to administration.
Receptionists	Nil	Additional period of change in set-up period.	Opportunity to acquire new skills and diversify work.	Could compromise patient recruitment, data collection.
Patients	Nil	Doctors may be diverted from clinical activity. Disclosure of personal health data to research team.	Opportunity to contribute to medical knowledge. Better informed, more reflective clinicians.	Could refuse to give informed consent. 'Non-compliance' with research protocols.
Academic department of primary care	Co-ordinating and supporting role for all local research practices.	Investment of time and effort in mentoring and support. Provision of set-up grants for training and administrative support.	Enthusiastic, committed and research-trained practice, able to participate in collaborative research with other local practices.	Could block training and development if practice considered unsuitable.
PCG or health acknowledge authority	Responsible for quality, education and professional development.	Diversion of clinicians' interests from service activities.	Better-informed decisions from research-aware clinicians. Improved practice records. Better quality population data.	Could refuse to the development of research as a priority for investment or staff training.

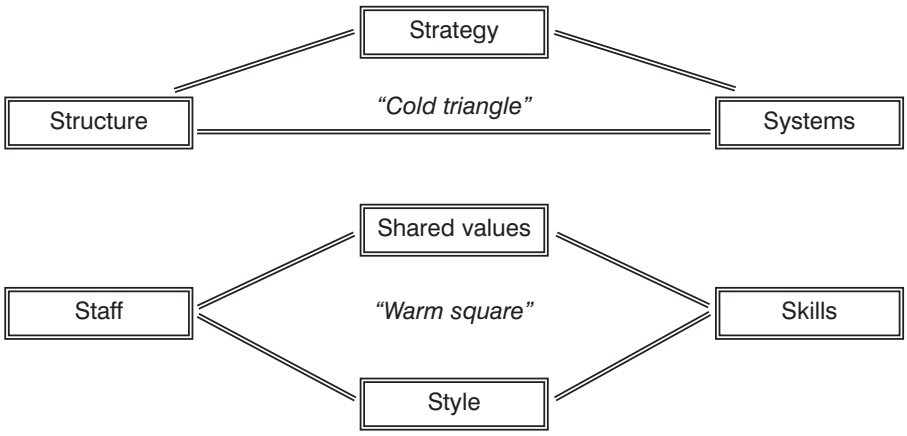


Figure 1: the 7S diagram.[5]

5 Postcards from a New Century

Accountability — For Whom The Bell Tolls

*This article is the fifth in a series of 12 commissioned and edited by **Paul Hodgkin**, co-director, Centre for Innovation in Primary Care, Sheffield, and **Alec Logan**, Deputy Editor,* British Journal of General Practice, *London.*

After the Bristol inquiry and the Shipman case, accountability is on all our minds. So we asked Susie Smith, a partner at Bevan Ashford solicitors, for her personal views about where the legal concept of accountability is heading.

> **accountable** (adj) 1. Liable to be called to account, responsible (for, to). 2. To be counted on.
>
> *Oxford English Dictionary*

Are you accountable? If so, for what and to whom?

The answers are 'yes' and 'it depends on the circumstances'. A typical lawyer's response, perhaps, but in this increasingly litigious society accountability is a key issue for clinicians, PCTs, and LHCCs. Get it wrong and some day soon the bell may toll for you.

All practitioners are aware of the possible outcomes of a failure to provide appropriate medical care. Patients count on their doctors and most professionals acknowledge that they should accept, at least in part, personal responsibility for the consequences of their actions, even if it is the insurers who pick up the financial tab.

The Shipman case has brought the issue of personal and organisational accountability under close scrutiny. In addition to the understandable public horror expressed in respect of those personal actions by Dr Shipman, both the Health Authority and the GMC were subject to considerable criticism in the press. Hopefully, we will never again be faced with such an extreme case of abuse of personal power by a GP. However other high profile cases are likely to arise and PCTs at the front line of community health provision will find themselves in the firing line for public criticism and will, no doubt, be called to account for the actions of GP constituents.

Accountability assumes many guises and, particularly as PCTs come into being, you may just find that you are caught out.

Financial and administrative decisions made by PCGs and PCTs can and will be challenged. Courts have found NHS organisations to be accountable to members of the public for the administrative or financial decisions they make. Health authorities have tended to be the main targets for those making claims. Recent cases have included issues such as the availability on the NHS of sex change operations and the provision of specialised medication. As PCTs gain greater independence and a wider remit it is increasingly likely that they (and so you) will be responsible for decisions of this nature. How accountable do you feel for these decisions and do you know how to minimise the possibility of a claim?

Even if a decision seems sensible and justifiable, PCGs and PCTs may be held to account for the way in which the decision was made: A recent case in North East Devon considered the responsibility of health authorities and social services for funding the provision of long-term care and focused on the eligibility criteria that the Health Authority used to make its decision. Similarly, as an employer the PCT will need to be careful to make sure that the way in which disciplinary matters are dealt with are appropriate. Failure to follow proper procedures can give rise to a claim by an employee even if, for example, a dismissal seems justifiable. So think: how does your PCG or PCT make decisions? What factors does it take into account? Do you know what your procedures are and do you follow them?

The concept of accountability towards users of your service and their carers is set to widen. The new Human Rights legislation will directly affect GPs, PCGs, and PCTs who will need to act in a way compatible with the European Convention on Human Rights. The right to privacy means, for example, that you need to think carefully about the extent to which you may inform relatives and friends of a patient's medical condition without their permission. A patient may claim that you are acting in contravention of the basic right to life. Staff may claim that recruitment practices run counter to the right to freedom from discrimination.

Involvement in the running of a PCT means that you may be accountable as part of the organisation or in a personal capacity. One outcome of the sinking of the *Marchioness* and the Lyme Regis canoeing disaster is that the courts have confirmed the principle of accountability of organisations by accepting that corporate manslaughter charges can be brought. While that sort of claim is probably unlikely in the context of PCTs, there is other potential for corporate and personal liability. You could be personally and criminally liable for breaches of environmental and health and safety obligations, such as failure to appropriately dispose of clinical waste, inappropriate handling and storage of hazardous substances, and maintenance of medical equipment. Many of these problems can be minimised by adopting risk management measures but PCTs first need to acknowledge that they are accountable, among others, to the Environment Agency and the Health and Safety Executive.

If you look at the wider picture then higher level organisational issues soon come into view. The NHS has, for example, been criticised for a lack of democratic accountability. Local authorities working in

partnership with the NHS often point to the fact that they are far more representative of the public. councillors answer directly to their electorate and are subject to considerable official and public scrutiny. If an electorate disapproves of decisions which have been made, Councillors can lose their political seats at the next election.

By contrast, provider organisations within the NHS have often acted as if they were relatively immune to public opinion. Public attendance at NHS board meetings has been a relatively recent phenomenon while it has been enshrined in local government legislation for many years. While the framework for structures encouraging openness are in place, PCGs and PCTs are going to have to work hard to address this perceived democratic deficit, particularly if the best value, joint working, and partnering arrangements between local government and the health service are to succeed. Pressure from local authorities or the public may, perhaps, result in the widening of the franchise with the introduction of publicly elected board members or an enhanced role for Community Health Councils

By adopting some very practical measures you can allay many fears and reduce the possibility of challenge. You should not be fearful of being open in the way in which you conduct your business. Members of the public should be positively welcomed to board meetings, efforts should be made to become involved in local authority area committees or citizens groups so that the PCG/PCT begins to 'belong' to the community.

So, to go back to the original questions: Whether you like it or not you are accountable. You and your PCG/PCT are accountable to patients and other users of your services, to the general public, and to your PCG or PCT board as well as external organisations, such as the Environment Agency and the Health and Safety Executive. The level and extent of accountability is broad — this article has not even started to tackle the raft of obligations arising from service level agreements within the NHS and legally enforceable contracts between PCTs and private sector organisations. Accountability is set to increase significantly in the near future but it is a challenge which can be met and risks can be managed. So start tackling those issues ... now.

Susie Smith

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Spaced Out

Where is cyber-space? Stop surfing for an instant and the radical nature of cyber-space as a space becomes apparent. Where is this compelling world? In what ways are we accountable to it and it to us? William Gibson, who coined the phrase, called cyber-space a 'consensual hallucination'. Such consensual hallucinatory space has existed before — the medieval world 'knew' that hell physically existed below the earth and that God was in the heavens just as certainly as we 'know' that Yahoo! exists somewhere. But those medieval spaces were extinguished by Newtonian space — a three-dimensional grid that extended to the ends of the universe and admitted no other. Cyber-space opens a door out of this prison and creates a real but non-physical space, an infinity that lies half way between our machines and our heads. Not surprising, then, that cyber-space is occasionally talked of in hushed tones, as somewhere that 'carries the scent of heaven', a place where we can be omniscient, free ourselves from gender and disability, shed the flesh and have a Tree of Knowledge in every living room. For others, cyber-space is where we recreate our own hells of pornography and anonymous garbage. Either way the psychological effects of cyber-space are likely to be as great as any of its economic consequences. We sit at the 'desktop' and peer through our Windows on to this new world and wonder whether the reality beyond the screen will take over. The linear novel is replaced by the tangential leaps of surfing. Inexorable new habits of thought are fostered by the frenetic, fasiculating weave of hyperlinks. And the effects of all this on medicine? Who knows — but watch this space, for cyber-space is moulding how we think just as surely as it extends what we can know.

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Treating relatives and friends: look before you leap!

When confronted by the demanding appeals of relatives or friends, doctors operate at an uncertain boundary between private and professional life. This may have serious consequences, and we start with a personal account.

The second author, then a doctor in hospital training, was approached by a friend and colleague to supervise his wife's pregnancy. Feeling flattered, she consented and agreed to making appointments different from routine. Halfway through the pregnancy she became concerned by the foetus's rate of growth and suggested an ultrasound — initially dismissed by the patient — that showed a fairly small, but not too small, foetus. The mother also arranged an ultrasound elsewhere, with a different doctor with whom she was on friendly terms. Again, no abnormalities were found. The author took this for granted, but shared her concerns about the foetus's growth with her supervisor. He reassured her that her worries were probably owing to the fact that she knew the couple well; this convinced her to take no further action. At birth, the child was too small and had a congenital abnormality that could have been detected by ultrasonography. Neither parent blamed their friend, but her self-reproach focused on her having agreed to supervise a pregnancy on the basis of feeling honoured, deviating from the regular intervals of checkups, refraining from taking action when she had serious concerns with the condition of the foetus, and crossing borders that she would normally not have crossed.

Doctors who treat members of their family or friends often experience disquiet when confronted by similar dilemmas.[1-4] General practitioners are perhaps in a particularly vulnerable position and we decided to survey a sample of 125 experienced GPs, anonymously, for their experiences. The GPs were asked to report, in writing, whether or not they had ever treated relatives or friends. If they had, we invited them to provide details of their experiences, including the consequences, if any, of problems they had encountered. If they had not treated relatives or friends, we asked them what motives, if any, they had for refraining.

Eighty-eight (70.4%) GPs responded, and 20 (22.7%) had never treated friends or relatives. Reasons provided by the latter group were: emotional involvement with an inability to remain objective or to keep a proper distance from the patient, feelings of being affected by personal bonds in evaluating a patient, decisions to keep private life and work life separate, expected difficulties with breaking bad news, and the possibility that any medical mishaps might be reasons for long-lasting reproaches. The main reason for the 68 GPs to treat or have treated relatives or friends was convenience, often described in terms of physical proximity to the other person, or as 'practical reasons'.

Most cases provided by our sample of GPs referred to the treatment of partners and children. Obviously, almost all parents — physicians or not — will look after their ill child, and thus, the boundary between normal considerate behaviour and medical treatment cannot be clearly defined. Moreover, individuals with a doctor as a family member or a close friend, are often in a convenient position to ask advice in case of illness or ailment. Doctors must, however, be prepared to acknowledge and carry the emotional burden, as illustrated by the following event. The spouse of one of our responders complained of increasing pain at a site where previously a tumour had been detected. Her consultant could not explain why she had pain, upon which the patient saw her husband. He felt he could not refuse but was embarrassed at being pushed into the physician role, also because he was unable or unwilling to disclose his — later confirmed — suspicion that the malignancy caused the pain. Evidently, this is where loyalty comes into play.

Another reason for treating family members or friends was 'because they were there' — confronted first-hand by a medical problem, some involvement was almost inevitable. This could be quite demanding, as was true for a responder who felt unable to refuse when a terminally ill, HIV-infected close relative asked him to provide palliative care. Despite his initial hesitations, the doctor's loyalty was great enough for him to give in, which he later regretted.

Doubts about the competence of colleagues was given as yet another reason for treating family members or friends by a minority of responders. One father, for example, changed his daughter's medication, as prescribed by her own GP — the father felt that an alternative agent would be more effective. Similarly, there were statements such as 'I trust my own expertise, and not always that of my colleagues'. Some responders described embarrassment at consulting colleagues, especially at inconvenient hours. One GP's nine-year old child complained of abdominal pains that became worse during the night. He suspected major problems, but felt unhappy phoning a colleague out-of-hours. He waited until early morning before taking the child to a surgeon, who was just in time to perform surgery on an infected appendix. The father indicated that he would have sent other patients, in similar situations, to a surgeon immediately.

The GPs who had treated relatives or friends mainly restricted their activities to minor ailments. This can be problematical when initially minor problems turn out to be

References

1. Schweitzer R. Difficulties in treating one's family. *Aust Fam Phys* 1993; **22:** 1207-1208.
2. Dusdieker LB, Murph JR, Murph WE, Dungy CI. Physicians treating their own childen. *AJDC* 1993; **147:** 146-149.
3. Reagan B, Reagan P, Sinclair A. 'Common sense and a thick hide'. Physicians providing care to their own family members. *Arch Fam Med* 1994; **3:** 599-604.
4. LaPuma J, Stocking CB, LaVoie D, Darling CA. When physicians treat members of their own families. Practices in a community hospital. *N Engl J Med* 1991; **325:** 1290-1294.

Acknowledgement

The authors wish to thank the anonymous GPs for their responses, and the department of General Practice at Erasmus University, Rotterdam for their assistance.

greater than expected. For example, one responder was repeatedly consulted by his spouse, during lunch hours, because of what seemed to be migraine attacks. At first, having little time to see her, he prescribed medication. Her headaches remained and she kept consulting her husband, who became annoyed and eventually referred her to a consultant. She was diagnosed with hyperthyroidism — a diagnosis her husband had missed — and was successfully treated accordingly. The GP decided to refrain from treating family members or friends in future.

Serious role conflicts may occur in cases of unexpected, or expected, problems, as exemplified by the following accounts. A responder was consulted by a friend for seemingly medical reasons, but hesitated to touch upon serious and evident psychological problems. When the friend subsequently committed suicide, feelings of guilt were unavoidable. Another GP treated his asthmatic daughter, who declined his advice to stop smoking. Would she, he wondered, have listened more thoughtfully to a doctor who wasn't also her father? A friend, and patient, of a GP disclosed — over an informal dinner — that she had made arrangements to see an ophthalmologist for double vision. The GP mentioned a neurologist as more appropriate, but left it at that. Inappropriate ophthalmological review led to a three-month delay in treatment of what turned out to be a cerebral aneurysm.

Delivering one's spouse is not uncommon, in the Netherlands at any rate, and little seems more natural when all goes well. The role of the father-to-be, however, may interfere with that of the responsible doctor, which in one of our cases led to a very late referral to a gynaecologist, a post-partum depression, and a near divorce, and in another case to 'groundless anxieties' over the physical status of the newborn baby.

Another potentially dramatic problem may ensue when the doctor unwillingly becomes involved in personal circumstances, as was the case with an unwanted, complicated pregnancy after an extra-marital affair involving a close female friend of a GP. The doctor knew that her husband had been sterilised for years, and felt embarrassed at knowing personal facts that would normally have remained hidden.

In conclusion, we suggest that doctors think twice before treating members of their family, friends, or themselves. In such cases doctors may be unable to practise objectively or rationally. Honourable loyalty to one's friends and relations may be doing them a disservice.

Benno Bonke
Cora Bouman

hilarie bateman

A parable of partnership

'Partnership' is a fashionable concept. We talk of partnership between academics and practitioners, between PCGs and patient representatives, between practitioners and patients, and we are probably all aware of the recent issue of the *BMJ* entirely devoted to 'Embracing patient partnership'.[1]

Recently, my own understanding of partnership was challenged and informed through several long conversations with Professor Carol Herbert (Dean of Medicine at London Ontario, Canada). Carol has considerable experience in setting up and working within partnerships between groups and in recording what we learn from such ventures. Her activities include participatory research, an approach helpfully explained by Macaulay.[2] Macaulay defines the collaboration that lies at the heart of participatory research as a 'partnership among equals with complementary knowledge or expertise'.

Carol told me a story. She said she had attended a review conference on participatory research in North America. A senior and established researcher who had spent years working and researching alongside a native Canadian aboriginal community was there. A representative from the native community was also there. The researcher spoke with force and eloquence about what the native community wanted from research. The representative from the native community then spoke and painted an entirely different picture. The researcher, clearly pained, pointed out that she had spent long years working to help the native community through her research, that she had committed her expertise to their interests, and that she cared passionately about their community. However, the 'distance' between the perspectives of the two individuals remained very public, very strained, and very unsettling.

I'm sure we can all feel for the researcher in this scenario — and equally for the speaker from the native community. Perhaps we are wondering who was 'right'. Was it inevitably the native Canadian aboriginal speaking for her own community or is it possible that the researcher, drawing on research data, could see what those involved within the situation could not? Can a research perspective that is not accepted as authentic and relevant by the community with whom it is associated ever have a validity — or not?

This conundrum may, in itself, have messages for us but, more than this, the story raises issues for me about the nature of a 'healthy' partnership and draws me back to some of the concepts raised within the Macaulay article. The partnership Carol described was not an 'even-handed' arrangement. The researcher appears to have placed herself in the position of 'giver' and 'selfless spokesperson' — but her altruism appears to have come dangerously close to disempowering the very people whose right to contribute as equals could and should have been strengthened through her method of researching. The researcher would seem to have expected a sense of 'indebtedness', 'gratitude', and perhaps even respectful acceptance of her evidence-based conclusions to form part of the bargain inherent in this partnership. One wonders if this was ever made explicit. One wonders if the native community might have felt that any indebtedness and 'respectful acceptance' should, in fact, have operated in quite the opposite direction!

The concept of 'partnership' is indeed fashionable. Embodied within that concept of partnership is a recognition of both the separateness and the equal status of each participant. Carol's story suggests that we need to enter into partnerships with scrupulously 'clear sight'. We need to understand how the account balances for both partners, now and into the future, and to do this we must be prepared to expose and openly discuss the full range of costs, benefits, and expectations involved on each side. We must remain alert to the potential within partnerships to both empower and to effectively disempower those with whom we work. Further, we may need to distinguish between our role and responsibilities within the partnership and our role and responsibilities beyond the partnership. If possible, we need to foresee and negotiate the tensions to which this dual position may give rise. As circumstances change and because our understanding will grow we will need to be prepared to review the foundations of the partnership again and again.

The *BMJ* issue was prefaced by a front cover depicting a couple executing a tango. An interesting choice. What issues must we address to change an effective but temporary working relationship into a sustainable collaborative partnership?

1. *BMJ* 1999; **18 September:** 7212.
2. Macaulay AC, *et al*. Participatory research maximises community and lay involvement. *BMJ* 1999; **319:** 774-778.

Remembering Nelson at Durham — Naval history and evidence-based practice

References
1. Greenhalgh T. Workshops for teaching evidence-based practice. *Evidence-Based Medicine* 1997; **3:** 7-8.
2. Lloyd WEB. *A hundred years of medicine*. 2nd ed. London: Duckworth, 1968.
3. Thomas D. *Cochrane: Britannia's last sea-king*. London: Andre Deutsch, 1978.
4. Cochrane AL. *Effectiveness and efficiency: random reflections on health services*. London: Nuffield Provincial Hospitals Trust, 1972.
5. Howarth D. *Trafalgar: the Nelson touch*. London: Collins, 1969.
6. Price A. *The Eyes of the Fleet*. London: Grafton, 1992.
7. Perrett B. *The Real Hornblower*. London: Arms and Armour Press/Cassell, 1998.
8. Anonymous. *Status Report*. Oxford: NHS R & D Centre for Evidence Based Medicine, 1997.
9. Pocock T. *Remember Nelson: the life of Captain Sir William Hoste*. London: Collins, 1977.
10. O'Brian P. *Master and Commander*. London: Collins, 1970
11. O'Brian P. *The Reverse of the Medal*. London: Collins, 1986.

The Second Northern and Yorkshire Evidence-Based Practice Workshop will be held at the College of St Hild and St Bede, University of Durham from 3–8 September 2000. For further details contact Toby Lipman at: ***toby@tobylipm.demon.co.uk***

Acknowledgements
The workshop steering committee consisted of Antony Franks, Karen Jones, Toby Lipman, Helen MacFarlane, and Tony Roberts. We thank the 18 tutors and 60 participants for their fortitude, enthusiasm, hard work, and failure to bear a grudge.

Background and aims
Week-long evidence-based practice workshops have been held in the UK since 1995, with the aim of introducing participants to the process of self-directed lifelong learning.[1] Most of the work is done in small groups, and at Oxford they used to be named after famous physicians of the past, such as Magendie, Louis, and Bichat,[2] although at the 1999 Oxford workshop they were named after local pubs.

Late one night, a couple of days before the First Northern and Yorkshire Evidence-Based Practice Workshop (College of St Hild and St Bede, Durham, 5–10 September 1999), the organisers realised that they hadn't named the groups yet. Inspiration struck as TL's glance fell from his glass of whisky to a book about Admiral Lord Cochrane, tenth Earl of Dundonald[3] and we decided to name the groups after Nelson and his Royal Navy contemporaries. The name Cochrane is of course intimately linked with the clinical effectiveness movement.[4] Admiral Lord Cochrane was, like his namesake, an inspired leader and innovator, a radical who fought the Admiralty and criticised incompetent senior officers with as much gusto as he fought the French Navy (but with much less success: ultimately his enemies framed him for a stock exchange fraud and engineered his dismissal from the service and imprisonment). But he had the last laugh — after fighting for the liberation of Chile, Peru, Brazil, and Greece, he was reinstated in the Royal Navy, became an admiral, and is buried in Westminster Abbey.

Collingwood was placed before Nelson in our list because he was born in Newcastle upon Tyne, and has lent his name to pubs, streets, a monument at the mouth of the Tyne, a health centre, and a psychiatric clinic. Collingwood's *Royal Sovereign* was also the first into battle at Trafalgar, and there is evidence to suggest that it was his governance of the fleet and critical appraisal of the subsequent storm that reduced the relative risk of sinking among British ships compared with the French and Spanish control group.[5]

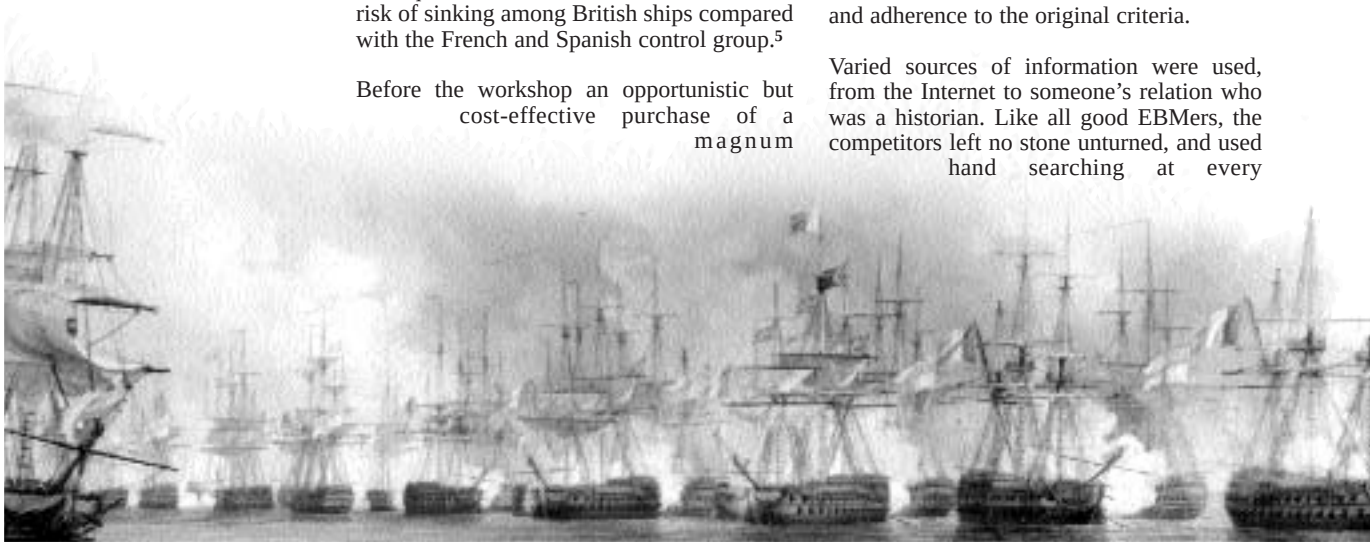
Before the workshop an opportunistic but cost-effective purchase of a magnum of champagne was made. We formulated the structured question: 'Are odds of 8-1 to win a magnum of champagne sufficient inducement for participants in an evidence-based practice workshop to apply their searching skills to British naval history and produce coherent, accurate and valid reports?'

Method
An invitation to enter the competition was placed on the notice board in the college lobby. It set criteria by which the entries would be judged (Box 2).

Qualitative methodology was appropriate to assess the entries. Content and thematic analysis would have been the main tools if there had been time to use them. The lead researcher's bias was made explicit, and AF and HM were also to assess the entries.

Results
Only one group, Pellew, failed to submit an entry, but could have written that Sir Edward Pellew, while commanding the small frigate *Indefatigable*, destroyed the much more powerful French line of battleship *Les Droits de l'Homme* in a famous action in 1797.[6] Pellew, a real historical figure, was placed in a fictional setting in the recent 'Hornblower'[7] series on television, quite unlike Kilgore Trout, a fictional character who works at the Centre for Evidence-Based Medicine.[8] Of the other entries, one was submitted within minutes of the deadline, just before the start of the workshop dinner. KJ had press-ganged HM and AF into clearing the decks for the post-prandial dancing, so they were unable to collaborate in assessing the entries. TR, whose group's entry exceeded the specified word count, attempted to influence TL's independent judgement by having a quiet word, but did not attempt overt bribery. His group, needless to say, did not win. No other group attempted bribery or other unethical research practices, unless you count a few pints in a local hostelry, so TL was obliged to assess the entries on the basis of their merit and adherence to the original criteria.

Varied sources of information were used, from the Internet to someone's relation who was a historian. Like all good EBMers, the competitors left no stone unturned, and used hand searching at every



opportunity. Furtive telephone calls were overheard, in which participants, instead of asking after their families, were demanding information on Troubridge, Hardy, *et al*. One enterprising group found an 1898 edition of the *Encyclopaedia Britannica* gathering dust on shelves above the heads of revellers in a Durham public house. Although they had already drunk several pints of beer, they did not flinch from climbing on the table to retrieve the ancient volumes in order to continue their search. One group discovered the problems facing researchers who use the wrong search term — they initially mistook the name 'Hoste' for the Norwegian word for 'cough' rather than William Hoste, the brilliant protégé of Nelson,[9] which demonstrates that international gatherings have pitfalls as well as pleasures. The entries are summarised in Box 3.

Discussion and conclusions

Seven out of the eight groups that submitted entries found valid and applicable evidence about their eponymous heroes and produced entertaining entries. Even the Hood group discovered Hood's Christian name and then displayed considerable ingenuity in covering up their ignorance about everything else. We concluded, however, that the group that best fulfilled our original criteria of wit, clarity, accuracy, and interest on one side of A4, was Jervis.

When the winner was announced at the beginning of the workshop dinner, another group (who shall be nameless) shouted 'We was robbed — shoot the ref!' We speculated that perhaps they were Newcastle United supporters, too inebriated to distinguish between soccer and EBP. On a more serious note, another group's leader felt that the competition saved them from failing as a learning group, because all members of the group started from the same level of ignorance (unlike their understanding of EBP) and everyone felt equally able to contribute.

We conclude that our question has been answered positively. However, further studies are needed. We also conclude that tutors would be well advised to get to know at least one member of each group, so they can congratulate the winner and sample the champagne.

Toby Lipman, Antony Franks, Karen Jones, Helen MacFarlane, Tony Roberts

Box 1: First Northern and Yorkshire Evidence-Based Practice Workshop, College of St Hild and St Bede, Durham, 5–10 September 1999.

Groups

1. Collingwood	**2.** Nelson	**3.** Hardy	**4.** Hoste	
5. Cochrane	**6.** Hood	**7.** Jervis	**8.** Troubridge	**9.** Pellew

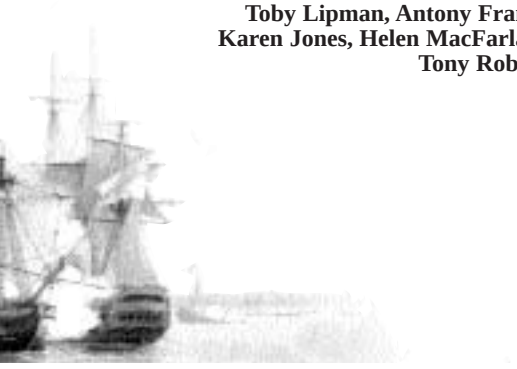
Box 2: Invitation to enter the competition.

You'll have noticed that we have named the groups after famous Royal Navy sea captains of Nelson's time. We are offering a prize — a magnum of champagne — for the group that finds out the most about the person they're group is named after and produces the best account, on one side of A4 paper, of their hero. You may already know lots, or you may have to search for information on the Internet or elsewhere.

When you have printed out your article, pin it to this notice board. We'll announce the winner at the dinner and present the prize then. We'll take into account wit, clarity, accuracy, interest, and also the obscurity of the subject (obviously it's easier to find information on Nelson than on some of the others!) Our decision is final!

Box 3: Summary of results.

1. Collingwood. A bullet list on one side of A4 giving the facts of Collingwood's life and some nice personal details, such as the story of him always carrying acorns to scatter so that there would always be oak trees to build Britain's ships. There was an appendix with the words of Newcastle Royal Grammar School's Song, which mentions Collingwood, an old boy. We liked this one.
2. Nelson. One side of A4 with a portrait of Nelson, a picture of HMS Victory and a reproduction of Nelson's last letter beginning "My dearest beloved Emma, the dear friend of my bosom..." with the name Lipman inexplicably substituted for Emma. Then there was a scatological joke. This would have won if none of the other groups had submitted an entry.
3. Hardy. An abstract entitled 'A retrospective study of Thomas Masterman Hardy 1769–1839'. The authors concluded that there was a triangulated three-tailed relationship between Hardy, Nelson, and Emma Hamilton and that further research was needed on the relationship between Hardy and Emma Hamilton. As the funding body, we didn't buy this one.
4. Hoste. This was hand-written, obviously in haste, after the group had discovered that they were researching a Royal Navy captain, Sir William Hoste, rather than the epidemiology of respiratory disease in Norway. Although accurate, it suffered from rushed preparation.
5. Cochrane. Cochrane's life was presented wittily and accurately in verse, with a good portrait and some interesting footnotes (although we disagree with the widely-held conclusion that Cochrane was the model for C S Forrester's *Hornblower*). Great stuff.
6. Hood. An entertaining attempt, on a sheet of flip chart paper, to demonstrate that Captain Samuel Hood was the father of EBP. This was done by sequences such as: Hood > likelihood ratios (likeli**hood** — geddit?) > diagnostic test > diagnostic code > Morse code > Oxford > David Sackett. Ingenious but sometimes inaccurate (for example, Fred Flintstone's wife is called Wilma, not Thelma). Anyway, it wasn't on one side of A4.
7. Jervis. This was in the form of a newspaper article entitled 'Admiral Jervis — Fascist or Philanthropist: the people decide'. It used quotes from contemporaries appropriately (for example, on Jervis's suppression of the 1797 mutiny: 'The bastard 'ung me man, and all he wanted to do was come 'ome for a while', attributed to Mary O'Reilly, widow of an alleged mutineer). It also gave a fair and accurate account of Jervis's life, and showed that he followed a path of lifelong learning and continued professional development. We loved it.
8. Troubridge. This pointed out some similarities between EBM courses and life in the Royal Navy in the eighteenth century: 'it was a hard and dangerous life and gentlemen had to mix with a scurvy crew'. It revealed that Nelson was known as "the odds 'Ratio" and that Troubridge became an early contributor to the Cochrane Collaboration by marrying Anna Maria Cochrane. We never



The Battle of the Nile, August 1, 1798, at the height of the action. Having led the British fleet round the head of the French line, *Goliath*, her ensign clearly visible, has dropped anchor beside *Conquerant*. To the right the French frigate *Serieuse* is sinking; on the extreme left is the grounded *Culloden* (Troubridge)...

From: *The Real Hornblower: the life and times of Admiral Sir James Gordon, GCB*, by Bryan Perrett, Cassell, 1998, 1-85409-406-8. Illustration: *The Battle of the Nile, 1 August 1798*, by Thomas Whitcombe (1752-1824) courtesy of the National Maritime Museum, Greenwich.

‘Well, here’s another NICE mess you’ve gotten me into ...’

NICE, CHI and the NHS Reforms -
edited by Andrew Miles, John Hampton, and Brian Hurvitz
Aesculapius Medical Press, 2000
PB, 192pp, £19.99, 1 903044 06 5
Available direct from Claudio Melchiorri, Research Dissemination Fellow
UeL Centre for Health Services Research, St Bartholomew’s Hospital, London EC1A 7BE
cmelchiorri@mds.qmw.ac.uk

> *Which of us runs an evidence-based life, anyway? Which of us performed a prospective double-blind randomised controlled trial to evaluate our future spouse?*
>
> Philip D Welsby, Chapter 10

The significant thing about the story of the Emperor’s New Clothes is that the crowd listened to the voice of the little boy. Most of the time crowds don’t listen to little voices. Only when the climate is primed, like a supersaturated solution, does the right catalyst of words precipitate a sudden, overwhelming, and irreversible crystallisation into a new phase of general understanding.

This book could be such a catalyst.

It is the book of the meeting of the same title held at the Royal College of Physicians in London in September 1999, which was ignored — not just by NICE, who withdrew their representatives at the last minute (although we spotted their name on some of the biscuits) — but by both the professional and lay media. Each of the 12 addresses is now updated into a chapter. Together they form the most authoritative and rigorous articulation so far of the intellectual foundations for the feeling so many of us have, and which so many of our patients share, that the present eruption of government-directed, doctor-regulating bodies is profoundly misguided. Twelve clear spotlight beams, converging from different directions. Definitive. Devastating. Demanding an answer.

Here is a taster:

- It would be absurd to be against excellence; but excellence will always be exceptional (that is what excellence means); to promise universal excellence is absurd.
- No one should doubt that knowledge of guidelines is very important; but guidelines deal with Type I complexity; clinicians deal with Types II and III. (Clear diagrams illuminate these crucial concepts.)
- The stated objectives of NICE are mutually incompatible.
- There is no scientific justification for NICE’s usurping of clinical freedom.
- NICE’s programme is impractical, extravagant and time-consuming; its bureaucracy will drive innovation abroad.
- As CHI begins its recruitment process, it may face the paradox that it really needs the individuals who would never apply for a post within it.
- The inspection process has numerous pathologies; for example, ‘… perfect documentation can blind an inspector to what is really going on.’
- The randomised controlled trial cannot determine the best management for individual patients.
- Meta-analysis is unreliable; but it increases the confidence with which authority believes in (and imposes) its mistakes.
- The government was breaking the law when it tried to prevent the NHS prescription of Viagra.

The attitude doctors take to this book is a microcosm of the central question — if doctors feel that the new order is inevitable, or indeed that it has already arrived, then there is no point in them reading it at all, it will only disturb them. If, on the other hand, they believe that they have an absolute duty to weigh up the rights and wrongs of this innovation — i.e. the benefits and the adverse effects of this new treatment — because that is the role expected of them by their patients (in other words, if they are still proper doctors — or even more, if they are ‘excellent’ doctors), then this book is a goldmine — the nearest thing to genuinely required reading that I have ever encountered.

That evidence-based medicine is itself not evidence-based is of course a commonplace; we simply do not know whether the numerous ways in which it may do harm will eventually outweigh its obvious benefits. This book stresses the importance of us trying to find out. It also suggests that this is not by any means the only way in which the current orthodoxy departs from science and logic, in spite of the irony that the current orthodoxy rests its authority so ostentatiously on science and logic. As Bruce Charlton says of meta-analysis in his chapter, ‘It is embarrassing for those who understand statistics and clinical medicine to contemplate the innocent enthusiasm of its supporters, and profoundly worrying that their armour-plated credulity has become the orthodoxy among politicians and managers.’

If the EBM movement wants to counter claims that it is underdressed it must welcome rigorous questioning and testing; that is the way of science. This book should be welcomed as a vital contribution to that process and the many questions it raises must be effectively answered.

James Willis

The Human Effect in Medicine: Theory, research, practice
Michael Dixon, Kieran Sweeney
Radcliffe Medical Press, 2000
PB, 157pp, £17.95, 1 85775 369 0

General practice is under attack. We had our backs to the wall long before the Shipman tragedy and have been fighting a rearguard action in defence of the skills of generalists against the knowledge of specialists and their primacy in the evidence-based medicine game. The evidence-based medicine movement is now being politicised through the documents that are emerging from the Department of Health to direct the formation of primary care groups. GPs are therefore at risk of surrendering the complexities and uncertainties of real general practice to the directives of scientific objectivity. This book thrusts a sturdy sword into our grasp in the form of a firm assertion of the value of the consultation as the 'specialist' skill of general practice.

The book's thesis is that, in the current context, medical practice is in danger of losing its ability to engage the self-healing powers of the patient in relation to the healing powers of the doctor *qua* doctor. This is a serious problem. Firstly, modern technology cannot help with the ills of modern life — such as loneliness or unhappiness — and it is being used inappropriately and causing greater anxiety to the worried well, such as those who may wait six months for an MRI scan for reassurance about their simple headaches. Secondly, technology is costly and is becoming increasingly unaffordable under the cash-strapped NHS. It is time, the authors argue, to rediscover and apply the real benefits of the placebo effect: their vision is that GPs and patients will 'recognise and regain their therapeutic potential'.

The book is divided into three sections. The first (by Kieran Sweeney) is a critique of the scientific nature of medical practice, challenging its historical basis and reviewing research (including that of Balint) on the ways in which the 'human' factors can influence disease. The conclusion here is that the quality of the personal interaction between two people, and in particular, between doctor and patient, can have important implications for health. Sweeney extends this conclusion to argue that continuity of care — up until recently a bedrock of general practice — is also important for the human effect to work. The research here is less certain and one might criticise this conclusion by looking at the results of homeopathic practitioners who can achieve results with a first-time patient in a single, albeit lengthy, consultation.

The second part of the book is a fascinating review by Michael Dixon on how, why, and in what circumstances placebos — and the placebo effect of the doctor–healer — work. He challenges our assumption, which is based on our own suspicion of the placebo effect, that placebos are only effective with neurotic and demanding patients — our 'heartsinks'. On the contrary, if we are to use the healing powers of the placebo intelligently, the research would suggest that we should focus on our 'normal' rather than 'neurotic' patients: the important variables are the attitude and motivation of the patient. In Part Three, Dixon moves on to some practical advice about how GPs can become more effective consulters and, by implication, healers.

I would challenge the view that what the authors describe is a 'new medicine' — is that New Labour, New Medicine? They themselves see this exposition as a 'rediscovery' of a very old medicine and we should perhaps stick with that. It is also interesting that, having challenged the scientific basis for medicine in part one, Dixon feels the need to soothe the scientifically-minded medical reader with the notion that it might be possible to 'measure' empathy by looking at the degree of synchronisation between patient's and doctor's EEGs. A horrible thought. Despite these minor points, the book puts forward a convincing argument for a refocusing on the power of human interaction in general practice and will appeal to many, not just GPs, working in primary care. It is an important contribution to the literature on the nature of modern general practice confirming that what it can offer is (in the authors' words) 'more than a soup kitchen for evidence-based medicine'.

Jane Macnaughton

An Intimate Loneliness: Supporting Bereaved Parents and Siblings
Gordon Riches, Pam Dawson
Open University Press, 2000
PB, 220pp, £17.99, 0 335 19972 0

This book is one in a series entitled 'Facing Death' published by Open University Press, and deals with grief and bereavement following the death of a child. It is firmly grounded in sociology.

The introduction sets the scene and explains the contents of the book. Then follow chapters dealing with the concepts and principles underlying bereavement: parental grief; sibling loss; grief responses; problems when the death has been more 'unusual', e.g. sudden, violent or inexplicable; what can be done to help; and finally a chapter drawing matters to a conclusion. Each chapter has a summary at the end.

The approach to this difficult subject is to be commended. The structure is well thought out and it is very clearly and logically organised. Each summary forms a neat straightforward précis of the individual chapter content.

Many aspects of the content deserve mention. I would single out especially the chapter dealing with 'unusual deaths'. Though some of these deaths might be very infrequent and perhaps never encountered by most general practitioners the sections on miscarriage and stillbirth are very pertinent. However I would have liked considerably more than the half page devoted to grief following termination which is a particularly difficult area. The final chapter on how to help is extremely useful.

I must confess that I had some difficulty with the language in which this book is written. It seemed very unemotional for what is such a distressing issue. Initially, I found it quite hard going, I struggled with the dry, somewhat dispassionate, sociological terminology and to be honest, found it rather irritating. However, as I progressed through the logical path the book takes, and as I began to more fully understand the language, I found it increasingly satisfying. Quite often there was a sense of validation for the feelings that I already had for particular issues, but perhaps hadn't quite thought through.

It was interesting and very educational to read such a clear and lucid work written from what for me is an alternative, sociological view. More importantly, I have already found it useful in general practice. The death of a 'child' is more common than I'd realised — 'children' can be quite old when they die.

I would commend this book to GPs, even if they were to only read the introduction, chapter summaries, and conclusion. However the whole book will help the practitioner to obtain a much deeper awareness of the issues surrounding death in children — and also perhaps serve as an introduction to sociology!

Euan Paterson

Graduated Extinction

[S]ome behavioural treatments, such as extinction (leaving the child to cry)…can be distressing…for some parents….[G]raduated extinction produced a benefit….[1]

Even should the screaming stop,
its imprint will disfigure your former childhood crassly.
Violence sings her shattering note,
lust throbs, and you drive
to the edge you would never see.
Thus tightening your grip,
you crank the pitch
and face the chasm ropeless. Beware.
Your bundle — no more of joy —
has weight.

Blair H Smith

Reference
1. Ramchandani P, Wiggs L, Webb V, Stores G. A systematic review of treatments for settling problems and night waking in young children. *BMJ* 2000; **320:** 209-213.

Men's Health:
Perspectives, diversity and paradox
Mike Luck, Margaret Bamford, Peter Williamson
Blackwell Science, 2000
PB, 288pp, £18.99, 0 632 05288 0

Men's Health
Edited by **Roger S Kirby, Michael G Kirby, Riad N Farah**
ISIS Medical Media, 1999
HB, 280pp, £39.95, 1 899066 92 6

The health of men has been a blind spot in health care until recently. The Fourth National Morbidity Study indicates a huge fall-off in GP attendances for men in their teen and middle years. Aggressive, heterosexual manliness may be linked to the rejection of health behaviours and indeed in help-seeking.

The book by Luck, Bamford and Williamson, examines how men maintain their health and how they seek help. It explores national and local policies and also examines what little international data is available. The book reveals what they call 'gender insensitivity', and indeed gender blindness. The collection of data is routinely linked to gender but the analysis of such data from the male perspective is generally shallow and uninformative. The authors repeatedly advocate a qualitative approach to explore such factors as attitudes to risk which may tell us a great deal about men's lifestyles.

They do feel that men can change, especially younger men. A number of local initiatives are described but their sustainability is at risk because of underfunding and relative non-interest among men and healthcare providers. The clinical approach to men's health has tended to focus on diseases of the prostate and testes and has tended to ignore the psychosocial aspects of men within modern society. The authors provide compelling evidence to show that research in men's health lags significantly behind that of women's.

This book is provocative, lively, and is an essential starting point for those wishing to research men's health. It will also be of use to postgraduates in general practice, public health, and the social services who wish to look behind the myth of the 'real man'.

Kirby and Farah's volume is a beautifully produced joint US/UK venture which will be of interest to general practitioners providing clinical care for men. It also includes a section on setting up a 'wellman' clinic in primary care and provides a template for such a clinic. We are fortunate in having such books about men's health available to us in general practice. Now if only the men would turn up …

Shaping Tomorrow: Issues facing general practice in the new millennium
Chris Milhill
BMA General Practitioners Committee, 2000
http://web.bma.org.uk/gpc.nsf/webdocsvw/Shaping

Tom O'Dowd

What do patients want when they visit their GP? What kind of service do GPs want to provide? What should general practice become? In a document recently delivered through your letterbox, Chris Milhill has drawn together the views of a large number of contributors on these and related questions. The intention is to 'provoke and inform a process of debate which will show us the way ahead for British general practice'.

As a summary of the issues that are most discussed by GPs at the start of the new millennium, the book is comprehensive and interesting: continuity of care, accessibility, career paths, patient demand, multi-disciplinary teams, NHS direct, walk-in centres, independent contractor status, primary care groups, funding, the gatekeeper role, quality of care, partnership working … the issues feel familiar but there is a refreshing diversity of opinion captured, with traditional and iconoclastic viewpoints expressed vigorously and sometimes bluntly. I was pleasantly surprised that, through this process, considerable common ground is uncovered.

As a result I have a better grasp of the implications of how we do what we do. But what is it that we do that is so special and unique? *Shaping Tomorrow* sheds light on this by grounding opinions in current issues. While this has its advantages, I was left with an uncomfortable sense of professional parochialism. Which of these will seem important in a decade? Are any considered to be important by patients?

I was disappointed that the question of what is important to our patients was relegated to the last chapter. Numerous commentators contrasted wants with needs. Only five of the one hundred plus contributors; however, actually represented patients themselves.

Despite a chapter dedicated to 'Future Pressures', I have not been left with a strategic vision of the role of primary health care in 21st century society. In an interconnected digital world with a globalised free market economy and immense worldwide inequalities in health and wealth, how and in what form will our core values survive?

Shaping Tomorrow is a useful and readable synthesis of professional opinion on current issues. It is however more about today than about tomorrow. I will hope for a far broader vision for the future to emerge from the arising debate.

Plus ça change — or why reading about the history of medical education is good for you ...

'There is not a more difficult problem in the world than the education for a particular profession.'[1] Thus wrote Dr PM Latham, retired physician from St Bartholomew's Hospital, in the mid-nineteenth century.

Change and pressure to change were features of the last decades of the twentieth century, and no doubt this trend will continue in the first decades of the new century. Certainly medical education, both undergraduate and postgraduate, is in a state of flux, with discussion around continuing professional development and revalidation among qualified doctors, and the upheaval in medical schools resulting from the GMC's document, *Tomorrow's Doctors*.[2]

The necessity to change, to produce doctors capable of lifelong learning and with the knowledge and skills to practise in the twenty-first century, should be an opportunity for innovation, and possibly risk-taking. However, as with most things, developments that seem new and radical, are often recycled ideas from previous eras — think flares and disco, left-wing ideology in the Labour party, early patient contact, and community-based teaching of medical students. Therefore, a study of old journals and books is useful to provoke ideas and gain ammunition for debate.

Reading through such old medical journals and textbooks you come across similar arguments, appreciative voices, and condemnatory writings that echo the medical literature of the last few years. For example, medical students now meet 'real' patients almost as soon as they arrive at university. This is deemed to be a good thing: the end to the traditional pre-clinical/clinical divide. Latham suggested this nearly one and a half centuries ago. He recounts the story of two prize-winning medical students who, on graduation, 'begged to be told how they were to learn their profession'. In three years of lectures they, and their peers, neglected the wards. Each scientist who taught medical students, in Latham's opinion, thought that the students needed all his knowledge but 'none are helped to become good practitioners by this discipline … those who, having gone through it, turn out good practitioners nevertheless, become such in spite of it'. Latham suggested that students should go onto the wards as soon as they started their studies and should learn by the observation of diseases first rather than the theory behind them. The lectures could be given at a later stage when the student 'from such experience as he has, can exercise some judgement upon the subject matter of what he hears'.[1]

Latham was going against the establishment. The prevailing view was similar to that of Johnson, who warned the students of Edinburgh in 1792 not to attend hospital rounds until they had acquired a theoretical knowledge of the most frequent diseases and were familiar with the general principles of medical practice.[3] Even Platt, writing a hundred years later than Latham, while acknowledging the problems resulting from lack of patient contact, suggested more rather than less pre-clinical science teaching. Platt wrote in 1965: 'The students I enjoy teaching most are those who, after two or three years of university education, are confronted for the first time by a real patient … the first staggering fact about medical education is that after two and a half years of being taught on the assumption that everyone is the same, the student has to find out for himself that everyone is different, which is really what his experience has taught him since infancy.'[4] He then advocated the need to introduce the behavioural sciences into the early part of the undergraduate curriculum rather than patients.

So early patient contact is not innovative; it is an old idea recycled, and the arguments against it are also similar. Reading about the history of medical education prepares one for debate: the same objections are met again and again.

Another modern trend is the increasing amount of core knowledge and skills that are being learnt by medical students in the community, particularly in primary care settings and with general practitioner tutors. The GMC states that students should have acquired a knowledge and understanding of 'how disease presents in patients of all ages' and 'the environmental and social determinants of disease'.[2] Again this idea has been suggested before. That clinical training took place predominantly in hospital was a state of affairs lamented by Sir James MacKenzie, physician to the West End Hospital for Nervous Diseases, 80 years ago. In his book, *The Future of Medicine*,[5] he suggested that students should spend more of their training in general practice in order to have the opportunity 'of seeing disease in all its phases, and of observing the symptoms it produces'. In the hospital setting 'it is manifest that neither the laboratory worker nor the hospital physician … have this opportunity. The early stages of diseases are, as a rule, insidious … The patient becoming conscious that there is something amiss with him, does not, as a rule, seek help from the hospital physician, but from his family doctor.' Thus, 'to achieve the aim of medicine, it is necessary to recognise disease, and to understand all the phases of its life history, it is evident that only one class of individual has the opportunity for acquiring this knowledge, and he is the general practitioner'.

The concept of community-based teaching was a long time in gestation. Writing in the *British Medical Journal* in 1965, Hunter[6] advocated hospitals as the best environment for learning medicine. He was dismissive of general practitioners, much of whose 'time is spent in dealing with trivial problems … they can spend long periods almost in technical idleness before meeting an emergency which may tax their resources to the limits'. I have heard similar sentiments expressed in teaching hospitals in the last five years.

I read to understand all the arguments: the majority both for and against are based on gut feeling and prejudice. Now is the time for medical educators to evaluate change to see if such 'innovations' as early patient contact and community-based teaching do make a difference to the calibre of doctors our medical schools produce.

Jill Thistlethwaite

References

1. Latham PM. A word or two on medical education and a hint for those who think it needs reforming. *BMJ* 1864; **I:** 141-143 (February 6).
2. General Medical Council. *Tomorrow's doctors*. London: GMC, 1993.
3. Johnson I. *A guide for gentlemen studying medicine at the University of Edinburgh*. London: Robinson, 1792.
4. Platt R. Thoughts on teaching medicine. *BMJ* 1965; **(ii):** 551-552.
5. Mackenzie J. *The future of medicine*. Oxford: Oxford University Press, 1919.
6. Hunter A. Medical education and medical practice. *BMJ* 1965; **(ii):** 552-557.

uk council, march 25, 2000

College Constitution
Council Executive Committee had discussed the proposal for constitutional change and agreed an incremental way forward. This was recommended to Council in the following terms:

- Reviewing the existing constitutional structure to examine the scope for creating more autonomous Councils for Scotland and Wales (based on the existing Councils). There might also be scope for creating bodies (which might not be Councils because of limitations in the constitution) for Northern Ireland and England.
- Examining the options and possibilities for geographical representation and grouping for England by means of the proposed one-day Conference of English Faculties in May or June 2000. The date for that event has still to be identified.
- Exploring ways in which the culture of exchange and interchange of ideas and policy developments between the existing Scottish and Welsh Councils and UK Council can be improved. It is likely that the Chairmen of the Councils will meet periodically and that when and if similar bodies are in place for Northern Ireland and England, the relevant Chairman will be included in those meetings.

Access to General Practice
Mike Pringle's paper, which is relevant to England, Wales, and Northern Ireland, was discussed by Council. The paper examines the types of primary care services and the various dichotomies that arise; not least that between personal doctoring, continuity of care, and the demands (as expressed by Government) for rapid 24-hour access. The paper goes on to propose standards of access to general practice

The position in Scotland is different, as outlined in a paper from the Chairman of Scottish Council, Colin Hunter. Scotland has, as yet, no NHS Direct and no Walk-In Centres and there are of course issues relating to access in remote and rural areas.

Council was grateful for the papers having identified the dilemmas of access but was cautious about being prescriptive about standards or aspirations on access given the wide variety of circumstances in which GPs work in terms of organisation, geography, and resources. The debate took place in anticipation of the continuing debate the College will have with Government on the *Modernising the NHS* agenda (see below). With this in mind, Council decided to develop the arguments on access more fully over a longer period.

The Shipman Inquiry
I reported to Council about the impact that the Shipman Inquiry will have on our work. We are doing as much preparation as we can as the inquiry is of vital importance to the College and all GPs. I shall be calling on members to assist in preparing evidence for the Inquiry. I expect some of the timescales for submitting evidence to be short.

Modernising the NHS
Council heard from Mike Pringle about the rapid developments the previous week of the Government's agenda for modernising the NHS. This will have a major impact on GPs, the College, its members, and others who work in primary care.The RCGP response is posted at **www.rcgp.org.uk** and comments and suggestions can be e-mailed to **comments@rcgp.org.uk**

Joint Hospital Visiting (JHV): Motions from Mersey Faculty
Chairman of Education, Has Joshi, reported to Council on the problems faced by the English Hospital Recognition Committee. Funding difficulties for this Committee and the fact that this is a service by the College to the NHS had led to the recommendation that NHS Trusts should be charged for the cost of visit. Work is in hand to introduce those arrangements. Work is also planned to centralise the administration of the process, as for many faculties this represents a major burden of work.

This report was debated alongside two motions for Mersey faculty: one proposing that College funding of JHV should cease as no other College met the cost of this work, and a second proposing that the administration of the JHV process should be centralised as it was putting a major burden on the Faculties. In the debate it was noted that the College was committed to providing the service in the coming year and that it represented an element in the overall quality assurance of GPs. It was also noted that NHS trust funding could only be a short-term solution. Further, some faculties had already arranged for the cost of the process to be offset by contributions from their local trusts.

Accordingly, Council agreed that the proposal to plan the administration on a centralised basis should continue but consideration should be given to local arrangements which worked well. The short-term funding proposals were also agreed as the best way forward, allowing discussion on a longer term solution to be developed.

Mental Health Act Reform
The College's response to the proposed reforms of the Mental Health Act 1983 was the subject of a paper which I presented to Council. One of the main concerns of our response is the lack of recognition for primary care in treating and caring for patients with mental health problems. In our response we also draw links with the National Service Framework for mental health. It appears to me that the Government has not integrated these two documents sufficiently. Our response will be submitted to comply with the closing date of 31 March 2000.

Mental Health National Service Framework (NSF)
Vice-Chairman Mayur Lakhani reported that we are still receiving contributions to the impact of the Mental Health NSF on general practitioners. A further report will come to June Council. The Mental Health Task Group is keen to support members in practical ways, not least in providing a forum on the impacts of the NSF. This can be achieved as a 'virtual' exercise by using the re-launched College Website for the purpose. There is the prospect of attracting funding for a conference to discuss the impacts of the NSFs generally on general practice. Additionally, a **Coronary Heart Disease National Service Framework** was published at the beginning of March and, as far as primary care is concerned, the aims are reducing heart disease in the population; prevention of coronary heart disease in high risk patients in primary care; management of stable angina and heart failure; and cardiac rehabilitation. I will be looking at the impacts on primary care in a similar way to the mental health NSF.

Racial Discrimination in General Practice
As I reported to you after the last Council Executive Committee meeting, an action schedule for tackling racial discrimination

issues was considered by Council in September and I brought back to Council a progress report. The College has a programme of work here and wants to involve and engage members as well at tackling issues at headquarters level. The responses from faculties to a letter from Vice-Chairman Paul Davis were referred to and this pointed to the need for greater communication and dialogue on these issues as well as finding ways to engage College members at large.

Council noted the report and agreed that it should be taken forward on the basis of the wider themes of equal opportunities and valuing diversity. This work will continue to attract high priority with training provision for racism awareness and we will continue the work to the extent that our resources allow.

Quality Team Development (QTD)
Chairman of the Assessment Network, David Haslam, reported to Council with the new criteria for Quality Team Development. As you may know, QTD is an initiative that aims to help primary care groups and primary care trusts assess the performance of the primary health care teams and plan their development.

Reciprocity of Qualifications
Philip Evans, Chairman of the International Committee, reported with recommendations from his Committee and Council Executive Committee that College should not develop criteria for reciprocity of qualifications worldwide, owing to complexity of the process and the implications for resources. Instead it was proposed to develop mutual agreements between the College and similar academic organisations overseas covering, for example, attendance at educational meetings, course and conferences, the availability of library and other facilities.

Corresponding Associates
This paper from Vice-Chairman Paul Davis proposed the freezing of the grade of membership Corresponding Associate. This grade was introduced to enable practitioners with overseas qualifications who do not fulfil the criteria for associateship to become corresponding associates. The grade confers the same rights and privileges as Associates but these doctors are not admitted as members of the College. This grade has only attracted 16 members and with a need to review a number of aspects of membership, it was agreed to freeze admission to this grade but allow the existing Corresponding Associates to remain until they relinquished this form of membership. Amendments to College Ordinances and Bye-laws will be needed and will be brought forward in due course.

Date of Next Meeting
Friday 16 June, at 9.00am at Princes Gate.

Maureen Baker

neville goodman

Irony

'And isn't it ironic?', sang Alanis Morrisette. I don't know the song well enough, but irony is tricky. The familiar and usually correctly understood form of irony is when language is used to signify the opposite meaning. It may be intended as humorous (a slip of the surgeon's knife provoking the anaesthetist's comment, 'Well, it's a good way to check the blood pressure'). This slips into ironic understatement ('It would probably have been better if you hadn't done that') but one person's irony is another's sarcasm. The British constantly taunt Americans that this form of irony is lost on them because of the American tendency to take things too literally. It might also explain why, to Britons, so many American TV comedies seem to be too obviously trying to be funny.

But when you ask, 'Isn't it ironic?', that is a different form of irony. It's when something unexpectedly and contrarily unfortunate happens. During the FA Cup semi-final between Aston Villa and Bolton Wanderers, the commentator said it was ironic that the last time each of these teams played in the Cup Final they had played Manchester United. That was coincidence, not irony. When a skiing commentator said it was ironic that a Norwegian skier won the giant slalom on a course designed by the Norwegian trainer, some may have wondered whether more than mere coincidence was at work. Irony, on the other hand, would be all the Norwegian skiers failing to complete the course.

We're used to irony in the NHS. It's ironic that NHS Direct, intended to put GPs in their place and show them modern health care, has increased the workload as telephone advisers look up the algorithm and say, 'Go and see your GP.' It's ironic that, two years after Clinical Governance was introduced to improve quality in the NHS, large sections of the NHS are unable to do anything at all because there aren't the beds to do it in. It's a constant irony, easy to understand but impossible for politicians to acknowledge, that improving access to an item of health care merely increases demand. A future irony will be the hours of work of present-day trainees when they find themselves consultants.

Irony should not, of course, be mistaken for ironing, which someone famously described as having been invented to give the brain something to do while watching television.

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Liam Farrell's seminal analysis of cats will enliven Spring Symposium 2001, in Belfast

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liam farrell

Aunties

When I was a lad we had lots of aunties, all of them fanatically devout. On one occasion, my Auntie Susie returned from pilgrimage and brought back, as A Present From Religious-Bigots-Ville, a little three-legged tea-stand. In rural Ireland, most of our lives were spent in the kitchen and the present was, accordingly, displayed there to all the family, plus assembled hangers-on, plus other aunties. We had a colossal family circle that was in a constant dynamic equilibrium: people coming, people going, babies being born, grannies dying, young people emigrating or losing body parts in farm accidents.

The little tea-stand received general approval, even from the usually viciously critical other aunts. This was unusual, as my aunts were committed Luddites, but perhaps they were seduced by the picture on the base of St. Luke removing a sebaceous cyst from the Good Samaritan's armpit, and also the tea-stand had irrefutable qualities of both practicality (the table cloth and table would not be singed), and of presentation (the teapot would at last have its rightful place at the top of the table, and now especially set upon a throne which originated in Religious-Bigots-Ville).

The friends, relatives, and aunts accordingly assembled in their accustomed places around the kitchen table, hundreds of them to my child's eye, and the table appeared as big as a football field, which is not as great an exaggeration as you might think, as in those days football pitches were rather small and distressingly full of cows and cow dung.

And then someone had an idea which seemed appropriate, if devastatingly lacking in originality: 'Let's have a cup of tea'.

Our teapot held about ten gallons and took three people to carry. Despite this size it had a seemingly magical quality in that it never ran out, no matter how thirsty the residents, no matter how many visitors might arrive at the last moment, aching for succour; there was always enough tea in that teapot, and so there was a vague ceremonial air as it was set upon the little tea-stand, a bit like you British guys getting knighted, I reckon.

For one brief glorious moment it perched there, a moment long enough to catch a glint of the sun's rays through the kitchen window. Our kitchen was subterranean, and this golden moment was redolent of Druids and Winter Solstices and meticulously plotted prehistoric maths and fleetingly sunlit tombs. Then the laws of physics, which had briefly nodded off, perhaps enchanted by the earth-power, reasserted themselves and realised that the whole structure was about as unstable as a sack of plutonium being flogged to Japan by Sellafield.

One of the legs of the tea-stand buckled and the teapot toppled over, exploding onto the table. A tidal wave of hot tea surged across the table and down onto the laps of those clustered closest around it; as my aunties were most senior in the hierarchy, they always had pride of place sitting in close to the table, the rest of us palely loitering round the door and leaning on the side-board. This usually meant they had first choice of whatever delicacy was on offer, invariably fresh bread and scones and a better vantage position to dominate whatever bitter and divisive family argument was in progress, but on this day it proved to be an unlucky choice.

Boy, it was funny — those aunts could move quick when they wanted to; pain is a great motivator, especially when it's your own.

The doctor, a man of great serenity, was called and I shall always remember his considered advice, an object lesson in the practicalities of preventative medicine, 'I don't think you should use that tea-stand anymore'.