The British Journal of General Practice

## Viewpoint

**'Up to 1000 specialist GPs will be created'**
I wonder whether you found this statement from the National Plan as confusing as I did. I chose to be a specialist — in general practice.

The perception, predominantly Germanic, that general practice is merely the sum of medical specialties spread thinly, finds echoes in the National Plan envisaging 1000 specialist GPs taking referrals from fellow GPs. The implication is that specialist GPs will be superior to those who provide family medicine and presumably should be paid more. Perhaps this is a career progression?

Another area where multidisciplinary intermediate care GPs may have an extended role is in the envisaged 'rapid response teams, providing emergency care for people at home'.

At the other end of primary care it is stated that the 'pressure on GPs will be eased as nurses take on more tasks, making and receiving referrals, ordering investigations and diagnostic tests, running clinics, and prescribing drugs'. Elsewhere it has been proposed that 'super-nurses' could take over from GPs if necessary. However, these super-nurses will never be treated as co-equals in family medicine — by patients, if not by professionals. Financial proximity may occur and the standing of nurses may be enhanced but nurses are nurses and doctors are doctors. Equally, if the new specialist GPs believe that they can approach the status and earning potential of consultant colleagues then I can assure them this is not true. Just as nurses remain nurses, GPs remain GPs.

As well as being a GP, I am also a part-time consultant in primary care with my local Trust. After six years it is obvious that, to the other consultants, I remain a GP. I am not considered for nomination as a consultant representative on committees but can contribute as a GP. Applications for discretionary points or a distinction award were not even acknowledged by my Trust or the DoH. Vice-Chairmen of other Royal Colleges would receive an 'A' merit award. GPs who imagine that their professional standing may be enhanced by becoming a 'specialist GP' should reconsider.

We are told that the pressures in general practice can be solved by super-nurses. I believe this will undermine and trivialise the specialism. On the other hand we can extend our expertise by becoming 'super-GPs', accepting the cast-off duties of consultant colleagues. Both contrive to marginalise, destabilise, and debase the specialism of general practice and the professional standing and financial stability of the practitioners.

Only a government that really does not understand general practice could suggest such reforms. To them we are just coughs-and-colds pill-pushers, self-interested moaners who fail to offer the service the middle class demand. The case for effective generalism is overwhelming, on medical and health economical grounds. It becomes ever more overwhelming as our specialist colleagues produce sub-specialists and sub-sub-specialists, like a Russian doll. The Government has failed to notice that, when admirers abroad try to copy bits of the UK healthcare model, it is the primary care bit they copy. To the authors of the NHS Plan, a GP who can juggle an endoscope is more admirable than the traditional model. Such myopia threatens general practice with extinction within a decade, and with it, nationalised healthcare.

The National Plan contains the seeds for the potential destruction of general practice unless the Government will acknowledge that primary care is the 'jewel in the crown of the NHS' and act accordingly. Promotion, support, understanding, and resources — both financial and more importantly human resources — are needed, coupled with the political will for general practice to flourish.

Will 1000 specialist GPs help?

**Paul Davis**

## The Back Pages...

**"... my taping days came to an abrupt end. The practice manager announced that, having discussed it with the partners in the practice, it was not suitable for me to videotape consultations as they feared it would slow me down! (This happened as I finished the morning surgery on time, having seen about 25 patients.)"**

Nancy Loader prepares for the MRCGP in trying circumstances ... page 934

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**Guidelines on science and health communication**

It is probably impossible to calculate how much of general practitioners' time is spent dealing with the consequences of unfounded health scare stories and 'miracle cure' reports in the media. However, all GPs are aware of the damage caused by irresponsible reporting on health issues, and the publication of the new *Guidelines on Science and Health Communication*, which aim to prevent such misleading reports, has been welcomed by the RCGP and other professional bodies.

The guidelines were developed by the Social Issues Research Centre and the Royal Institution, in consultation with a forum of scientists, journalists, and doctors — including representatives of the RCGP, the Royal Society of Medicine, and the Royal College of Surgeons. The guidelines provide advice to both journalists and scientists, who share equal responsibility for ensuring accurate and unbiased reporting of research findings.

The SIRC/RI guidelines include a basic rule-of-thumb test to help scientists and journalists judge the potential effects of their reports, as well as more detailed guidance on responsible communication of health risks and medical advances. The rule-of-thumb asks scientists or journalists about to release a report about a potential health risk or potential cure to imagine what effect the story could have on a relative or close friend who is sensitive or vulnerable to such information — a parent with cancer, for example, or a friend on the Pill.

The guidelines recommend that journalists and scientists should always state any limitations or caveats clearly, preferably within the first few lines of a report or press release — particularly where findings are preliminary; have not been peer-reviewed; have not been replicated; differ markedly from previous findings; are based on small, unrepresentative or animal samples; or have found only a statistical correlation. When reporting on potential health risks, scientists and journalists should always cite 'absolute' rather than 'relative' risks. When reporting on medical advances, the limitations of any new treatment, procedure or product should be stated very early and prominently in the report.

Lord Wakeham, Chairman of the Press Complaints Commission, welcomed the publication of guidelines as they underlined the importance of the PCC rules in regard to reporting of scientific and medical stories. He also urge those directly involved in these matters who are aware of inaccuracies in newspapers to ensure that they lodge a complaint so that the PCC can deal with it.

**Kate Fox**

**Adolescent Working Party**

The RCGP Adolescent Working Party will be holding two conferences in November.

The first conference will be on Thursday 30 November at Princes Gate and entitled 'Confidentiality and Adolescent Health'. It will feature the launch of the tool kit, *Confidentiality and Young People*; this publication, produced by the RCGP and Brook, and published by the Teenage Pregnancy Unit, aims to encourage primary care teams to reassess their practice policy on confidentiality. Dr Pat Troop, the Deputy Chief Medical Officer, will give the opening address and the Teenage Pregnancy Unit and the Working Party chairman will be in attendance. Other topics for discussion will include 'Risk-taking in Sex' 'Mental Health', 'Chronic Conditions and Confidentiality' and 'Teenage-friendly Practice'. Speakers will include Dr Ann McPherson, Dr Ruth Chambers, Dr Dick Churchill, Dr Aiden McFarlane and Dr Chris Donovan.

The second conference, entitled 'Measuring Adolescent Care in General Practice: Successes, Pitfalls and Problems', will be on Tuesday 21 November in the Atrium at the Royal Free Hospital. Academic departments from Cardiff, Hertfordshire and Nottingham will present the details of this successful project during the morning session, followed in the afternoon by a discussion of some of the less orthodox examples of GPs' attempts at measuring adolescent care.

The latter conference has been organised by the RCGP Working Party Research Committee and the Department of Paediatrics and Community Health of the Royal Free Hospital in London. PGEA approval has been sought for both conferences and charges have been kept to a minimum.

Further details are available from Kathleen Dyer at the RCGP (tel: 020 7581 3232; e-mail: **kdyer@rcgp.org.uk**) or from Pat Gussetti, Department of Paedatrics, Royal Free Hospital, London NW3; tel: 0207 830 2288.

Both conferences should be of interest to GPs concerned about young people's health and the services available to adolescents.

**Chris Donovan**

**Society of Expert Witnesses**

General practitioners are in demand as expert witnesses. However, top professional skills do not necessary go hand-in-hand with the best expert witness skills: this is where membership of the Society of Expert Witnesses can be of benefit.

The SEW is dedicated to providing relevant services that will help anyone involved in expert witness work. As a non-profit making society it provides a range of services for for both novice and experienced expert witness for a modest annual membership fee.

Members can call the Society's helpline, which provides access to a voluntary panel of experts offering members practical support on the professional, legal and business aspects of providing expert witness services.

Every Society member is entitled to a free listing on the Society's website on request, and the Society's free mentor scheme places new members with experienced ones. This is far more valuable and practical than a training course, providing one-to-one guidance.

Twice a year the Society organises a low cost conference, offering expert witnesses from all disciplines the opportunity to polish up their skills, network, and learn from each other.

All members receive the Society's quarterly newsletter *Dispatches*, containing news and information on expert witness-related issues.

The evolving nature of the role of the expert witness and the changing expectations of clients reflect the changes brought about by new laws or the amendment of existing regulations. The work is becoming very competitive but is extremely rewarding.

If you are a practising expert witness, or are interested in becoming one, and would like to find out more about the Society of Expert Witnesses please contact Teresa Baron at the Society of Expert Witnesses, PO Box 345, Newmarket CB8 7TU; tel 0845 7023014; e-mail **helpline@sew.org.uk** or visit the SEW's website at **www.sew.org.uk**.

**Fiona Nevile**

**RCGP Spring Symposium: Belfast 2001**

The Waterfront Hall in Belfast is the venue for the next RCGP Spring Meeting for 2001. This is the first time Northern Ireland has hosted the event and preparations are well underway for the conference, which will be held between Friday 6 and Sunday 8 April. Around 500 delegates are expected to enjoy a very full programme of academic and practical interest, with an imaginative social component.

'Taking Pride in Primary Care' is the theme for next year's conference. Among the speakers will be Professor Susan Greenfield, Director of the Royal Institute of GB and a neuroscientist in Oxford, will look at the impact of science on the future of medicine. An American flavour will be given by Professor Larry Culpepper of Boston, with a response from Professor Mike Pringle, RCGP Chairman. There will also be a collection of local speakers and the Symposium will be under the chairmanship of Professor Domhnall MacAuley.

The social programme includes a tour of the Stormont Parliament buildings, and a grand banquet in the luxurious setting of the City Hall — a chance to get dressed up and enjoy a night of entertainment. A daytime accompanying programme will include sightseeing tours for delegates and partners.

The event organisers for the Symposium have arranged for discounts with ferry and major air companies and have booking details for local hotels. More details can be found at **www.rcgp2001.com** or by contacting Project Planning International, Montalto Estate, Spa Road, Ballynahinch, Northern Ireland BT24 8PT.

**Barry Mitchell**

# 11 Postcards from a New Century

## The Roots of Change

*This article is the eleventh in a series of 12 commissioned and edited by **Paul Hodgkin**, and **Alec Logan**, Deputy Editor,* British Journal of General Practice, *London.*

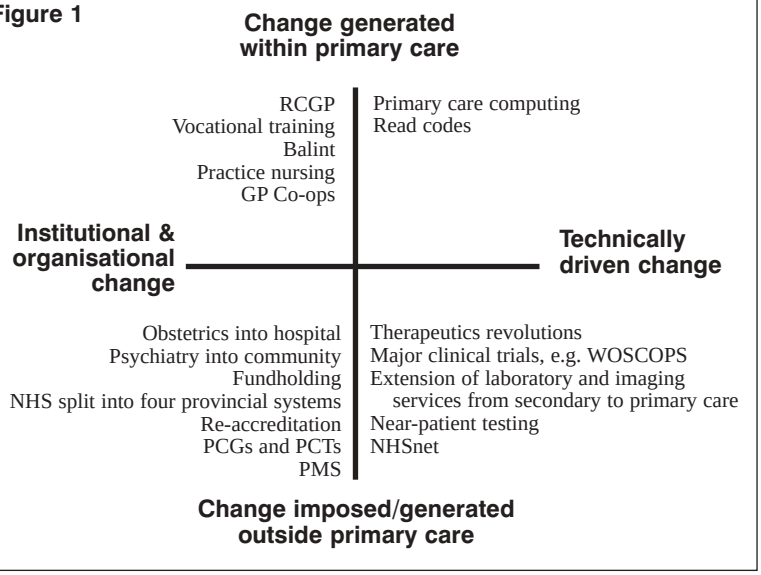
In a storm it's a good idea to understand the weather. And at a time of unprecedented change in primary care it's worthwhile taking a step back to think about the history of change in general practice. Where have the changes that have moulded primary care over the last 50 years typically come from? For most hospital specialties, such as cardiology, the roots of innovation derive from research within the profession and external, technically driven change. Several things are strikingly different for general practice (Figure 1).

First, only a very small amount of technically driven change has originated from within primary care itself. Read codes are one of the few examples and almost the only one to have had any impact outside general practice. By contrast, cardiology, gastroenterology or radiology have produced an enormous amount of technically driven change that has had, in turn, a large impact on general practice.

Secondly, research from within primary care has had much less impact on practice than research originating and led by other specialties. All the major clinical trials that have revolutionised clinical care in recent years (e.g. WOSCOPS, 4S, UKPDS, etc) have been conceived and led by hospital clinicians. All could, and perhaps should, have been led from primary care. The RCGP oral contraceptive studies show that we are quite capable of generating such world-beating research yet it is very hard to think of any other piece of GP-led research that has had significant impact on other specialties.

Finally, general practice has benefited — or at least successfully absorbed — an enormous amount of institutional or organisational change that has been imposed from outside. Fundholding, primary care groups, major shifts in other professions such as obstetrics or psychiatry — all have been the cause of major upheaval.

**Figure 1**




So development in primary care has often been reactive to other people's change. This is not necessarily a bad thing. We have proved enormously adaptable and developed a great ability to turned imposed changes, such as fundholding, to best advantage . However, the time when technology and all its associated impetus for change was essentially a hospital phenomenon, is ending. Near-patient testing, intermediate care facilities, patients with Internet-driven questions — all demand that GPs know more about secondary care topics. All demand yet more change from us if we are to shape our future rather than be subject to further uncomfortable 'hospital outreach' or data-mined by outside researchers.

In the past, the NHS has taken a grossly simplistic approach to change by assuming that it was a linear process — from research, to results, its implementation, and better care.

While we are now, quite rightly, paying much more attention to implementation, naivety about innovation is still widespread. Mantra-like calls about 'spreading best practice', for example, assume that good practice can be spread around like butter simply by illuminating it with a few beacons. Yet generating widespread innovation is an enormously complex endeavour (Box 1). Industry understands that successful innovation demands 'both a developed innovation and a prepared market. It is characterised as series of problem-solving loops dealing with unexpected difficulties in technical and marketing areas'.[1] Most of us in the NHS simply do not recognise the complex processes which are embedded in this business view. Researchers often cling to pre-set protocols with all the adaptability of a limpet; managers want a clear programme laid out with tick boxes even if it bears no resemblance to any clinical reality; and GPs and those charged with HImP implementation rarely have time to think about whether, say, creating a market for their change might be important.

Innovation in the public sector is also constrained by crazy incentives. For industry, making a better widget provides the wherewithal to expand widget production, but improving patient care by prescribing statins blows the bottom line. Business worships profit, the NHS worships the balanced budget.

So what might we take from all this? First, that professionals in primary care are extremely inventive — GPs, health visitors, practice managers — there are many people out there who can see great ways to do things better. This creative independence is the seed corn of change and needs to be nurtured — especially, perhaps, at a time which emphasises the clinical governance virtues of consistency and transparency. However, most innovations in the NHS remain corralled in a ghetto called 'one off projects'. We need to

**References**
1. Tidd J, Bessant J, Pavitt K. *Managing Innovation: integrating technological, market and organisational change*. Chichester: John Wiley, 1997.
2. Shapiro C, Varian H. *Information Rules. A strategic guide to the network economy*. Boston, MA: Harvard Business School Press, 1999.

**Box 1. The complexity of successful innovation.**

Successful innovation is complex and involves processes — such as creating a market — that we hardly ever think about. The 3M company once developed an adhesive that was very weak and never dried. This useless product was destined to be dumped when a manager found some of the glue on the piece of paper he used to mark his place each week at choir practice. Its re-usability was impressive but his colleagues remained sceptical, so he made up some small pads backed with the glue and left them round his department. Two days before the next product development meeting he removed them from all his colleagues desks. At the meeting everyone wanted to know where those little sticky pads that were so useful had gone and Post-Its were finally on their way to the world.

***Box 2.*** **Why do we say 'Hello' and not 'Ahoy'? Getting the telephone into widespread use.**

When Thomas Edison was trying to encourage people to use his new-fangled telephone he realised that he had to actively help them learn how to use it. One useful way of doing this was to supply free telephones to hotels and bars so that guests could surruptitiously observe the new machine in use. Another problem for a class conscious society was how to address whoever answered — was it the maid or the lady of the house? Edison realised that the answer lay in a new — and hence classless — greeting and his 1878 handbook suggests the invented word 'Hello' as the way to address on the phone. Meanwhile Alexander Bell, the phone's inventor proclaimed that 'Ahoy' should be used. By 1880, 'Hello' had won this particular standards battle largely due to Edison's persistence in finding ways to overscome the barriers to adoption.

**Box 3. The difference between invention and innovation.**

Some of the most famous inventions of the nineteenth century were invented by people whose names are forgotten. The names associated with them are of the entrepreneurs who brought them into commercial use. For example, the vacuum cleaner was invented by one J. Murray Spengler. He approached a leather goods maker who knew nothing about vacuum cleaners but had a good idea of how to market and sell them — one W H Hoover. Similarly, Elias Howe produced the world's first sewing machine in 1846 in Boston, USA. Unable to sell his ideas in England, he returned home to find Isaac Singer had stolen the patent and built a successful business from it.

become skilled at the complex, iterative, political process of taking a successful innovation through into widespread adoption. This requires a whole new set of management skills that are as yet barely articulated[2] but which are absolutely crucial to such things as turning HImPs into reality. The PCT or LHCC that can master these skills will find the world beating a track to its door.

We also need to build a new order of excellence in primary care research. One answer might lie in groups of PCTs going directly to the research networks that are burgeoning throughout the UK and directly commissioning large scale studies to answer key questions. Such a strategy will have been successful when we see major landmarks, such as the STOP IT trial, (study of total outcomes in primary care using IT, Wessex Research Network, *Lancet* 2000, which showed unequivocally that primary care had better outcomes than equivalent hospital outreach services), actually being performed and published.

Many of the most productive changes in primary care — vocational training, the 1996 Contract, PMS, GP co-ops — have come from the happy confluence of good government policy working in concert with inspired professional leadership and a workforce with a strong desire to provide a good service. PCTs and LHCCs provide opportunities to build the intermediate mechanisms necessary for 21st century primary care — planning, capital financing, risk management — that have in the past always been lacking. Whether they can deliver this, amid the gale force winds of change, remains an open question.

**Paul Hodgkin**

## It's all goo now

Have you noticed how gadget shops have become full of soft and amoeboid things, brightly pink squidgy knick-knacks that do nothing in particular but feel disconcertingly flesh-like? Such 'blobjects' are the ephemera of the quiet revolution that is gripping the material sciences. Fuel cells that can power buses, paper-thin VDU screens that can be rolled up and plastics that emit light and conduct electricity — a new cornucopia of products is about to rain down on us.

Many of these will have medical applications. A recent conference highlighted BioMEMS which are devices that marry a tiny microchip to materials with sophisticated drug release or cell sensor properties. BioMEMS are designed to be injected and then seek out particular cell types. Once there they do their stuff — release a drug, implant a stem cell or ream out atherosclerosis.

Those squidgy blobjects also mark a switch to the next cultural paradigm. The 20th century was the era of the hard-edged: from *blitzkrieg* and mass production to R2D2 and the etched pathways of the microchip, the leading edge of the culture was full of mechanistic, robotic images. The wave of innovation now beginning to drive the 21st century is biological. Hardware is mutating to wetware and geneware. And the sloppy goo of eggs is becoming the culture medium of our dreams and nightmares.

Sources: HYPERLINK http://www.Wired.com www.wired.com Med-Tech Centre; Dery M, *Red Herring,* August 2000

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# How to make the MRCGP more challenging ...

Let's face it, taking the MRCGP examination is hard. However, there is plenty of good advice available on how to make it easier. It's just not always possible to apply it, as I found out last year.

I had thought about taking this qualification since finishing vocational training a few years ago but, somehow, giving birth to children and working as a locum GP got in the way. It was not until we decided as a family to uproot and travel to New Zealand that I thought, now is the time to do it. A time limit can be a useful motivating tool in some respects; in my case things also became very rushed, but more about that later.

Having made the decision I read articles in the free doctor magazines and borrowed copies of the *Journal* to get advice on preparation. Six months to a year was recommended. That was fine — it was autumn 1998 and we planned our move to New Zealand sometime in the summer/autumn of 1999, so there was plenty of time to prepare. I had just given birth to our fourth child, but that was fine too. There was the demand of breast-feeding, which seemed to occur every two hours day and night but, heigh-ho, at least I could do some reading at the same time.

Further advice included getting together with other candidates to discuss 'hot topics', attending a course and getting someone, perhaps a GP trainer, to review the video consultations, for quality if nothing else.

At this point stumbling blocks abounded. No-one in the area was taking the MRCGP or interested in preparing for it. A course was out of the question for two reasons. The first was financial; as sole income earner for the family, having just had six months unpaid maternity leave and with locum posts thin on the ground things were a little tight. The second was the baby; I knew she wouldn't be too happy about me disappearing off for three days with her food supply!

Video consultations — now that was a problem. First, I asked the practice manager at the practice where I was working as a locum part-time. Yes, I could videotape my consultations, but no, I couldn't use their equipment as one of the GP trainers was using it. So after a quick think I bought a video camera, tripod and tapes (after all, it would come in useful for recording all those wonderful moments with the children).

Thus, to work on the video consultation module. After two mornings of taping consultations — having barely managed to deduce how the video camera worked, let alone whether it picked up sound adequately — my taping days came to an abrupt end. The practice manager announced that, having discussed it with the partners in the practice, it was not suitable for me to videotape consultations as they feared it would slow me down! (This happened as I finished the morning surgery on time, having seen about 25 patients.)

I looked at what I had and decided it might just make the grade. I completed the workbook, failed to show it to my ex-GP trainer, and sent it off.

Then the written examination. I prepared for this by reading as much as I had access to, using practice papers and learning as many 'hot topics' as was feasible, which wasn't that many when you consider the scope of the exam.

Anyway, the day itself. Up at 5.00 am to drive to the nearest examination centre. Two and a half hours later, feeling slightly car-sick and very nervous, I took my place at a table in an enormous room in a motorway hotel on a hot May morning. The tables were shared between two people, sitting beside each other. I found myself sitting beside a very wise, mature-looking GP — no doubt one of the GP examiners retaking the written paper, as they are required to do. This was immensely intimidating and I almost gave up as I noticed the copious notes issuing from her pen. She gave me an encouraging smile at one point so I plodded on. The MCQ paper in the afternoon was slightly better, with the end in sight. Then a long drive home with a headache and breasts engorged with unsuckled milk.

Last hurdle — the oral exam, or viva voce. At this point I was very busy. I had been offered a position in New Zealand, starting a week after the oral examination. That meant completing the sale of the house and car, arranging the packing and shipment of our household contents, and endless paperwork — passports, visas, medical registration, meeting with our solicitor, bank manager and accountant. There was also the bittersweet experience of seeing friends and bidding farewell to them.

Thus I found myself travelling up to Edinburgh with my head spinning, and not just with potential viva questions. It was an exacting viva, no doubt made more so by my preoccupations. I cannot recommend this approach.

We arrived in New Zealand and I waited for the results. Somehow I had managed to pass three out of four modules. I failed the video module.

All was not lost — a quick fax to the Examining Board and I could go ahead with a New Zealand-produced videotape. It was not easy; I had to learn a different system of health care on the job. Many of the patients in the low socioeconomic area where I was working viewed the presence of the video recorder in the consultation room with deep suspicion. I completed another tape, failed to show it to a colleague, sent it off and

**Acknowledgement**
To my husband and children.

failed again.

In desperation I wrote to the Convenor of the Panel of Examiners and was greatly encouraged by a personal reply from Roger Neighbour. He advised me to try again.

This time I enlisted the help of an expatriate GP to review my videotaped consultations and I was further aided by the improved instructions and definitions of the required competences in the 2000 Workbook. Also, the patients were used to me now and were more willing to co-operate by taking part.

The only dark cloud hanging over me at the time was the possibility of the practice closing, because my senior partner and employer was about to be struck off the medical register!

I managed this problem to the best of my ability while keeping the practice running, and managed to get my third attempt off to London.

I am glad to report that I finally achieved MRCGP in July 2000.

What have I learnt from this? A great deal. I have learnt that it is possible to communicate with institutions and receive personal advice. This included not only the RCGP but the Medical Council of New Zealand and the Medical Protection Society. I have learnt at first hand the potential hazards of accepting a post overseas and how it feels to work with a problem colleague. I have learnt how to hold together the morale of a practice team when everything is in dissolution. I have learnt how to concentrate on a goal when there are multiple other distractions. Besides all that I have learnt about many aspects of general practice, and had my enthusiasm renewed in the process.

If you want to make it easier for yourself when attempting the MRCGP examination then follow all the good advice offered. Take the MRCGP when you are a GP registrar with all the support systems in place. Always ask a colleague to review your videotaped consultations before you submit them, form a 'hot topic' group and go on a course. Don't attempt a move to New Zealand, Malaysia, the USA, or Timbuktu while studying for the examination.

On the other hand, don't be put off if you are a locum GP, or between jobs. It's tough, but not impossible. If you can get to London easily then opt for the simulated surgery module rather than attempting to produce a videotape of consultations.

You may not win medals or merits but you will learn more about general practice and you will learn an immeasurable amount about your resources and supporters.

I'd say give it a go!

**Nancy Loader**

## Commentary

I felt the ice round my examiner's heart melting as I read Nancy Loader's tale of heroism in pursuit of the MRCGP. Replying to it makes such a change from my usual letters to disgruntled candidates, gently explaining that the reason they failed the examination was not our negligence but simply that they didn't do well enough to pass. I sometimes think the exam ought to test 'staying power', a premium quality in GPs and one which Dr Loader has in spades.

One of my first priorities as Convenor was to convert the exam from its previous 'fail one bit, fail all' format to the modular structure without which even Nancy might have given up at the first setback. I'm glad we've got that bit right.

She didn't make things easy for herself, though, did she? The exam is intentionally designed to be best taken during or shortly after vocational training. Certainly, the written papers are easiest at that stage of a career, when factual knowledge and a structured approach to problem-solving are freshest in the mind.

The videotape consultation is another matter. It's the element with the highest fail rate, largely because (despite shelfloads of pundits, including Peter Tate the video Convenor and me banging on about it for over a decade) newly-trained GPs are not very good at the patient-centred consulting style the exam is unashamedly looking for. The performance criteria that most young doctors fail on are: sharing management options, exploring psychosocial contexts, and responding to cues. More worryingly, our evidence is that many trainers haven't even read the comprehensive workbook which sets out in detail what the MRCGP video module is looking for, let alone geared their teaching towards it. And, Nancy, I think the local Dean would be interested to know which training practice was so lamentably unhelpful.

That said, simply recording two surgeries and hoping for the best is almost guaranteed to result in failure. It takes more raw material than that to provide a portfolio of highlights of your consulting ability. By all means get someone (not an examiner, please) to vet your tape before submission. But make sure that person is familiar with the exam's passing criteria. They are not the same as for the UKRA summative assessment method.

Nancy, have a great career. I hope doing the exam has helped you identify the lights by which you'll judge it.

**Roger Neighbour**
*Convenor, Panel of Examiners*

# The nature of clinical competence

## Introduction

While there are many qualities that we might desire our doctors to display, none can be so important as clinical competence. That is the ability to find out what is wrong and to make an appropriate response. How *does* the 'clinically competent' doctor find out what is wrong, and how does that doctor ensure that response *is* appropriate?

## Knowledge

In this century, knowledge relevant to medicine has increased by geometric progression and shows no sign of slowing. By knowledge I mean those refutable statements that are the best available approximation to reality.

It has been said that half of what one learns at medical school turns out to be wrong but that one does not know which half. This popular jibe is nonsense. In reality two things happen: old knowledge becomes refined and almost always more complex and new knowledge is acquired. Little of the old knowledge is completely replaced, although useless therapeutic fashions may be discarded. The main problem with the knowledge we acquire during education is its short half-life, which seldom exceeds 12 months. Only the knowledge which is reinforced or used remains. Most new knowledge is only relevant to the margins of the discipline and rarely affects our proper day-to-day practice. The common conditions seen either in general or specialist practice can be completely managed without recourse to the most recent apparent advances.

The volume of new knowledge threatens generalists who are aware that there are others whose in-depth knowledge in certain areas is much greater than their own. This carries real dangers to the well being of patients because their care may become increasingly fragmented between super specialists at the expense of consideration of the unique human being who has the misfortune to be, for the time being, a patient.

All practising doctors rely on their experience: a fallacious guide which usually results in continuing to make the same mistakes with increasing confidence. Experience is of two kinds — experience of diseases, which leads to statements such as 'in my experience this sort of case does well with ...', (a statement which is untenable in the age of the randomised controlled trial), and experience of individual patients. This second sort of experience is characteristic of general practice where continuity of care is still, despite threats to its survival, a not infrequent reality. This sort of knowledge is valuable and can lead to an understanding of anxiety which might, in other circumstances, be seen as inappropriate. It can also lead to a more accurate appraisal of the significance of symptoms. Some people are fearful and easily worried by symptoms while others can be stoical to the point of danger. However, the hypochondriacal are not immune from serious disease and all symptoms deserve proper consideration. Experience, despite its dangers, can often identify the discordant, the 'funny peculiar', which should counsel caution.

## Listening to people

The important evidence base of medicine is what people tell you and what we find by examination and investigation. This is the evidence that leads to sound diagnosis and the possibility of appropriate therapy.

Of course, many decisions we make in clinical practice, such as starting a statin or hormone replacement therapy or considering whether a patient should be encouraged to opt for measurement of his prostate specific antigen, require us to consider evidence gathered from points far beyond our consulting room. Nevertheless, if we forget the primacy of what that individual patient tells us and what we find on examination, then we flirt with incompetence.

A 'good history' is unobtainable by asking questions. It may only be obtained by encouraging the patient to talk and by careful and attentive listening. It is not necessary to have attended a course in 'communication skills' to know that encouraging people to talk depends upon the ambience of the encounter and a body language which signals commitment and attention. Information that is volunteered is gold dust by comparison with that which is extracted. All clinicians with experience recognise the characteristic use of words, accompanied by certain tones of voice and body language that predict with high probability the presence or absence of certain diseases. Sadly, there has been almost no research into the positive and negative predictive value of the use of language. General practice is in a position to rectify this deficiency, although it has to be recognised that the findings will be culturally and locally specific.

## Looking at people

While there are diseases and disorders that are obvious at first sight (Down's syndrome and many dermatological conditions, for example), looking at people generally

**Acknowledgement**
I am very grateful to Alec Logan and his reviewers for constructive criticism of earlier drafts.

opinion

involves some form of examination. There are, however, other kinds of looking at the whole person that are important. The body language of apprehension and anxiety, of sadness, that slight moistness of the eye which anticipates weeping.

Medical students used to be encouraged to do 'a complete physical' and, I suspect, sometimes still are. This is an impossible task. Examination must be driven by at least some notion of diagnostic possibility. It should be used to confirm, or better still to refute, diagnostic hypotheses. Approaching the abdomen with an open mind is a recipe for disaster and leads to false negatives and sometimes false positives. The search for tenderness or splenomegaly must be relevant to that which has gone before, specific, and thorough.

The emphasis on skills in eliciting physical signs characteristic of examinations is in many ways appropriate but ignores the extent of intra- and inter-observer variability. Very few signs are so easy to elicit and so definite that agreement is universal. While it may happen that one stumbles upon an unsuspected and real sign of disease — a breast lump, a melanoma on the back — findings that are unrelated to diagnostic sense should be viewed with great suspicion. Many important signs are difficult for most of us: popliteal pulses, raised venous jugular pressure; others, such as crepitations at the bases, are useless. By comparison with the substantial body of research on observer variability in the interpretation of x-rays, cardiographs, and histological specimens, there is a relative dearth of enquiry into the ability of doctors to agree about physical findings. Yet these very physical findings are the basis of many diagnoses.

**Tests**

The commonest test in medicine is the attempt to measure blood pressure, and it is appallingly badly done. Digit preference, especially zero preference, is universal; little account is taken of arm thickness or arm difference; Osler's phenomenon is ignored; anaeroid machines remain uncalibrated; and mercury sphygmomanometers uncleaned.

Other tests, especially those involving the laboratory, are abused. There is a general failure to realise that when the prior probability of abnormality is low, false positives outnumber true positives by a large margin. There is also failure to recognise that many biological variables are not stable (serum cholesterol, for example) and we underestimate the extent of laboratory error.

Mindless investigation, like mindless examination, produces misinformation. There is proper concern about the cost of high technology imaging but the cost of unnecessary and wasteful common laboratory and microbiological tests is many times greater. In addition, inappropriate tests and false positives harm the health of our patients.

**Commitment**

Clinical competence is impossible unless there is a commitment to put the patient first despite other competing claims on time and energy. The lack of such commitment is the chief cause of patient dissatisfaction, complaints and recourse to the courts. On the other hand, the provision of such commitment is the chief cause of doctor unhappiness and stress in personal and family life. Unfortunately, this may be a problem without a solution. The best that can be hoped for is damage limitation.

Such limitation begins with recognition that the practice of medicine is primarily a social function and that those who are, or believe themselves, to be sick have always needed the possibility of seeking help from someone whom they can trust to mediate between themselves and misfortune. Thus the nature of the relationship is intrinsically different from that which exists between ourselves and our plumbers, accountants, or bank managers. Illness is accompanied by a degree of regression towards childhood and dependence. People come to their doctors with their begging bowl and only become aggressive when it is not filled.

The problem of commitment is made more tolerable if it is appreciated that its rewards are more than money. Other professions receive much less in the way of gratitude, which no matter how little justified, is one of the major recompenses of being a doctor.

Damage limitation may also be reduced by difficult decisions to set some limit to outside involvements. Outside involvements that are often connected with professional life — to committees, to Royal Colleges, to medical associations, to good causes. Saying 'no' can only be learned with difficulty.

An essential component of commitment is enjoyment of the job. Once work becomes a burden, a task to be completed as soon as possible and with minimum stress, any commitment to patients is eroded beyond recovery. Few of us can maintain commitment throughout our professional life without some method of recharging our enthusiasm. For some this may be achieved through involvement in teaching, for a smaller number by undertaking research. Perhaps the most valuable protection is the opportunity to share concerns with supportive colleagues. 'Me too-ing' provides valuable comfort.

**Scepticism**

Scepticism is the scalpel that frees accessible truth from the dead tissue of unfounded belief and wishful thinking. It is not a synonym for cynicism. It always seems strange that the word is so often accompanied by the tautologous addition of 'healthy' — it is always healthy. It may be that those who favour this usage also recognise 'unhealthy' scepticism, which presumably casts doubt upon the validity of their cherished beliefs.

Clinical competence must include recognition of ignorance. 'I don't know' tends to reassure rather than appall those who seek our help. Recognising ignorance is an important prompt to appropriate referral. It is also the best spur to individually tailored continuing education.

Scepticism recognises that all treatments alleviate symptoms, whereas only some affect diseases. By being aware that the faith and enthusiasm of the therapist are major determinants of therapeutic success, the clinically competent are unlikely to be seduced by the apparent successes of absurd placebo therapies.

**Continuing medical education**

While it is self-evidently true that to practice medicine with nothing more than whatever one acquired in medical school is a recipe for disaster, mechanisms for continuing growth are many and varied. The best antidote to fossilisation is not quasi-compulsory attendance at lectures and courses but fascination with the tasks of medicine; fascination, which is a subset of commitment to patients and the enjoyment of our profession.

**Conclusion**

Clinical competence depends upon a quantum of knowledge, the ability to listen to the patient, and to elicit physical signs while recognising their limitations, and the intelligent use of investigations. There are two other essential and relatively neglected pre-conditions: scepticism and commitment.

**James McCormick**

**Telemedicine and Telehealth - Principles, Policies, Performance and Pitfalls**
**Adam William Darkins and Margaret Ann Cary**
Free Association Books, April 2000
PB, 316pp, £16.95, ISBN 1 85343518 X)

**The Telemedicine Toolkit**
**Roy Lilley and John Navein**
Radcliffe Medical Press, 1999
PB, 185pp, £30, ISBN 1 85775480 8

I remember first going abroad and being entranced by the difference — the smell of Gauloises, the different advertisements, the oddly-shaped cars. Now the cars are Fords or Peugeots, Virgin is ubiquitous and cigarettes are not discussed in polite society. It is, however, a lot easier to travel, and I don't have to wait half a day clutching my passport and sterling in a mahogany banking emporium. Times change and the globalisation of medicine will follow the globalisation of the banking and auto industries. The French still take their medication in unusual ways, the Germans still believe in unusual compound prescriptions but international standards are emerging, driven by new technologies and the convergence of global consumerism.

We live in professionally effervescent times. The government is committed to modernisation and increased funding is coming our way. The profession no longer expects to work 24 hours on the trot with a wife-led telephone answering service and the advent of new technologies daily promises a better life for all, just over the horizon. We are living through the digital revolution. General practice contains a normal distribution curve of attitudes to new technologies with those who regard the stethoscope as innovative at one end and foaming-mouthed disciples of Nicholas Negroponte talking technogarb at the other. The truth lies somewhere in between.

The advent of the computer means that information does not have to be stored in the professional's brain and therefore the power of the professions no longer lies in a monopoly of specialised knowledge. The role of the clinician is now to interpret, explain, guide, and mentor the patient. Such changes do not happen overnight but mean that both patients and professionals have to adjust to a new world. This world is less paternalistic, more consumer orientated, and will see an enormous change in the roles of the Royal Colleges from Guilds to standard-setting enablers.

How we deal with new technologies is therefore crucial. We can try to restrict them, make them conform to the rules of the Guild and hedge them about with rules that will not contain change. We can be led by the manufacturers and enthusiasts into a series of equipment-led experiments that lead to frustration, disappointment or blame; or, if we are enlightened, assemble the participants in the process of care and discuss where the difficulties lie in producing the best outcome for the patient. When we do this we obtain the best outcome for all involved. Re-designing a fragmented system is satisfying.

Telemedicine is one of the tools that will help in this process but should not be seen as a stand-alone. The new technologies that include the Internet, digital imaging, and data transmission together with older technologies, such as the telephone, could be better described as being about 'e-health' — the appropriate use of digital technology to enhance clinical care.

*Telemedicine and Telehealth* is a reflective, thoughtful, well put together book that looks at the development of e-health from a variety of perspectives. The layout is logical and includes a sensible philosophy underpinning practical steps on how we might use the new technologies for all our benefit. A historical perspective is followed by views from professionals and patients. The setting up of systems and their management and an overview of the business issues and selection of technology completes this densely crafted little textbook which emphasises throughout that the only constancy is change. A very useful volume.

*The Telemedicine Toolkit* offers a very different approach to the same subject. Arguably, this is a book written more for the digital age, with a workbook format, a 'dip-in-and-out' style, lots of learning points, and a generally less academic air. I remember getting a magazine called *Motorcycle Mechanics* in my youth which used to feature articles with titles like 'Eight steps to stripping down your Beezer 250'. Reading the *Telemedicine Toolkit* brought back a whiff of the past: enthusiastic, breathy, a bit laddish in style; it covers the same ground in a different way. As you would expect of a book co-authored by Roy Lilley, it sets out to be controversial and to point out the potential for change in a more positive and confrontational way. This book will be useful for members of a group from a range of backgrounds who want to develop a project together. Less reflective, more action orientated and written in a way that might encourage group discussion, this book will stimulate debate. It's not reflective and it's much less philosophical, but it will stimulate thought and discussion.

In short, two useful volumes in a fascinating and changing field. Buy the first one for reading, reflection, and planning and the second for discussion, and team-building, and giving it a go.

***Gordon Peterkin***

**Implementing evidence-based changes in healthcare**
**Edited by David Evans and Andrew Haines**
Radcliffe Medical Press, April 2000,
PB, 291pp, £27.50, 1 85775382 8

Evidence-based practice is a big industry. There are now many books and workshops designed to help health care professionals develop and practice the skills required for EBP; in particular, finding and appraising the evidence. However, the last step — implementing the evidence — remains as difficult as ever. As someone involved in helping clinicians develop their critical appraisal skills, it doesn't take long until I hear the question 'Yes, but how can I apply it in practice?' being asked. With the advent of clinical governance primary care groups, trusts, and local health care co-operatives are asking this question as well.

This book addresses the issues surrounding the implementation of research evidence head on, based on the experience of the North Thames R&D Implementation Programme (a series of 17 projects based in North Thames Health Authorities during 1996–1998). The programme itself was externally evaluated by the King's Fund. This book describes 11 of those projects.

The overall aim of each project was to change clinical practice through the implementation of proven research evidence. In all but one case, the setting for these projects was primary care (the exception being an A&E department). All projects were led by the health authority. However, the more successful projects were located within primary care and had a strong multidisciplinary ethos, i.e. implementation *in* primary care, rather than *on* it. Topics included *H. pylori* eradication, leg ulcer treatment, and open-access echocardiography.

The strength of the book lies in the 11 chapters in which the project leaders describe their experiences 'warts and all'. There is a refreshing degree of honesty in many of these accounts, describing why particular approaches were taken and why they failed. Each chapter contains a list of lessons learned and things to do differently. In addition, there is a brief commentary on the project by the King's Fund evaluators. There is also a good introductory chapter on the overall evaluation, written by the external evaluators.

There is much to reflect on. No project achieved all of its aims. Few were able to demonstrate improved patient outcomes, although many were continuing to evaluate outcomes at the time of writing. Audit was a key monitoring tool; strong multidisciplinary team-working within primary care was essential; flexibility and a realistic timescale were also essential. Projects using a variety of implementation strategies were more likely to succeed. Worryingly, however, many projects depended on the charisma and hard work of the project worker — individuals who were generally on short-term contracts and who often moved onto other posts.

Given the difficulty in 'making a difference' for many projects, it is disappointing that the external evaluators chose not to round off the book with a concluding chapter on how to move on from here. That apart, this book contains many lessons for those involved in the implementation of research evidence and it is surprisingly easy to read. Individual clinicians trying to achieve change within their own practice will probably find it to be of least help. Those in PCGs, Trusts and LHCCs concerned with clinical governance should certainly read it. Those in charge of policy should be forced to read it, if only to help them realise the enormity of the task in applying best evidence to everyday practice.

***Catherine O'Donnell***

**Not Another Guide to Stress in General Practice!**
Edited by David Haslam
Radcliffe Medical Press, June 2000 (2nd edition)
PB, 156pp, £17.95, ISBN 1 85775 446 8

I had to read this book surreptitiously for the *Journal*. I didn't want my partners to think I was in trouble. I've only known them a month. 'Stressed, Shaun?' 'No, no! I'm loving the job.' (It's true.) But six months ago life was quite different. I was then over two years into my first partnership and I wasn't finding life so rosy. I read the book during a co-op night shift (no-one saw me then) and even in the small hours, perhaps especially then, I could relate to the scenarios described — too many demands, too little time, too much change, too many examples to list.

Stress is a difficult subject to talk about, and as for buying a book on it ... C'mon! But, I learnt a lot about myself and my last practice reading this book. Personally or professionally, this book's an education.

The book is practical but and derives much from a readable academic base. In the first chapter, Andrew Eastaugh just has to mention the Starling curve and the balance between stressors and coping resources. Heard it before? Of course — but the explanation is clear and fun: without a modern need to run from sabretooth tigers our bodies instead burn off the adrenaline rush from stress with racing minds, churning stomachs, and higher blood pressure. Good science? Who cares! Exercise *does* help.

That others find the constant dripping of daily minor hassles worse than rarer major events made me feel better, and examples such as this, where the reader can think 'Yes!', make this a good book. One has confidence in the authors throughout — they know what they're talking about; something to do with being GPs, I guess. The burnout inventory is scary — so many GPs will have a high score that it should be part of revalidation. Kate Wishart's chapter on 'Women and Stress' emphasised situations that men often prefer to ignore. In this chapter, renowned cartoonist Martin Davies is especially outrageous but undeniably true and thus shameful. All men should read this chapter. Kevork Hopyian's 'Looking After Yourself' is good advice. I used it the next day! Listing Burn's common cognitive distortions is, again, enlightening and reassuring.

Haslam wonders if, with so many stresses, a career in bomb disposal would be easier, but with a book of such clarity, understanding, and encouragement I know general practice is more satisfying. Moving practice is sometimes an option but it's a bit drastic, and when its impossible this book will undoubtedly help.

***Shaun O'Connell***

# The London Eye in early September

I have to admit that Lady Luck was on our side when visiting this new attraction in London recently. At first we were told that most 'flights' were booked up when we tried to organise the trip the previous week, but the pleasant man on the desk took pity on us and he booked us on anyway. Also, on the day we arrived the sun shone, albeit intermittently, and the skies were relatively blue and clear and we had a great day.

Part of the exercise was to entertain our two nieces (aged nine and three years respectively) who, by and large, behaved impeccably through the day — though they had their moments.

On the day, we parked the car about a mile from the 'Eye' and walked to this now famous landmark on the south side of the Thames. The official instructions are to arrive at least thirty minutes before the flight. Despite this the queues were worryingly long, as it was the last full weekend of the summer and tourists were still in abundance. Once the stewards had checked our tickets the progress was fairly rapid. On board the capsule, or 'pod', there was a great sense of anticipation, that the wait was finally over and the adventure was about to begin.

By now the day was cloudy but generally bright, the sun appearing just enough to make the view — undoubtedly spectacular from all angles — optimal and without the usual climatic obstacles.

Our nieces were overawed. Inside each pod geographic directions are clearly marked and obvious landmarks appear almost straightaway as the giant wheel rotates. Waterloo Station, The South Bank, Centrepoint, Hyde Park, and Buckingham Palace are instantaneously recognisable. As we rose, picking out special features became quite fun; for example, St Pancras station, the Dome, our own practice area in south east London, and Hampstead Heath. Because of the Eye's position it felt strange that parts of south east London appeared behind us as one looks across at the Houses of Parliament — apparently it's all about perspective, I was told.

As our pod reached its zenith the whole of London and beyond became visible. It was at this stage that I remembered someone telling me that, on a good day, St Albans was visible from the top. My personal thrill was seeing the River Thames snake its way eastwards into the distance and beyond the Thames Barrier, making us realise that London is at once expansive and yet, paradoxically, compact. How we wished we remembered those binoculars!

By this stage our youngest niece was more interested in our rapidly dwindling orange sweets, a sure sign that boredom had set in. On the downward leg of the half-hour flight a few spots of rain seemed to threaten a downpour but nothing, thankfully, appeared.

What were our overall impressions? We had managed to acquire tickets for a busy Saturday in September, and our two nieces seemed to enjoy it. Our experience of the flight was overwhelmingly positive, and I admit that it was so enjoyable that it was tempting to book up the next available night flight. We even acquired the official guide which was glossy, helpful, and full of views not possible from the Eye. It is an impressive European collaboration, with its various constituent parts manufactured in the different EU countries. For example, the main structure is Dutch, the hub and spindle are from the Czech Republic, and the capsules are French.

Winter flights start at 10.00am and finish at 6.00pm. Go on — be daring and enjoy your flight!

My thanks go to the kind man who managed to get us on the flight, Anya and Nisha for their patience, and Lucy who did most of the organising.

**Surinder Singh**

John Holden

**One hundred flowers**

‘Let one hundred flowers bloom’. The phrase has a resonance even for those of us who rarely see meadows, and accept agricultural monoculture without question. It suggests creativity, spontaneity, variety, life in its natural state, freshness, open spaces. Why not leave a useful phrase alone?

For all children of the 1960s the image of Chairman Mao is easily recollected. Benign, faintly smiling, and egalitarian decades before the National Health Service was given the task of reducing health inequalities. It was he who said, in 1957, ‘Let a hundred flowers blossom and a hundred schools of thought contend’ in the sinisterly named ‘On the Correct Handling of Contradictions’. The following year he returned to his authoritarian instincts and launched the Great Leap Forward, which in turn led to the deaths of over 20 million people, the greatest famine in recorded history.

The ‘hundred flowers’ phrase remains popular in the type of medical writing of which Mao would approve. Aimed at inspiring the workers, written by those far from difficult clinical decisions, it has become a weasel phrase. It is associated with exhortations to try even harder, to change the culture, eliminate errors. So we separate easily into those who believe others need constant cajoling, and the rest.

My selective memory and a few random photocopies suggest that floral allusions appear seasonally, less often used at present as we experience the icy blast of centrally driven modernisation. Yet those who work in the health services of rich countries are condemned to experience the cycles we once associated with our economies, so expect its re-emergence around the time of the next election.

When I see it start to be used again I shall know — Mao lives.

# uk council, september 2000

**Revalidation**
Council considered a series of papers on the subject of revalidation.

The RCGP's response (co-ordinated with the General Practitioners Committee) to the General Medical Council revalidation proposals is generally supportive, but a number of key issues need to be resolved. What resources will be available to support revalidation? To what extent can a system designed to maintain minimum standards also aspire to excellence? Ambiguities between appraisal and assessment in the proposals should be resolved. These issues were incorporated within the RCGP/GPC response in time for the deadline on 25 September.

The remaining papers on revalidation were presented by Chairman of Council, Professor Mike Pringle.

The paper on the criteria, standards, and evidence for revalidation was debated in the context of the discussions mentioned above. Council was concerned to guard against a structure that would enable a doctor to provide the evidence for revalidation but which did not reveal incompetence.

On the question of local revalidation groups, the proposals were supported. Council noted that this part of the proposals for revalidation were where the additional cost would be most likely to arise. The evidence and standards would, under the College/GPC proposals, rely as far as possible on existing standards and sources of evidence that doctors already had to maintain for other purposes such as clinical governance.

Mike Pringle's paper looking at the relationship between College quality standards and revalidation had been redrafted following detailed consideration by the Revalidation Working Group on 14 September. The recast proposals are now presented as 'acceptable processes for evidence', meeting all or part of the requirements for revalidation. This paper begins to explore how College standards, such as Accredited Professional Development, Membership by Assessment of Performance (MAP), Fellowship by Assessment, trainer accreditation, etc. may provide the evidence required in whole or in part. Council agreed the concept in this paper but wanted the College to be able to sign off for the local revalidation group that a doctor had attained the necessary standard, subject to periodic assessment of selected cases by the GMC. If this was introduced then it would avoid submission of the whole folder for MAP; for example, as part of the evidence for revalidation.

The final paper looked at the relationship between appraisal and assessment and whether the 'State' appraisals as proposed for England in the document *Supporting Doctors, Protecting Patients* might offer a system on which to build. The question remains as to whether these appraisals would be formative as the College would wish and provide a route for appraisal, at least in England. If not then there appears to be no alternative but to introduce a parallel system of appraisal for the purposes of revalidation leading to the five-yearly summative assessment process. Council was happy for this possibilty to be developed.

Once all of these papers have been refined in the light of Council's discussions they, together with associated documents, will form a package for the purposes of consultation with the entire profession which, jointly with the GPC, will be sent out this month.

**NHS Plan for England**
Council noted the initial responses that have been given by the College in conjunction with the GPC in England to the NHS plan for England and the issues to which the plan gives rise. It was agreed by Council that while the thrust of many of the proposals in the Plan is directed at England alone, aspects do relate to Wales and it is important to see what effects this could have elsewhere in the UK.

TheCollege's major concerns on the Plan are:

- the shortfall in the planned increases in numbers of GPs, given that the increase in numbers would not meet the needs identified ahead of the Plan, let alone the needs identified and forecast in it;
- the unwelcome focus on single-handed practice which the College views as an issue of professional isolation and accessibility;
- the omission of the quality agenda and the lack of reference to 'caring' that there is in the Plan;
- the rush into PMS when the result of the pilots have not been evaluated; and
- the abolition of the Medical Practices Committee and its illogical inclusion in the work of the proposed Medical Education Standards Board (see more on this below).

There is a raft of other issues in the Plan which the College will need to monitor. We will be looking to produce a series of papers jointly with GPC as our detailed response to the Plan. These papers will cover issues such as workforce, PMS, intermediate care, and health inequalities, and will be produced over the coming weeks.

One specific proposal in the Plan is the abolition of the Joint Committee on Postgraduate Training for General Practice and to combine its functions with those of the Specialist Training Authority to form a new Medical Education Standards Board. Council


The **RCGP Annual General Meeting** will be held on **17th November** commencing at 14.00 at the **Paragon Conference and Exhibition Centre**, 47 Lillie Road, London SW6.

**UK Council** next meets on **Saturday**, **18 November** 2000, at Princes Gate.

was concerned that, under this proposal, the accepted efficiency of the Joint Committee may be lost and there is a danger that the work for GPs may be overshadowed in the larger body.

Council was especially appreciative of the work of Mike Pringle in his rapid and intelligent initial response which was felt to have balanced carefully the perspectives of our three major audiences: GPs, patients, and the Government.

**Future of GPs and their Training**
Council considered again a paper from Mike Pringle which looked at the issues of GP training and how these might develop in the coming years. The 15 broad recommendations covered aligning the structure and status of training for general practice with those of non-general practice doctors. The Europe-wide ramifications of general practice training were discussed.

**Genetic Testing**
Council welcomed a motion from Sheffield Faculty which suggested that the College should urge the Government to ensure that insurance companies could not discriminate on the basis of genetic information. Council supported the thrust of the motion but felt that genetics was a wider issue than its implications for insurance. Further discussion will take place at the next meeting of the Council and Executive Committee.

**Confidentiality Principles**
Iona Heath, Chairman of the Committee on Medical Ethics, suggested that a fresh look should be given to the principles surrounding confidentiality. The full text of Dr Heath's paper is available on the RCGP website. Subject to some minor changes, the paper in its final form will be issued as a College Position statement.

**Recruitment, Retention and Return to General Practice**
The Health Inequalities Task Group has as its aim to reduce inequality in the health of the people of Britain. The Group had produced a report looking at the current evidence regarding recruitment, retention and return to general practice and the distortions there could be in the market as a result of inequalities. A series of solutions had been proposed to reduce or overcome the issues that have been identified. Council agreed that these views should be promulgated and would be valuable in the discussion on workforce planning on the NHS Plan for England.

*If you require any further information on any of these subjects or others on the agenda, then please do not hesitate to get in touch.*

**Maureen Baker**
*Honorary Secretary*

## neville goodman

Young girls starving themselves to supermodel thinness is a worry for doctors, teachers, and parents. There are repeated cries to the fashion industry to get real, in a country where the average size for women's clothes is 16. I don't usually read the *Daily Mail*, but I happened to see a copy containing a letter to the Editor commenting that 'the whole female world spends its time slimming [to] emaciate their bodies into fashionable lines'. With a fair turn of metaphor, the writer asked when the fashion houses are going to stop using 'human coat-hangers'.

'Not yet' seems to be the answer: the letter appeared in the *Daily Mail* of 2 June, 1953. I happened to see it when clearing out my father-in-law's house. The newspaper had been kept (though probably never looked at again) for the coverage of the coronation, not for the letter, nor for the story about the 16-year-old girl murdered and thrown into the Thames. Old newspapers are an excellent way of reminding us that not as much changes as we like to think.

Another find was the *Daily Mail Yearbook* for 1938 (price: one shilling). Proposals had been published to end the '"irreconcilable conflict" between the Jews and Arabs in Palestine' and, among other constantly uttered refrains we were assured that 'Britain has the finest health services in the world'. The BMA was concerned that more than 40% of the population between 14 and 40 didn't do enough physical exercise. Notwithstanding, it was reckoned that 1937 would be remembered for the many efforts to achieve a 'Fitter Britain' by making its citizens 'acutely and permanently health-conscious'. An advert in the charities section had the Minister of Health, Sir Kingsley Wood, asking for 'help to remove this blot upon our civilisation' by donating to the Royal Cancer Hospital, because cancer 'takes its toll of 60 000 lives every year'.

So, to the recent plans for selecting Key Areas, setting national objectives and targets, and constructing frameworks for their monitoring and development. I'm sure we're all convinced that the initiative represents a 'major step forward in improving the health of the people'. We note the particular emphasis on the 'importance of active partnerships between … organisations and individuals', the promotion of 'focus groups', and the need for 'decisions about the use of available resources [to] reflect the priorities'. Indeed, 'additional resources are being made available', and I'm sure we can believe it because the signature to this document is Virginia Bottomley, and it is dated July 1992.

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

# bruce charlton

**The right side of the line**

Growing-up, I often heard it said that one must not expect too much from life. That life was a matter of compromise, with a large element of routine drudgery. One cannot expect to be happy all of the time.

All of which is true. But not the whole truth. Because this implies that it is, fundamentally, a matter of indifference what choice one makes of job, spouse, friends, school, college, work, religion. Since all are imperfect the main task is for each individual to accept radical imperfection and make the best of it. The happiest man is the stoic who accepts the inevitable without illusions or false hopes.

In a sense this is the ultimate truth about the human condition. But, within limits set by disposition and the state of the world, there is scope for difference big enough to make a difference.

Some time ago when I was single and seeking a mate, I devised the concept of 'side of the line' for evaluating the physical attractiveness of potential girlfriends. I was aware of the more traditional 'marks out of ten' system, but that gave excessive weighting to looks. Looks matter — true; but it didn't take much experience to realise that looks don't carry a relationship very far, or for very long. On the other hand, since looks do matter, insufficient attention to them can lead to excruciating situations.

The idea was that once a woman was attractive enough then she could be classified as being 'on the right side of the line'. From the 'looks' point of view she was suitable as a potential girlfriend. But — and here is the crux — all women on the right side of the line were regarded as equal. Once someone was classified as being on the right side of the line, further physical comparisons were ruled out. Other factors could come into the equation.

Similarly, work is terrible: why must we live by the sweat of our brows? Yet I have worked in some jobs that made me dread Mondays and count the days to a holiday; I have worked in other jobs that did not cause me active distress but which I did for as long as I was paid and no longer; and I have also had jobs in which I found myself 'working' through weekends and holidays purely for my own satisfaction. All these are possible tracks — some jobs are 'good enough'. Choices are important, and the difference can be qualitative.

'Life's like that'. Imperfect but importantly differentiated. And this — precisely — is the arena of medicine. Medicine is not about attaining perfect health, a beautiful appearance, optimal fitness, and euphoric happiness. Medicine is about moving people to the right side of the line. Moving from a life dominated by the consciousness of pain to a life in which the pain is controlled enough that we can forget about it. About having skin disease treated, not to the point of a flawless baby's bottom, but to the point that we are no longer self-conscious about our appearance. Accepting that life is not about a continual state of transcendent euphoria, but that it is well worth alleviating psychiatric symptoms to the point that we can engage in creative work and rich human relationships.

If personal life is a set of existential thresholds, then we should try for better-than-threshold levels in as many significant areas as we may. When life is on the wrong side of the line in love, in work, in family, in community. then at best we may suspend judgment. Life is a matter of waiting and hoping.

Existence is flawed, the human condition is one of conflict and chaos. But some lives feel good-enough from the inside, and that distinction is worth striving for.