Note to authors of letters: Letters submitted for publication should not exceed 400 words. All letters are subject to editing and may be shortened. Letters may be sent either by post (please use *double spacing* and, if possible, include a Word for Windows or plain text version on an IBM PC-formatted disk), or by e-mail (addressed to journal@rcgp.org.uk; please include your postal address). We regret that we cannot notify authors regarding publication.

Roles of President and Chairman of the RCGP

Thank you for publishing the article by Southgate and Pringle in the October issue (pages 854–855) on this important subject. As the person who has most recently held both these offices, I would like to describe two other roles of the President of the College which were not mentioned.

First, the President traditionally visits most or all of the Faculties during the three-year term. This is a great privilege and allows the President to meet more members of the College and hear more comments direct from members than anyone else in the College. He/she is usually asked to speak or lecture at Faculty events and is thus responsible for describing and defending College policy on these occasions. I would like to thank all the College Faculties which invited me during my term, and their Officers who provided extensive hospitality to me, and often my wife, which has been very much appreciated.

Secondly, the President of the RCGP has been a member of the Academy of Medical Royal Colleges (formerly the Conference of Medical Royal Colleges and Faculties in the UK) since 1976. Two RCGP Presidents have been elected Vice-Chairman of it: Sir Michael Drury from 1987 to 1988, and me, from 1998 to 2000. My election as Chairman of the Academy in June 2000 was only possible through the RCGP President's membership of that body, since the Chairman has to be a member or recent member. I would like to record my thanks to the Presidents of the specialist Royal Colleges and Faculties, who have for the first time elected a general practitioner to be Chairman.

PROFESSOR SIR DENIS PEREIRA GRAY

Past-President, Royal College of General Practitioners

Reciprocity

As a College member practising in the United States, I read Smart's letter on abandonment of reciprocal recognition of training between the RCGP and its overseas counterparts and Evans' reply with interest (November *Journal*, page 916).

Like Smart, I am taken by surprise by the lack of discussion prior to making a decision and rapid implementation of such a radical departure in policy. The reasons cited by Evans do not justify the course of action taken. As he states, reciprocity simply allows for a candidate trained in one country to sit an exam in another. If competent in the practice of medicine, a practitioner from the United States is unlikely to be successful in the reciprocal exam without a period of adaptation to British medical culture (or vice versa). While standards for reciprocity should be uniform, the effort expended by the College to verify these standards may be variable. In the case of the United States, there is an abundance of authenticated statistical and reporting information gathered in the formal process of accrediting individual programmes in Family Practice every 2 to 5 years as well as compliance data for federal government health programmes, not to mention alternative information sources. The training regulations form a stable base and do not undergo frequent changes.

In consequence, the burden on College resources would not be as large as Evans suggests.

Finally, Evans states that only a few are disadvantaged by these changes. Our College is dedicated to improving healthcare and academic standards. In the age of the 'global village' with internationalism and convergence of technologies being reflected in medical education, research trials, evidence-based medicine, and comparative health care, withdrawal of reciprocity suggests that the College is a regressive organisation unable to learn, adapt or lead.

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Shared decision-making

I read Elwyn and colleagues' paper on shared decision-making with interest.[1] However, I am surprised that the doctors would only involve patients in decision-making when the doctor perceives that a range of treatment options is available. I would liken this approach to the doctor offering the patient a 'menu' of options from which to choose. This does not allow the patient to contribute to the content of the 'menu'. I would argue that people regularly make decisions regarding their illness and may consider doctors' advice alongside their own opinion and advice gathered from other sources.

It is well known that the rate of compliance with medical advice is often

low.[2] Therefore, patients commonly decide not to follow the treatments that doctors recommend. It might be that they consider 'doing nothing' to be an option even when doctors do not. Furthermore, patients may be able to identify options that the doctor had not thought of. Although the doctor is 'the expert' in the provision of health care, the patient is 'the expert' in his own illness.[3] Patients may consider lifestyle change or alternative therapies alongside medical treatments.

In conclusion, the 'shared decision-making' model should be extended to allow patient participation in the formulation of treatment options. Therefore, it is potentially relevant to all consultations.

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Can anyone pass the summative assessment MCQ?

Summative assessment consists of four parts. The trainer's report, assessment by video of consultation skills or simulated surgery, a written submission (usually an audit), and a multiple-choice questionnaire. The latter differs from the others (except simulated surgery) in that it is not open to assistance from a trainer or other person. As with the audit, it can be attempted any number of times.

The examination consists of a small number of extended matching questions and a much larger number of traditional true/false questions with no negative marking. Randomly guessing answers to these questions will on average give a score of 50%. The pass mark is set by a group of doctors who attempt to guess the proportion of 'minimally competent' doctors that do not pass.

Problems with this form of assessment arise when candidates are allowed to sit the examination many times. While, on average, guessing without any knowledge will give a mean mark of 50%, scores will be evenly distributed around that mean, with some being considerably higher. Not even the worst registrar has no medical knowledge and so a below minimally competent registrar with some knowledge will increase his or her chances of reaching the set pass mark if he or she makes several attempts.

While on each individual attempt the less-than-competent registrar has the same chance of failure, the chances that he or she will fail five out of six times is much less. Although many of us may not be prepared to bet our shirt on heads coming up on the toss of a coin, we would be much happier about betting on it coming up once in five, six, or seven, or even more tosses of a coin.

The JCPTGP needs to seriously address the problem of multiple attempts at the MCQ. There are already reports of registrars passing on their fifth attempt at this examination. If we are to believe that the need to pass summative assessment is a protection for patients then either the examination must be altered to reduce the risk that poor candidates may pass, or candidates must be limited in the number of attempts they are allowed to make. As it appears European legislation may prevent this latter course, the nature of the examination should change.

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NHS National Plan

Congratulations to Davis[1] for highlighting the lack of recognition in the NHS National Plan for the existing specialist knowledge of general practitioners. For as long as the Government, the public, or our colleagues believe that general practice involves just the application of specialist medicine at a less technically advanced level, then the future of general practice in this country will remain under threat.

I entered vocational training because I want to be a GP, and because I believe that GPs have a body of specialist knowledge about medicine in the community and the many ways in which patients present. My enthusiasm for general practice started when, as a student, I was lucky enough to have been exposed to the wide range of problems and concerns, physical, psychological and social, that are dealt with daily by general practitioners. Being a registrar has confirmed my choice of career and, although frustrated by a system where acute hospital service provision forms more of vocational training than primary care, I remain enthusiastic about the actual and potential benefits of general practice in this country. While I accept that certain defined diseases can be dealt with (in most cases) using guidelines and with an increased role for non-medical professionals, much of what I see on a daily basis does not fall into this category.

Communication skills tutors emphasise that many patients may present with one thing, but have another more serious physical or psychological complaint which they are less willing to admit. The best GPs that I have been taught by use not only the immediate history and examination but also a knowledge of the patient's life history, family, and social background when making decisions. If we move to seeing only those patients who fall outside the nurse practitioner protocols, and ignore the 'non-scientific' aspects of primary care as Lipman suggests we do,[2] then we will be doing a disservice to a number of our patients — and we will never know who or how many.

GPs need to assert proactively their knowledge and specialist contribution to the NHS, and ensure the quality of their services. They need also to determine the future shape of GP training themselves, to make it more primary

care-based and more relevant to modern general practice, rather than let it be dictated by others. Perhaps then the future will not be as bleak as some currently predict.

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Evaluating primary care research networks – exposing a wider agenda

The juxtaposition of two papers in the same issue of the *BJGP* examining how primary care research networks should be evaluated exposes a fundamental tension that offers insight into the evolving NHS Research and Development strategy.

Carter's thesis[1] reflects an entrapment in the modern — a confident assertion that the rigorous application of science will generate knowledge that can be engineered to achieve specific goals. This approach is characterised by a reductionist world view (systems can be understood by reduction into their component parts) and a linear relationship between process and outcome. The emphasis is on hierarchy, command, and control, and rigorous evaluation at every level of health service delivery.

In contrast, Griffiths[2] applies a postmodern perspective on evolving research networks. A critique that rejects the view that organisations are concrete entities that can be systematically described and explained but sees a fragile world that is socially constructed — 'non-hierarchical organisations with informal internal relationships based on trust and cooperation and driven by a common ethic.' A world that can accommodate goal-seeking behaviour but is cognisant to the importance of network history, relationships, culture, and aspirations. What insights does this dissonance offer us about the broader NHS R&D picture?

The evolving NHS research plan remains firmly aligned with the modern. The emphasis is on top-down strategic direction, goals, planning, and accountability. An alternative perspective would be to recognise that we live in a complex environment; that simplistic solutions are rarely obtainable and that we can only make general remarks about the behaviour and dynamics of a system; that we learn by reflecting on the interaction between rhetoric and experienced reality. There is a need to concentrate on being vaguely right and recognising that outcomes are never a final solution; but part of a learning process which leads to a decision to take certain actions in the knowledge that the problem will not be solved but may lead to a new situation in which the whole process can start again.

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Concordance in medicine

Concordance in medicine-taking is described as a new approach to prescribing and taking medicines that involves negotiation between a patient and health care professional.[1] We interpret this as a two-way process that is different (although related) to compliance or adherence. We were puzzled, therefore, by the report by Hermoni *et al*[2] that purported to describe doctor–patient concordance and the treatment of low back pain. Their own definition of doctor–patient concordance: 'the difference between physician's recommendations and subject's self-reported adherence' shows that their definition of concordance is at considerable variance to the definition described above by the originators of the concept.

If the prescribing of a medicine does not fully involve an informed patient, then any subsequent behaviour cannot be described as concordant or non-concordant and the term compliance or adherence should be used. This study does not examine the doctor–patient relationship in the context of the concordance model; what is described is actually based on the orthodox model of compliance or adherence. A useful criterion to apply is to remember that a patient cannot be concordant (or not concordant) on their own and neither can a prescriber. Concordance or non-concordance is the result of the behaviour of both parties.

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In their interesting article on the behaviour of patients with an acute episode of low back pain Hermoni and colleagues state that they measure patient 'concordance'.[1] However, I would argue that they have measured patient 'compliance'. 'Compliance' has been defined as 'the extent to which a person's behaviour (in taking medicines, following diets, or exacting lifestyle changes) coincides with med-

ical or health advice'.[2] In contrast, 'concordance', has been defined as a negotiated agreement on treatment between patient and health care professional.[3] The data presented in the paper show no evidence that the treatment recommendations were a 'negotiated agreement' rather than the physician's instructions. 'Concordance' should not be used as a politically correct term for compliance.

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To syringe or not to syringe, safety is the question !

In the light of the principles of the new NHS and with the aim to reduce referrals to specialist centres by 20%, we felt that investigation of the provision of ear care in the primary health care setting should be undertaken. We investigated the competency of the nurses practising aural care in the primary health care setting to reveal the quality of care being delivered to the patient. The implications to the general practitioner (GP) are extremely important especially in the litigious climate that exists in medicine at the present time.[1] Training in ear care for all practice nurses (as provided by the Rotherham ear care agency) is essential if they are not to leave themselves and their employers open to litigation following inadequate practice.

Our department sent out a questionnaire to 120 practice nurses and 60 were returned. Each practice nurse performs syringing on average 3.3 times a week. None of the nurses carried out aural toilet. A total of 56.7% of them feel that they have received training in aural care and 43.3% feel that they have not. The GPs did not examine the ears that were deemed suitable for syringing in 17.6 % of the nurses who had received training. However, the GPs did not examine the ears in the untrained group of practice nurses more often (23.1%). The untrained practice nurses suggested a mean confidence in syringing of ears that was higher than the confidence level in the trained group of nurses.

The findings agree with research suggesting a lack of training and knowledge in the provision of ear care.[2] The results identify that the practice of GP examination of the ears prior to syringing, is not dependent on whether the practice nurse is trained in ear care but on tradition or GP/nurse preference. The findings raise professional issues regarding the accountability of the nurse or the practice in performing ear syringing without training. The conclusion of the study highlights the importance for improvement in ear care within the primary care setting. An improvement in training of ear care within the primary health setting would also reduce referrals to the ENT outpatient department, increase efficiency of GP time, improve practice nurse knowledge, technique and accountability, and most importantly, improve the quality of life for patients with problems of the ear and hearing.

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Counsellors in general practice

Professor Michael King's letter on counsellors in general practice, published in the November *Journal (*page 920), makes two very important statements, one possibly correct and the other totally incorrect.

What is more, in the original paper he quotes from, it was for some reason not claimed that 'severely depressed patients were more likely to respond to brief counselling' and it is of interest to see he now makes this remarkable claim.

The second statement where he appears to criticise Green's integrative approach seems to betray a lack of awareness of the way skilled and experienced therapists actually work in the hurly burly of day-to-day clinical practice. Very few skilled and experienced primary care counsellors or psychological therapists in other settings use exclusively the approach dictated by their 'core model' belief system.

Certainly in primary care the reality is that, like all effective brief psychological therapists, they use what works, matching the clinical approach to the patients needs and not vice versa, as sometimes happens in an exclusively psychodynamic or cognitive behavioural therapy environment.

Green made no claim to be 'proficient in the methods of six independent schools of psychotherapy' — and to claim that she did shows King and Lloyd's flawed understanding of the practice of brief psychological therapy.

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Treating depression in primary care

I am puzzled. Six of the seven authors of Khaira *et al*[1] appear to have provided the answer to the request they made in the last line of their paper; 'for studies that evaluate the effectiveness for depression in primary care'.

In this month's *Br J Psych*, a paper 'Assessing the effectiveness of treatment for depression in primary care'[2] the six joint authors of the *Br J Gen Pract* paper were listed as members of the eleven author team that reported that eight weeks of counselling and eight weeks of antidepressants were equally effective in the treatment of depression.

What puzzles me is that the *Br J Psych* paper was accepted for publication in May 2000 and the paper in the

Br J Gen Pract was accepted in August 2000.

If they knew the results of the counselling versus depression study, why did they not mention them to show that perhaps the public actually does know something about counselling as a treatment for depression that maybe psychiatrists, general practitioners, and health service researchers sometimes have such a problem admitting?

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Learning from complementary medicine

Philip White asks what general practice has to learn from the exodus of patients to practitioners in the complementary medicine (CM) sector.[1] Many good points are presented including the importance of encouraging a positive mind set in patients with chronic illness — to which I would like to add the following:

It seems a pity that CM practice and general practice have to be set apart as we see in this article. One response of general practitioners (GPs) to this rise in interest in CM could be to learn to integrate CM into their personal therapeutic repertoires. I have for instance been practising acupuncture for minor musculoskeletal problems on a daily basis after only a two-weekend introductory course with the British Medical Acupuncture Association. I now have a therapeutic option that I can do safely at little cost, within a 10-minute consultation and with a high level of patient satisfaction.

Similarly, whatever your particular take is on the effectiveness and mode of action of homeopathic medicines, the application of the homeopathic process, though less compatible with the 10-minute consultation, seems to fulfil a basic need in patients to have their problems addressed in an individualistic and holistic fashion. Homeopathy offers a coherent handle on many conditions with which modern medicine struggles.

I am not sure I agree with Dr White that we can replicate the added value of CM simply by doing our jobs better as 'deeply caring doctors'. That will do a great deal but we also need to start to think about directly employing these methods (and teaching them in our medical schools). It would be worth building on what we know already (for example, the work of May and Sirur)[2] about the experience of GPs already using CM. It has certainly helped to keep me enthusiastic about general practice and engendered very satisfying clinical relationships.

I am not speaking against private CM practice but I do feel that the best model is one of integrative care within the NHS and GPs may be well placed to deliver.

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I was very interested in the discussion paper by Philip White.[1] However, I am not convinced of the value of discussing these widely differing practices and philosophies as one amorphous mass of 'complements'. My experience is limited to a definable part of what is crudely so identified, now commonly referred to as musculoskeletal medicine that, if Hippocratic practice and teaching are to be regarded as the cornerstones of western medicine, is seen to be fundamentally orthodox.

White stresses the inadequacy of many general practitioners' (GPs) consultations, suggesting that this is a major factor in the patient's decision to seek help elsewhere. He specifically cites a common lack of educational content in the consultation and comments on the desirability of providing a more personal service. Of course, he is quite right. As far as musculoskeletal matters are concerned, I would add the further strong desirability of the GP treating the patient on the spot, (so long as there are no contraindications to his proposed therapy). This inadequacy extends to therapies currently seldom on offer, chief of which is vertebral manipulation.[2]

Unfortunately, many doctors seem to have accepted the view that the medical manipulator is '… an expensively trained specialist'.[3] The same source also maintains that '… provided a medical diagnosis is first made, and the known contraindications to specific manipulations are respected, the registered lay manipulator probably provides the community with a safe and helpful service'. What is does not say is that the GP may quickly and easily learn the theoretical and practical aspects of vertebral manipulation at minimal expense, and may thus offer his patients immediate, safe, simple treatment, with reasonable expectation of success.[2] From all points of view, this would appear preferable to any sort of referral or patient-ordained by-passing of the GP. and there is today evidence aplenty, both to cast serious doubt on some complementary teaching on the subject and to support the wide development of musculoskeletal therapies within general practice, on a sound scientific basis.[4,5]

I was prompted to seek further guidance from the RCGP *Members Reference Book*. John Dickson and Gillian Hosie discuss bone and joint disease. They offer a figure of 15% of the GP's workload as being in respect of musculoskeletal medical problems and refer to the 'red flags' of the published guidelines.[6] If local examination of the spine were to become normal practice then this figure might well prove an underestimate. In the very limited compass available to them, other than saying that '…musculoskeletal problems will move up our agenda…' Dickson and Hosie make no comment on these very common conditions, let alone on how best to deal with them.

It would seem reasonable to move

musculoskeletal medicine to the very top of the agenda.

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The future general practitioner

Dr Lipman provides an important discussion paper on the rapidly evolving role of the general practitioner.[1] The emphasis of his paper is on change and a need to change as a result of evidence-based medicine (EBM). This would lead to general practitioners (GPs) becoming specialised, managed, delegating generalists following evidence-based guidelines, thus assuming the role of consultants in primary care. In turn this begs two important questions both of which could lead to the need ultimately to change the College motto, *Cum Scientia Caritas*, translated as 'scientific care with loving kindness'.[2]

First, what if continuing professional development (CPD) leads a GP or primary care team to the conclusion that they are achieving current best practice and so there is no reason to change their practice? Second, are we excluding the consultations in which no diagnosis is reached? GPs are trained to make diagnoses and to recognise illness without underlying disease. It is the latter which constitutes the bulk of a GP's workload. In training and in practice a GP applies the most important of 'tools', the consultation, in the art of diagnosis. This is not evidence-based but an art of how and when to apply science.

Finally there is Balint's proposal of the doctor as a drug in the consultation, which is as yet unmeasured and unevaluated[3] but a potentially powerful therapy that can improve the health of those with illness, whether or not they have a definable disease. Lifelong learning — yes, but CPD should be wider than EBM if it is to meet the health needs of patients.

If Dr Lipman's vision is implemented then *Cum Scientia Caritas* is threatened and so the health of the nation. Why such an apocalyptic conclusion? Simply because the role of GPs as they practice now through the doctor–patient relationship would be limited to a mechanistic rulebook.

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