The Back Pages

viewpoint

Public involvement in primary care: time to turn good intentions into practice

Public involvement in primary care has been recognised as a good idea for over 25 years. It is a vital component of needs assessment, health promotion, and clinical governance, where patients can add value to audit, risk management, and quality assurance. Public consultation is of particular importance when developing and improving services for hard to reach groups, such as teenagers.[1] Participation is in itself health promoting and can enable communities to tackle their own health problems.[2]

And yet, training in public involvement is wholly foreign to most GPs, who consider consumer opinion unhelpful because of unrealistic patient expectation, invalid methodologies, and the bias of those with vested interests .[3] Of the 20 000 accredited meetings run in the West of Scotland, for example, since 1990 none have focused on the training of GPs in public involvement.

An editorial in the *BJGP* describes how a combination of burgeoning consumerism, rapidly escalating patient expectations [and] relentlessly increasing accountability is putting GPs in the hot seat .[4] Ruth Chambers refers to pressure from local champions or special interest groups for their particular pet causes in the context of the need for restraint when planning educational programmes.[5]

How can GPs reconcile the difference between their ethical obligations to the key stakeholder in the NHS and their own professional values, which are too often tainted with prejudice or altruistic paternalism? Hard pressed GPs find difficulty in allocating equal value to the patient perspective, however honourable their intent. How do GPs address the unconscious and learn to value the expertise and unique information provided by voluntary organisations and single issue groups?

Education and training is the key. Training in public involvement is omitted from most GPs undergraduate and postgraduate education. GPs need to be convinced of the benefits of patient participation, given practical support, and advised of pitfalls.

The devolution of power and delegation of responsibility to PCGs and LHCCs requires that educational activities are extended to the primary care team and the populations within their remit. After all, uninformed people make uninformed decisions. The result in terms of public involvement will be to build capacity, not only into the community but into the NHS as a whole.

Currently, despite considerable political rhetoric, there is no financial or serious educational provision for such training. National strategic plans emphasise the what but not the how of public involvement. The how requires some basic knowledge, such as sampling techniques and an understanding of the concepts of community development, empowerment, and equity. While quantitative methods of data collection can give a global view to advise health planning, qualitative information (from interviews, focus group discussions, and other forms of interaction) allows us to go from macro to micro, identifying existing community resources, harnessing the enthusiasm and expertise of voluntary groups. But GPs need the relevant training, and such training needs to be funded adequately.

There is considerable literature on public involvement, several useful websites and resource packs for primary care teams available from the Health Education Board for Scotland. For the enthusiast, there are postgraduate degrees.

To formulate judgements and make informed choices the public requires education about different treatments, services, clinical effectiveness, and the need for explicit rationing decisions. It is through education and training that we can develop a constructive relationship out of apathy and adversity and change the culture of medicine and our society.

Jill Murie

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"A short waspish professor of liverish things told me to go away, drink what I liked, and never, ever let anyone check my LFTs again. Soon I felt much better ..."

Alan Munro, page 86

contents

16th WONCA World Congress of Family Doctors
13 – 17 May 2001
International Convention Centre
Durban, South Africa

THE Congress's scientific programme will include daily plenary sessions from well-known experts: Dr David Satcher, the United States surgeon general, will speak at the first plenary session.

Clinical practice sessions will offer workshops and seminars on disease updates, clinical skills, therapeutics, respiratory medicine, geriatric care, sexually-transmitted diseases, environmental and occupational health, as well as other topics for family physicians.

There will also be workshops on evidence-based medicine and sessions for those involved in research, teaching and training. There is a special one-day track that focuses on rural and remote medicine and another that focuses on women's health.

No Congress is complete without its social programme and the Traditional Dinner is always a highlight of the WONCA Congress. There is an Accompanying Persons Programme, and Registered accompanying delegates will be able to attend the Opening Ceremony and cocktail function on Sunday evening, the Opening Plenary Session on Monday morning and the Closing Plenary Session on Thursday.

If you would like more information or to register, click onto the WONCA Congress web site at **http://www.wonca2001.org.za** or e-mail the South African Academy of Family Practice at **saafpncb@saafpncb.co.za**

The What, How and Why of PCRTA

PRIMARY Care Research Team Assessment (PRCTA) is the most recent assessment scheme being launched through the RCGP. Having undergone a pilot phase over two years, the scheme is being supported by the Department of Health (DoH), with funding to enable PCRTA to launch as a national scheme in March 2001.

What is it?
There are already a number of assessment schemes in existence, such as the RCGP Quality Practice Award or the King s Fund Organisational Audit. None of these consider the research aspect of a primary care team and yet, there are an increasing number of research practices across the UK. PCRTA therefore aims to measure and recognise the quality of primary care research undertaken within general practice against professionally developed, tested, and published standards and criteria.

The increase in the number of research practices and the variety of work undertaken has been recognised by the DoH who are developing new funding arrangements for R&D in the NHS.[1] The terminology used within these arrangements is reflected within PCRTA where two levels of assessment for research practices collaborator-led and investigator-led have been developed. The scheme also fits with a recent DoH document on the development of a framework for research governance.[2] Similar to the principles of clinical governance, this aims to provide a framework to promote improvements in research quality. It is envisaged that PCRTA will be a key step in achieving the elements of research governance.

How are research teams assessed?
On confirming their intention to undergo PCRTA, research teams will be provided with advice as to possible sources of mentoring. This may be from a number of sources such as a local primary care research network (PCRN) or perhaps research teams may wish to contact practices who have been accredited within the scheme. Practices are then asked to prepare and submit written documentation relating to key criteria. We envisage that this will be a team activity which, as highlighted within the pilot phase, allows research teams a dedicated forum for discussion and strategic thinking. Having assessed written documentation, a multi-disciplinary team of three assessors then undertakes a half-day visit to the practice. Feedback is provided on the day of the assessment visit, highlighting strengths and areas for development.

Why undergo assessment?
PCRTA provides a process of continuing development for the research team. Systems are being developed to ensure that local support is available from appropriate sources for practices entering the scheme. For example, building on the work from the pilot phase, a series of workshops is being held with PCRNs across the UK to investigate ways in which they can participate in the scheme.

Continuing development is not only about practices having access to support and guidance. The assessment process itself encourages discussion and planning amongst both the research and wider practice team. An independent and external assessment process complements this and allows practices to gain independent feedback, encouraging them to develop in the most appropriate way.

Above all, PCRTA recognises and rewards excellence. PCRTA accreditation provides a kite mark of quality. This may be useful, not only in relation to the proposed research governance arrangements but also in reassuring patients involved in practice research, as well as providing a useful demonstration of a practice s capabilities and standards when seeking funding.

If you are a research practice and would like to find out more about PCRTA, are interested in becoming an assessor or would simply like more information, please contact Jenny-Kathleen Thurkle (tel 020 7581 3232 ext. 338; email: **pcrta@rcgp.org.uk**).

Sara Shaw
Jenny Thurkle
Yvonne H Carter

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The Child Bereavement Trust Conference

The conference, entitled Baby and child death: managing the issues , will take place at the Theatre Royal Drury Lane in London on 15 May 2001. The keynote speaker will be Professor Liam Donaldson, and the programme will have discussions on: regaining public trust; partnership with parents; the law; ethics and emotions in a multi-faith society; and best practice and policies for the future.

For more information contact Conference Creations (tel 01491 419800; fax 01491 419801) or visit the conference website at **cbtinfo@conference-creations.com**

requests for help

GENERAL practice must be the most interesting medical speciality to study. In the UK we have registered lists of patients, often kept for many years, with ailments ranging from the commonplace to the exceptionally rare. Wherever in the world we are working we still have great freedom to observe the natural history of disease, whether modified by us or not, from its earliest manifestations to the grave.

Why then do we lag behind other branches of the profession when it comes to our research output? Why are practices bombarded with unsolicited requests for help (16 to 24 a year, according to a recent paper[1]) when they would like to be able to distinguish quality research proposals. One answer is the relative isolation of those who are keen to study our discipline, whether as leaders or collaborators. Yet only a very small proportion of the very large number of readers of this *Journal* need to participate to make a worthwhile study. Below are a couple of examples from my experience, by way of illustration.

A decade ago I responded to a request for help in the *BJGP* about patients with gout on long-term allopurinol. This led me to examine how quickly we diagnosed gout. This year the results from 111 patients in our practice were published. Some years later I saw a request for help, again in the *BJGP*, with a study on the history of British general practice. I had recently read the day-book of a local GP from 1903, and so was able to contribute information that would otherwise have lain undisturbed indefinitely. Last year I was gratified to read an acknowledgement in Anne Digby s *The Evolution of British General Practice 1850–1948.*

We are all busy, but those of us who enjoy research can often find time to explore something new. We should therefore like to publish a quarterly column, Requests for help , where researchers can seek collaborators. Usual studies would be anonymised observations that would not normally need formal ethical approval. To avoid yet more half-finished projects we are asking potential requesters to tell us something of what they have already published (which need not be highbrow). We shall similarly not publish a second request for help until the first has seen the light of day. Finally, to encourage everyone we should like to print a synopsis and reference when it does.

Is there a demand for such a column? Are the rules of thumb we have suggested reasonable? Should we be more or less open-minded? What sort of subjects do researchers need help with? Let us know at **journal@rcgp.org.uk**.

John Holden

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writing about general practice ...

In October the *BJGP* asked for potential columnists to submit their wares. The response has rather taken us by surprise, being intimidatingly large and enthusiastic. Not at all Collegey!

There must be a short intermission while our panel of experts deliberate amidst high security. New recruits to our distinguished team of columnists will be announced in the February issue of the Journal.

As an editor, I love this sort of thing. Splendid copy from all over the place, to mull over at leisure. I would like to thank everyone who has been brave enough, and creative enough, to take time to write. (And more non-UK contributions are still welcome...)

But in the meantime, and with authors permission, here is a taster...

Alec Logan
journal@rcgp.org.uk

Clever Young Doctors

I have a relative who lives in New Zealand. Let us call him Lane, for that is his name. He s an ordinary bloke who likes talking, lying around in the sun, tinkering with cars and fishing. I like him. He s a relaxed sort of person who always seems to have time to discuss life as it comes. But he was not always like that. Once upon a time he owned a company, had to meet deadlines and worried his guts out about what seem to be trivial things to outsiders. Then something happened which changed him entirely. One day he had a chest pain and was admitted to hospital. He was there a day or two having all sorts of tests. He was monitored, had serial ECGs , and blood was taken for things like cardiac enzymes, cholesterol, and electrolytes. Eventually he had an exercise test which was entirely normal. The consensus seemed to be that the chest pain had been due to indigestion. But fortunately for Lane the tests had taken a day or two to organize. And while he was sitting there in his hospital bed a clever young doctor (CYD) who was on another firm sauntered by, glanced at Lane and had a thought. The thought turned to conviction so the CYD beetled off and found the consultant who was looking after my relative. For the CYD had observed that Lane looked acromegalic. Predictably, this was something which nobody in the family had noticed. But now probing questions were asked, scans were done and the upshot was that the patient was referred to a neurosurgeon and had his pituitary adenoma removed just before it got to his optic chiasma. A fact for which he was extremely grateful. So grateful indeed that he decided that if normal life could hang by such thread he would take steps to enjoy it more. He sold his business and retired. Nowadays he spends a lot more time talking, fishing and sitting in the sun.

Which brings me to a patient of mine who found that she was allergic to the sun. Or so she thought. Every time we had some sunshine she would be out in the garden, but she noticed that a day or two later she would develop quite severe nausea. By the time she appeared in my surgery the weather had usually changed and her symptoms had disappeared. Physical examination, urine tests and blood tests were all normal. It was a puzzle. But in due course she attended the hospital outpatients and reported her symptoms to a CYD who hit on the diagnosis straightaway. My patient had sarcoidosis. Her blood calcium was usually within normal limits in the winter, but exposure to sunlight caused her body to increase its production of vitamin D, which in turn resulted in a rise in her serum calcium. This was the cause of the extreme nausea and lassitude of which she complained each summer. She was much improved by steroids, which she took in a small dose for several years until the sarcoidosis had burnt itself out.

Both these stories illustrate how important it is that other doctors, and especially CYDs should have the opportunity to see our patients. No matter how clinically alert he or she tries to be, the average mature GP is going to miss things which might seem perfectly obvious to a CYD. Medicine is not easy, and the flash of inspiration only comes to a prepared mind. It is all the better if that mind has been freshly prepared

EE Cockayne

Sheep trials and tribulations

I have a nagging sense of unease about the situation with our sheep. Every morning that they don t all come running promptly when we go to feed them, I immediately start imagining they are lying diseased in some corner. Luckily, my imaginings have not yet turned into reality. They have all always appeared in the end, usually just concluding some private conversation before coming running.

The problem is we have no way of transporting our sheep. My anxiety is about how we can get them seen by the vet if they do fall ill and my horror of having to request a home visit simply because we have no transport.

I imagine it must be easy for urban sheep. No doubt they can amble a few doors down the street to see a vet when they are feeling a tad weak on their hooves. And even when they cannot make it, at least the vet does not have to travel far to get to them.

Up here in the wilds of England, perilously close to a contradiction in terms as that may be, the time cost to a vet of coming to do a home visit, a field call, is probably at least an hour. Quite possibly more than that if you take into account our ineptness at catching our sheep. Call it an hour though, since you would expect a sick sheep to be a bit easier to catch than a healthy one.

At that rate of visiting it takes precious few requests for visits to completely wreck a working day. The only way our vet can cope with this is because, presumably, such days are few and far between. Nevertheless, my fear of helping to cause a day like that is enough to keep me worrying about our lack of transport.

This is not the end of my concerns either. I also fret that vets will be forced into co-operative working out-of-hours. For all I know, urban sheep may already be used to this sort of arrangement and it may be that none of them bleat about it, finding it to be an arrangement that is at least as efficient as any other they have known. But I do not really believe our sheep would be so impressed were the change to happen around here.

The simple mathematics of such changes dictates that, where the population density of vets is small, the area needed in order to have enough of them to make a viable co-op rota is large. Therefore, a veterinary out-of-hours co-operative in this area might well mean that

the travelling distance to the out-of-hours centre is even further than the distance to the vet is already. Which would in turn probably mean that the vet on duty on any particular night would be even less in a position to do a field visit than at the moment, being inundated at the centre with coughing dogs and mewling cats.

It is illegal to transport livestock by car these days. There have been prosecutions. What could I do?

As if all this is not enough, it is something else that actually stops me from sleeping. Something far more pernicious. Something so awful to comprehend I have already thought of a name for it: NHS4Legs. That s right, I am talking about a national helpline service that triages all calls to vets. Then, the night Murdo develops Rams Hurt Syndrome, I will spend two hours on the phone before being advised to go direct to Edinburgh veterinary hospital. What would I do?

Saul Miller

Splashing Out

It s a blustery day, white horses at a trot from the South-west. Force five, six? I must swot up on the Beaufort scale if I'm going to earn my living doing this sort of thing. We descend the granite steps of St Mary's fine old quay, clamber over the legs of bemused visitors in a couple of pleasure boats, and are welcomed onto the medical launch by Martin its skipper, and his dog Scout. As we head out towards Tresco, Martin brews the tea while I watch the waves, elation tinged with apprehension. This is not exactly trial by sherry.

The health centre, which I was shown round yesterday, is magnificent, a white-walled and slate-roofed octagon commanding grand views of the islands and ocean. The waiting room is airy, light, and spacious, the offices and consulting rooms generous, and the meeting room upstairs feels like a first-class lounge on an upper deck. No wonder Toby, the senior partner looking for someone to join him, is so cheerful: he used to work in the Royal Navy.

What I like about this job, ' he says, only half joking, is that the nurses do the real work, and the doctors go boating!

And so we do. Safely across the channel, and my tea still safely *in situ*, we jump ashore and head off to the branch surgery held in a room in Tresco s community centre. I ask an 80-year-old what brought him to the island.

'I was sent here for a rest forty years ago, and seem to have stayed .

Such stories are commonplace, I soon discover. And having visited Scilly many times with my young family for glorious holidays amid turquoise seas, white sands, and tranquillity, I can understand why. The question is whether the reality of life on a small island 30 miles off Land s End will live up to the fantasy I have long nurtured, and which I have thrust on my wife only three weeks ago. The other question, of course, is whether Toby thinks I m right for the job, and for him.

After three home visits on foot on Bryher (population circa 60), we head back to St Mary s. The sea is running across us, the boat is tossing about, it is very wet, and I can t stand up. Scout opens one eye, shuts it, and snoozes on the warm engine housing. Toby and I repair to the cabin and he eagerly opens the packed lunch thoughtfully provided by his wife, Anne. Now it s trial by crab sandwich.

That night Toby and Anne take us out to dinner. My wife and I have each had a wonderful day, and are slightly high on the sights and smells of the sea and the strand, and overwhelmed by the kindness of our hosts and the friendliness which we have met everywhere. We are wondering whether I m actually being offered the job, and wondering if Toby is wondering whether I still want the job. I take the plunge halfway through our meal:

Er we d like to come if you want us.

Oh, good. We hoped you would.

So that s how it s done! And I always thought job interviews were close encounters of the fierce kind.

There remains the question of accommodation, not an easy one in a place where freehold values reflect the scarcity of housing and its desirability for retirement, and where rented accommodation is strictly controlled by the Duchy of Cornwall. Fortunately, an incoming doctor is regarded as a key worker isn t that refreshing? and we are offered a flat the following day. It will be a challenge to reduce our gallons of possessions into this pint-sized pot, but the view is breathtaking, looking westward to the twin hills of the now deserted island of Samson. We dream of sunsets beyond number, and cosy evenings battened down against storms and gales. I try not to think about night visits to the off-islands.

Dougall Jeffries

The Cure

Complementary therapy is not just for placenta-eating, feng shui affician-ados. Long before the trendy set discovered the benefits of acupuncture or colonic irrigation, alternative therapy has had a well established place in some rural parts of Ireland. These therapies are collectively termed Cures .

In my mother s family, in Donegal, there are two Cures. My aunt Florence has a Cure for erysipelas. My uncle has a Cure for epistaxis. This he has also used to help sufferers of threatened miscarriages and, on one occasion, brain haemorrhage. More distant relatives had Cures for heart failure and ligament sprains. A woman down the road has a Cure for thrush. Nearby Raymochey School has compiled a book of local Cures. Everybody seems to be at it!

So what is it that they re doing? Well, let s take the erysipelas. Patients self-refer with any sort of spreading red rash. The odd one has even been sent by a GP (heartsinks, no doubt). Diagnostic criteria seem less important here. The key ingredients are the desire of the sufferers to be helped and my aunt s willingness to do so. There is faith on both sides of the therapeutic fence. Florence takes a quantity of butter and divides it into nine pieces. She has a blessing which she must say away in private. Then she asks that three pieces of the butter are rubbed into the rash on each of three consecutive days. The Holy Trinity must be recited during the butter application. At the end of the treatment, any butter remaining must be buried in the ground. No money changes hands, but hard-pressed gifts, accepted to avoid offending, are later given to charity. Most Cures involve a process like this. There is a prayer, incantation or ritual of some sort. There is a material, such as butter, tea leaves, ribbon, cord or clay. The patient is given a role in the treatment.

The parallels with a GP s own ritual (the consultation) and material (the drug) are obvious, but while Florence s punter leaves with a belief and a positive frame of mind after a Cure, can the same always be said after a GP consultation? I suppose, dear old auntie Flo doesn t have the constraints of ten-minute appointments to harness her healing ways. The only computer she has in the place is a new-fangled gizmo that can tell if the milk in the dairy is at the wrong temperature, and as for generic prescribing ... well, all butter is undeniably the same salt-laden, arteriopathic dairy fat, but you just can t beat Kerry Gold for patient satisfaction.

Okay, so the Cure isn t doing anything other than making the individual feel better. That s the great thing about Cures they don t guarantee a cure! But positivity they do give, and in large amounts. The power of positive thought is a great thing, but giving it to someone is a skill few of us possess. We could learn much about this from other spheres. Take the world of sports coaching, for example. Martin O Neill is a former Northern Ireland football international and now a bespoke team manager. He took Leicester City from nowhere and transported them to Europe. Now he s doing the same sort of thing for Glasgow Celtic. Whatever it is, he s got it aplenty. Man-management. People skills. The ability to inspire people to feel and perform better. Celtic magic. The Cure.

My aunt says that, for some reason, her Cure is not as powerful as her silver-tongued brother s.

How powerful is yours?

Boyd Peters

From unsustainability to national beacon practice: providing primary care to a homeless population

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It is nearly 20 years since the Acheson report recognised that homeless people have difficulty registering with mainstream general practice.[1] A key recommendation was for alternative arrangements to be made to provide primary care services for such groups. The last report for the Department of Health on services for homeless people documented 13 primary care centres around the country providing services exclusively for homeless people.[2] The number of such centres has risen since then with the introduction of Personal Medical Services pilot schemes. This paper seeks to give a personal, yet logical account of the threats and opportunities inherent in providing such a service. It is hoped that a framework will be provided to help overcome the sense of mutual suspicion and powerlessness that is often generated when the two worlds of homelessness and primary care meet.

Unsustainable reactive primary care

In 1996, I started working as a salaried general practitioner to the homeless population of Leeds. I was effectively single-handed, though I had the good fortune to be based in a small cohesive team, comprising practice nurse, community psychiatric nurse, two part-time client support workers, one secretary and one receptionist. The service had been running for 11 years though I was the fifth GP to take on the post (the high GP turnover is in itself an indicator of the level of deprivation and need among the client group.).[3]

It quickly became apparent that we would not be able to run a sustainable service without radically altering the way in which the service was delivered. Though we had purpose-modified city centre premises, the GP was expected to provide a peripatetic service in the different hostels around the city. This equated to providing 13 surgeries per week. Over 60% of the consultations were for drug misuse but we had no strategy for prescribing. The centre had become a target for opportunistic criminal drug dealers who received a prescription simply by declaring that they were homeless. They would often verbally harrass the GP into prescribing large amounts of methadone on a white FP10 prescription and, as such, avoid the need to take the daily dose of methadone in a supervised way in front of a pharmacist. Prescribing of methadone ampoules was the norm. Though the topic of prescribing methadone ampoules in a primary care setting is controversial,[4,5] it was obvious that by being the only primary care centre in the city to do so we would become a target for drug users who simply wanted to augment, and not address, their drug habit. Other factors contributing to our unsustainability were that many of our patients fitted the criteria of heartsink or difficult patient.[6,7] Eighty per cent of GP consultations were for drug use, alcohol use or severe enduring mental illness (or a combination of the above). Although the team had good informal working relationships, there was no forum for discussion of difficult patients. The skill-mix of the team was biased towards the clinical, with poor administrative and management support. It has long been recognised that homeless people have difficulty registering with a GP[8,9] and, by seeking to address that problem, the team had become a dumping ground for many difficult-to-place, but not homeless, people. The evidence base has since confirmed what as a team we realised in 1996, that to move towards a proactive sustainable service we needed a strategy for development.[10] This would encompass an appraisal of where our service was currently at, where we wanted to be in five years, and how we would get there. Through an annual team away day , we sought to review our progress towards our goals.

Devising and implementing a strategy

Our strategy encompassed short-term, medium-term, and long-term goals. Short-term goals centred on improving the level of practice organisation to the extent whereby the service that we provided was accessible and available yet not placing intolerable demands on the practice staff. The first

Practice nurse Caroline Brown at work in the surgery, meeting with a patient.

essay

priority was to organise the GP clinics in such a way that there was not an inordinately large number of patients dropping in demanding to see the GP urgently, often for matters related to methadone prescribing. Though drug use is very common in the homeless population it was apparent that homeless people with other health problems (e.g. severe mental illness, alcohol dependency, and other general medical problems) felt too intimidated to use the service. Achieving a balance was inextricably linked to devising policies around safe prescribing of opiates. Policies related to ensuring daily pick-up of methadone from the pharmacist, declining to replace any medication that claimed to have been lost or stolen, avoiding concomitant prescribing of benzodiazepines with methadone and ensuring that prescribing methadone was part of a larger package of rehabilitation. Such policies encouraged the patient to take responsibility for his recovery. These policies are now in keeping with national good practice guidelines.[11] While achieving this, we worked towards medium-term goals that included defining our priority group for prescribing, seeking to secure drugs counsellor support so that the GP was not prescribing in isolation, developing the cohesion of the multidisciplinary team, and increasing the level of computerisation within the practice. We sought, and still seek, to maintain a democratic multidisciplinary team with shared power and decision-making. We aimed for team members to be clear about their roles. We sought to create informal and formal forums whereby team members felt supported. Butler *et al* have described team discussion about problem patients as one of the most powerful means of effectively managing heartsink patients.[12] I would add that as well as such a formal forum, active investment in building the teams cohesion has helped us to achieve most of our goals as a team. Working interactively across the professions rather than competitively or co-actively helps teams to mature and optimise their effectiveness.[13]

Having achieved such a working environment we then had a strong case to put to the Health Authority for increased funding to further help our effectiveness.

Funding centred around two areas: the first was support for the GP through providing a drugs counsellor, additional community psychiatric nurse and increasing the hours of the client support workers, and the second was to secure additional GP time so that the existing GP could be free to reduce his clinical commitment to a level whereby the two-to-three-yearly cycle of GP turnover would be broken. If such additional time could be secured, it would free the GP to take a lead on developing the practice s long-term goals, namely developing a robust undergraduate and postgraduate teaching and training programme and developing relevant research projects into topics pertinent to the health of homeless people.

Personal Medical Services Pilot Scheme as the vehicle for fulfilling the strategy

The NHS (Primary Care) Act, 1997 provided the legislation for new ways of delivering primary care through Personal Medical Services (PMS) Pilot Schemes. A central objective was to improve the quality, range and accessibility of services through: tackling unmet needs with new or alternative services to specific populations deprivation services, e.g. for the homeless .[14]

Why are PMS contracts proving so effective in improving the health of homeless and other socially excluded, deprived client groups? We must await the central evaluation of first wave PMS schemes for the answer to this question. However, from our team experience the answer is likely to be fourfold. First, deprivation (and not primarily list size) can be negotiated as the priority for adequate GP remuneration. Taylor and Leese upon reviewing recruitment, retention, and time commitment of GPs in England and Wales for the period 1990 1994 predicted that a new contract could in part improve retention .[15] PMS has allowed us to become employed on a contract similar in practice to our hospital consultant colleagues with time ring-fenced for clinical activities, management and administrative activities, and teaching and research. Secondly, PMS allows for projects at primary care level to be funded from monies additional to cash limited General Medical Services monies (e.g. growth or HCHS monies). Through growth monies we were able to employ an additional half-time GP. Thirdly, PMS provides funding whereby additional non-GMS (secondary care type services) can be provided in a primary care setting. Pre PMS-contract, our community psychiatric nurses and client support workers were employed by the local community mental health trust and the rest of the staff employed by the Health Authority. PMS contracts overcome the inherent problems of having a multidisciplinary team line-managed by more than one organisation. Finally, the PMS contract enables primary care staff to work corporately in our case through the whole team being employed by the local Community and Mental Health Trust. Homelessness has been described as a complex social problem that requires a collaborative, joined up multi-agency response.[16] By thinking and working corporately, primary care staff are able to make a significant contribution to ameliorating the suffering caused by homelessness.

Summary and recommendations for future service provision

In July 1999, the Department of Health awarded beacon practice status to the NFA Health Centre for Homeless People for the improvements made in service delivery leading to measurable health improvement of the homeless population. It has been our experience that the heartsink phenomenon can be competently managed and doesn t need to be shied away from. To manage the phenomenon, we as primary care staff need to move away from a rigid medical model based on diagnosis, treatment, and cure to a soteriological model that goes beyond the clinical to acknowledge and empathise with the full range of human suffering that presents at our surgeries. We need to be freed from feeling that we ve failed if we hold patients suffering, yet don t effect a cure.[12] I often describe myself as a social palliative care doctor , since in common with other colleagues working with the homeless population we are very successful at ameliorating unpleasant symptoms yet intractable root causes remain. Mathers *et al* noted that the personality and skills of the doctor could affect whether or not the doctor sees the patient as heartsink .[17] Greater perceived workload, lower job satisfaction, lack of training in counselling and/or communication skills and lack of appropriate postgraduate qualifications explained the significant variance in the number of heartsink patients that GPs reported. Such factors need to be taken into consideration when planning future health services for homeless populations. There has been little research into health care of homeless people in the United Kingdom. As a result, using evidence-based medicine to change practice is sometimes simply not possible. This imbalance needs to be redressed with some urgency. I would like to propose several key areas in priority need of research:

1. mainstream GPs attitudes towards the homeless and the consequent permanent registration of such people at their practices;
2. homeless peoples dependency on specialised primary care centres as described in this article and their ability to move into mainstream general practices once they are no longer homeless; and
3. developing fine tools to assess and quantify the risk to primary care staff posed by homeless people.

Many of the risk assessment tools currently in use are neither relevant to the homeless population nor to the primary care setting.

In conclusion, it is my hope that GPs and primary care staff will feel empowered and motivated to work with the homeless in an intelligent, professional manner and experience the rewarding nature of such work when our mindset is broader than a medical model of diagnosis, treatment, and cure.

Nat M J Wright

A study of story telling, humour and learning in medicine
H M Queen Mother Fellowship — Eighth Lecture
Sir Kenneth Calman and Peter Ustinov
The Stationery Office and The Nuffield Trust
July 2000
PB, 175pp, £17.50, 0 11702516 X

Illness and the art of creative self-expression
John Graham-Pole
New Harbinger Publications
August 2000
PB, 226pp, £10.99, 1 57224202 7

THESE are your post-Christmas, reducing-the-January-blues read, with their humour and zest for life. Sir Kenneth s is a must for every medical school and practicing doctor; John Graham-Pole s is intended for patients of serious illnesses, but is good for all of us.

A study of story-telling, humour, and learning in medicine is exactly what it says it is, in Sir Ken s inimitable, readable, racy style Scots accent and humour included. Don t be put off by the possibly lightweight title (it would have been more lightweight, but the Queen Mother objected this being the result of the Eighth Nuffield Trust Queen Mother Fellowship). Stories are at the heart of clinical practice : the patient tells theirs, the doctor caps it with hers, the student and questing practicing physician learn from those of experienced colleagues. Things packaged as stories are memorable: we don t store things like a computer, we story them. Stories help us to make sense of the world around us. [They] allow us to explore areas which are tentative, uncertain and even heretical ; they can be used to teach and understand ethics. Why stories? What are stories? How do we interpret them (hermeneutics and exegesis)? When, where and to whom are they useful? All are covered in depth.

Humour is a serious matter , because it can make us better, as well as feel better. A good laugh can support relaxation, raise the pain threshold, tone up muscles, boost the immune system, and help lift shadows of distress and anxiety. It can enable us to examine issues that are otherwise taboo, help us see things we hadn t seen if we are willing to interpret metaphors and parapraxes. It s a shame this book has no cartoons in it. At the Queen Mother Lecture we were treated to belly-laugh pictures. Described cartoons are not so funny.

We learn from stories; from humour. Our behaviour changes as a result of material transferring itself into our conciousness: ideas, feelings, and attitudes are caught, not taught. Sir Ken has coined a word for the role of story in this process transmid a contagious theory of behaviour .

JOHN Graham-Pole s book is equally riveting. A handbook for patients with serious illness, it is equally useful for the worried well who would benefit from acquiring a positive attitude to themselves, their physical, emotional and mental problems, clinical advisers and life situation. John asks his reader: are you noticing yourself more in charge of your surroundings, or your situation? Are you feeling more supported, less intimidated and overwhelmed, less out of control and helpless?

The title is a slight misnomer as an active spiritual and practical approach is offered, as well as creative arts. Exercises throughout the text are interspersed with good sound advice, stories about patients and staff, and quotations. The exercises are a mixture throughout of the artistic how to start drawing, begin a journal; and the practical how to befriend your doctor, start a support group. They are presented imaginatively, attractively and straightforwardly, making me feel like buying a blank workbook immediately (if only I didn t have to sit at my computer hour after hour writing things like this). Of course I keep a journal already and can recommend the process of writing to help you understand, love, and care for yourself better. The exercises teach how to listen, not only to others, but also to our strong, wise, inner voices.

The tone of the text is light. John Graham-Pole, a paediatric oncologist, deeply believes in the power of humour to lighten troubles, enable us to accept and still hope. His hugely successful playshops for staff alleviate stress, create positive attitudes, increase effective teamwork, and offer strategies for alleviating mental, emotional, and spiritual pain in patients. Patch Adams, the funny doctor who wrote the foreword, habitually dresses and acts as a clown, and attends dying patients in a pair of angel s wings to alert them to coming attractions . Patch writes: This century has pushed compassion, humility, mystery, and joy out of our health care system in favour of corporate medical business, where the bottom line is profit not care. The focus of this book is to bring these back, as well as creativity, self-expression, and sheer fun.

To learn how to learn, how to gain more practical, spiritual and creative insight, and how to have much more fun: read both these books, and buy them for others.

Gillie Bolton

The Great Court of the British Museum, London

IT has what somebody, in a different context, called the metaphysicians quality of absolute unplayableness meaning that no words, written or spoken, didactic or discursive, can prepare you for that first sight. The Great Court of the British Museum is a colossal space at the heart of the museum, originally housing the Reading Room with its miles of shelving and now, thanks to the re-siting of the British Library, transformed into a glass-roofed space with a massive central rotunda within which is the restored Reading Room.

The mØlange of styles the square bordered by straightforward classicism, including that portico with its cut-price stone, the roof with its asymmetric pattern of triangular panes and arching struts compelling the eye to follow them round, and the Rotunda embraced by its great outer staircases should jar but, triumphantly, it does not. There is, somehow, a light-hearted grace about the Great Court almost an impudence, when one places it against the four-square solidity and solemnity of the museum as a whole. There are shops around the base of the Rotunda. There are cafØs, and a restaurant high up in the Rotunda, with exhibition galleries at lower levels. There are seats and tables at which to sit and eat, or perhaps just to sit and watch and wonder.

The Reading Room is, for the first time, open to all, with public access to the ground floor shelves. There are touch-screen computers for searches of the museum s treasures, and the whole thing is liberated from the stifling old regime of silence and study and eccentricity and appalling difficulty of access in a way that changes the entire museum into something so much more approachable.

The Great Court is huge the largest covered public square in Europe, but there is nothing portentous or massive about it, and nothing of the bated-breath syndrome. All is light and air and clarity. It is London s newest treasure, and it may be, for this generation of Londoners, what the South Bank was so many years ago, for ours.

Michael Lasserson

THE first thing you notice as you enter the newly restored Great Court at the British Museum is the white stone cylinder that encloses the Reading Room, not just for its striking shaping but for the names which adorn it. The lower walls list benefactors in fonts of differing sizes, presumably based on how much they contributed, in a display of vulgarity not matched since Sir Joseph Duveen had his name plastered all over the old Tate and the Parthenon Galleries elsewhere in the British Museum. Worse, however, is that around the top of the cylinder is inscribed a millennial dedication to, of all people, the Queen. While we should all be grateful that such dedications are no longer made respectfully , it is a nauseating spectacle. HM contributes just about nothing to artistic life in this country, actively impoverishing it by the difficulty with which the Royal Collection can be viewed; a collection which, incidentally, is largely paid for by our past contributions to her family s fortune. Short of dedicating the Court to Norman Tebbitt, it is hard to think of anyone less appropriate.

The use of the Great Court itself is scarcely more inspiring, with two corners filled by grandiose information desks and two by cafeterias that generate long queues of bored and grumbling families. A few large sculptural pieces scattered about on plinths only reinforce the sense that, having got this wonderful space, the Trustees just didn t know what to do with it. The bizarre Hotung Gallery, an exhibition space wrapped around the back of the Reading Room, is equally directionless; its first show, a meaningless grab-bag of images of humanity, points up its unsuitability for either the blockbuster or the intimate exhibition.

And what of the portico controversy? For a start, it is through this entrance that one comes into the Great Court, so only if you come in backwards will it be the first thing that strikes you. That diminishes any early impact a lot, and it actually just looks new rather than out of place, although it will never be exposed to the weathering that would rub off some of its brightness. As a howler by the Trustees, it does not compare with the grovelling to HM.

The redeeming feature of the Great Court is the extraordinary roof. Its litheness and strength are clear from inside, but it is not possible to appreciate its sinuous shape properly. For the best view you need to go up in the London Eye, where its irregular folds can be seen more clearly undulating around the central dome of the Reading Room. The other completely successful restoration is the courtyard on the Great Russell Street frontage, where beautiful Portland stone walls and seating enclose new lawns either side of the main access to the Museum.

All in all, though, the restoration is a very mixed bag, an initially grand and exciting concept undermined by half-baked commercialism and embarrassing deference, a combination that perhaps defines this country at the moment.

Frank Minns

Transport

Numbers, erstwhile people, follow each other,
They walk in rugged lines,
No — they walk no more but drag themselves along,
Only to disappear within the streets.

Thus by drops and rivulets
They gather in this dreadful sludge.
These are not people who walk,
Who only drag themselves along.
It's only the drags of misery
Soaked up by the ghetto walls.

There walk rows of suddenly broken backs,
Yet again burdened by fate.
They have to atone for sins of others.
Baruch Ata — who hast given and taken.

Karel Fleischmann

Translation from the Czech courtesy of The Theresienstadt Martyrs Remembrance Association, Beit Terezín, Givat Haim - Ichud, Israel.

Karel Fleischmann — physician and artist

KAREL Fleischmann was born in 1897 in Klatovy, Bohemia (later to become Czechoslovakia). He studied medicine at Charles University, Prague and from 1925 worked as dermatologist in Ceske Budejovice.

Ever since childhood he had painted and written literary works and he was one of the founding members of the avant-garde group Linie (The line). He published several novels, including *The Return* (1933), *The Finger on the Map* (1936) and *People in the Doctor's Waiting room* (1937).

On 18 April 1942, he was deported to Ghetto Theresienstadt (Terezín), where he practiced as a physician and worked as one of the leaders of the health administration and the social care department. He gave lectures and participated actively in the cultural life of the ghetto.

He continued to draw, paint and write mainly poetry and essays; his best known writings dealt with the borderline between

Medicine and Art. He was a close friend of Dr. Erich Munk, the head of the health care system in Terezín he drew him many times and dedicated many of his paintings to him, including Waiting for the doctor (pictured below). However, on 23 October 1944, Fleischmann was deported to Auschwitz, where he perished.

After the war, about 1200 of his poems, notes, lectures, and drawings were found preserved in Terezín one of them was a long appreciation of his friend Erich Munk, who also perished in Auschwitz.

Fleischmann's work, created in Terezín is, together with the work of the many other Terezín artists, an integral part of the anti-Nazi resistance.

Most of Fleischmann's works are now in the Jewish Museum in Prague but some are in the Art Museum of Yad Vashem in Jerusalem, including the ones shown below.

Tomi Spenser

Left: *Hippocrates in Terezín*
Brush and Indian ink. 37 x 18 cm. Art Museum of Yad Vashem, Jerusalem.

Above left: *Dr Erich Munk* (b. 1904 in Bohemia, later to become Czechoslovakia; died 1944 in Auschwitz). He was deported to Terizín in 1941, where he was head of the health care system and one of the key citizens of the ghetto. By all accounts he was a very complicated personality: elegantly dressed, with complete self-control; unapproachable but also uncorruptible, with outstanding medical and organisational knowledge. A talented and ambitious despot, but capable of enormous self-sacrifice he often gave his food rations to the children in the Dresden Barracks, even when he himself was severely ill. He was deported to Auschwitz in 1944, where he perished.
Brush and Indian ink. 30 x 22cm. Art Museum of Yad Vashem, Jerusalem.

Below left: *Waiting for the doctor in Terezín*
Pen and wash. 30 x 44cm. Art Museum of Yad Vashem, Jerusalem.

Courtesy of the Art Museum of Yad Vashem (The Holocaust Martyrs and Heroes Remembrance Authority), Jerusalem.

The Sea of Faith and the Death of Evidence-based Medicine

The sea is calm tonight
The tide is full, the moon lies fair
Upon the Straits; on the French coast the light
Gleams and is gone; the cliffs of England stand,
Glimmering and vast, out in the tranquil bay.

OVER a hundred years ago, in 1897, Matthew Arnold wrote Dover Beach , a poem in which he lamented the erosion of Victorian faith and a clergy whose liturgy echoed an emptiness of despair.

Evidence-based medicine has been likened to a Deity. A confident assertion that judgements about the nature of reality can be based on technical authority and compressed into an increasingly esoteric set of linear equations and mathematical manipulations. The creed inferential statistics and its ultimate instrument, the randomised controlled trial a thing of beauty . Now the essential truth without us can be discovered and our interventions directed by explicit guidelines derived from rigorous inquiry.

But the early signs were to go unheeded. The foundation of modern science was to be one of uncertainty:

The Sea of Faith was once, too, at the full, and round Earth's shore
Lay like the folds of a bright girdle furl'd.
But now I only hear its melancholy, long, withdrawing roar,
Retreating to the breath
Of the night wind, down the vast edges and drear
And naked shingles of the world.

Like their Victorian counterparts, the Paradigm continues to preach their sermons as they seek to bludgeon their way to solutions. The modern marches on, each year producing millions of research papers that in general inform no-one but academic exercises.

Do they secretly question their faith as they seek the truth? In their hearts they too must wrestle with a description of reality as an ever-changing approximation which, as they make it more real, slips from their grasp stories for children?

Listen! You hear the grating roar
Of pebbles which the waves draw back, and fling,
At their return, up the high strand,
Begin, and cease, and then again begin,
With tremulous cadence slow, and bring
The eternal note of sadness in.

Did Arnold know how prophetic his metaphor was to be? Against a background of rhythmical change The Sea of Chaos.

Waves and pebbles, subservient to the laws of complexity. Sudden bifurcations, strange attractors, sensitive dependence, self-organised criticality direct the equation of state. Each of us a unique fractal only ever viewing a limited gaze different yesterday than today, different again tomorrow.

How can a rule-based analysis ever capture the rich internal detail that drives the systems in which we live?

Sophocles long ago
Heard it on the Aegean, and it bought
Into his mind the turbid ebb and flow of human misery; we
Find also in the sound a thought,
Hearing it by this distant northern sea.

The tension between empiricism and scientific insight is not new. The debate was founded in ancient Greek literature. Alexander argued for the uncertainty of medicine in a way that reflects modern chaos theory where behaviour of whole systems can become unpredictable, even if their components behave in a simple way. Galen s view was that within medicine there existed a science with progressive truth that would be resolved by future progress. More recently, in 1789, Cullen proclaimed that for 2000 years there had been two plans proposed for the study of medicine: the dogmatic and the empiric and we still do not know which choice to make.

The sermons continue, The faithful intone their creed. Will evidence-based medicine ever die? The dehumanisation of medicine that undermines the art of healing. And the mutual interconnectiveness that drives complex systems and their therapeutic emergence.

The real world is not always defined by cosy certainties like guidelines, needs-based planning, and optimal solutions. But a chaotic, complex, non-linear system driven by the very factors that the randomised controlled trial seeks to exclude. Contextual, irregular, and subtle. A system of human frailties, feelings, and complex social rituals with limited room for manoeuvre.

The danger that those charged with making decisions will be seduced by the simplistic solutions that the canon supplies.

Ah, love, let us be true
To one another! For the world, which seems
To lie before us like a land of dreams,
So various, so beautiful, so new,
Hath really neither joy nor love nor light,
Nor certitude, nor peace, nor help from pain;
And we are here as on a darkling plain
Swept with confused alarms of struggle and flight,
Where ignorant armies clash by night.

David Kernick

Arnold M. *Dover Beach and other poems.* London: Dover Publications, 1994.

UK Council, November 2000

Communications with Faculties
To improve and develop our communications with Faculties and members, Council agreed that the unabridged Council summaries should appear on the College website under Our College and Faculties , attached as Council Summaries to the UK Council button (**www.rcgp.org.uk/rcgp/corporate/ council/coun_index.asp**). They also agreed that, once approved at the following Council meeting, Council minutes should be made available on request to any member of the College.

Devolution
Council noted that as part of its incremental approach to devolution, the Chairs of UK Council, Scottish Council, Welsh Council and of the Northern Ireland Faculty were now meeting periodically to exchange views and catch up on developments in each of the constituent countries of the UK.

The Chairman of the Northern Ireland Faculty has been appointed as an additional Council member, and also of CEC. The current Chairman is Dr Peter Colvin. This is a precursor to what it is hoped will be the formation of a Northern Ireland Committee from next Spring and in due course a Northern Ireland Council, although that requires formal constitutional change.

Valuing Scottish General Practice
This important report being issued by Scottish Council has started to influence the debate and shape of the modernisation proposals as they emerge in Scotland. The paper draws on work that had already been developed at UK level but within the landscape of Scottish General Practice.

Revalidation
You will recall that the College together with the General Practitioners Committee of the BMA held a conference entitled *Revalidation: The Way Forward* on 31 October. Despite the travel difficulties this was very well attended and well received. The major issues facing the College at this point were aired by the presenters and during discussion. An edited video is now being produced with the intention that it will be sent to all Faculties for viewing.

We intend to consult all GPs in due course on our Methodology for Revalidation in General Practice ; however, we await the resolution of a number of important issues beforehand. These include:

Resources for revalidation where there remains no firm assurance about what is to be provided. Resources are needed not just in the form of financial resources but in the capacity of the general practice workforce, the capacity for continuing professional development to conduct appraisals and to ensure that patients do not suffer because GPs are diverted away from surgery time for appraisal and other revalidation purposes.
The appraisals themselves. We are still unclear what proposals might emanate from the NHS and that there might be differences between the approaches developed for England and other parts of the UK. One matter still unresolved is the appraisal regime for England where we await the CMO s proposals and whether they will prove to be appropriate for revalidation purposes.
The need to pilot many aspects of revalidation. Pilots are planned by the GMC and we are ready to assist in ensuring that these are effective and informative.
Ensuring that the systems for revalidation that we develop and which the GMC is aiming for are simple, straightforward, and effective in identifying at an early stage poor performance with the means of addressing that.

We intend to keep members informed of the development of our methodology towards revalidation. In the meantime, on the RCGP website, you can find the College s methodology work-in-progress document and the current version of our *Good Medical Practice for GPs* which is very nearly a final document. The link for these documents is **www.rcgp.org.uk/rcgp/corporate/reval_menu.asp**. With regard to methodology, we welcome feedback to **comments@rcgp.org.uk**.

GMC consultation on its future structure, constitution and governance
Council debated the College s response to this important document. The view was that while the GMC has analysed the need to change correctly and has developed a number of workable options, there was more work to be done in considering the roles and accountabilities of its future governing and statutory body and any wider body. One key part of this was the extent to which lay representation should be strengthened and how lay members should be accountable. The College s response has now been revised in the light of the debate and submitted to the GMC.

Winter pressures
The College is endeavouring to influence the planning for winter pressures in the NHS at several levels. You may have read the exchange of letters between the Chair of the General Practitioners Committee of the BMA and the Prime Minister. Our Chairman, Mike Pringle has written as well and sent a fully referenced paper to demonstrate that GPs do not make inappropriate referrals. This activity stemmed from remarks made by the Prime Minister at an address at the Royal College of Surgeons recently. The Prime Minister suggested that the problems of long waits and high volumes of patients requiring acute admission or other secondary care services over the winter might be due to inappropriate referrals from primary care.

President, Officers and Committee Chairs 2000–01

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Professor Dame Lesley Southgate

Chairman of Council
Professor Mike Pringle
Vice-Chairman Dr Paul Davis
Vice-Chairman and Chairman of Communications Network
Dr Mayur Lakhani

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Chairman Education Network
Dr Has Joshi
Chairman Research Group
Dr Amanda Howe
Chairman Publishing Network
Professor Ruth Chambers
Chairman Int Committee
Dr John Howard
Chairman of Ethics Committee
Dr Iona Heath

The Lay Chairman of the Patients' Liaison Group, Dr Patricia Wilkie, completes her term of office in December 2000.

Council: Next Meeting
Council next meets on Friday, 26 January 2001 at 9.00am at Princes Gate.

This is set in the context of wider fears being expressed that primary care will be blamed for the NHS s inability to cope this winter. It will be of special importance to the Government in what is expected to be the winter before the next General Election. If you can offer actual evidence of the ability of general practice and primary care to absorb peak demand effectively, then please feed this into any member of your UK officer team or your Faculty representative.

NICE
Council had an important discussion about the College s interface with NICE which covers England and Wales. I have reported to you before about the very heavy workload we face with the NICE appraisals process. There is also the work on NICE Guidelines and the College s bid to run a Collaborating Centre for Primary Care for NICE Guidelines.

Council noted a letter sent to the Chairman of NICE some weeks ago and a faxed response received the previous day from the Chairman. While this gave some possible reassurance, Council very much wanted the robust line to continue. The continuing concerns also reflected how guidelines might be used in audit; the impracticality of GPs operating within such a regime; and that NICE appeared to be relying on the Royal Colleges to disseminate its Guidelines.

NHS Plan for England
We had a further discussion of the more detailed response the College is preparing to the NHS Plan for England, in conjunction with the General Practitioners Committee of the BMA and some other primary care organisations. There will be a series of papers, some of which have already been finalised. One of those is the **Personal Medical Services** paper and the second is the paper on **Workforce and Skill-Mix**. Other papers in the series are in preparation and Council had a discussion about the content of these in broad terms and was very supportive. All will appear on the website as well as coverage of the **Future of SHO Posts**, and **Genetic Testing and Insurance**.

Rejoiners Campaign
Council endorsed the proposed campaign to encourage lapsed members to rejoin the College. Former members will be mailed with a list of the services and products available to them from the College, how they can become involved and directions on how they may rejoin. This is an important issue of which Faculties need to be part and we look forward to working with everyone to make this campaign a success. It will be rolled out over England, Wales and Northern Ireland and it has already started within Scotland.

Maureen Baker
Honorary Secretary

neville goodman

IDLING away a few spare hours in the British Museum I learnt a thing or two about the ancient Egyptians ideas on anatomy and physiology. They regarded the heart as the seat of the intelligence and the location of memory. What a hoot! How could they be so stupid?

The ancient Egyptians lived a few thousand years ago. *The Observer* is published every Sunday, now, in the 21st century. According to their Barefoot Doctor , one Stephen Russell, the ears are the flowers of the kidneys. Thus, when kidney energy is depleted, the result is tinnitus. It seems that the hair is controlled by kidney energy as well. Hair loss is helped by massaging the kidneys to increase circulation to the head. The kidneys are obviously pretty important. While their energy is not tickling up the hair roots or tuning up the hearing, the kidneys are also responsible for the overall maintenance of the womb and reproductive system. As an aside, they are also in charge of eliminating waste through urination.

Kidneys maintaining the female reproductive system was in a piece about pre-menstrual syndrome (*Observer Life*, 22 October 2000). Much of the syndrome is due to the spleen, which governs the appetite for sweet things and short-term memory, but is diverted from this by the need to build blood lost during the period. I seem to remember that the spleen is not a haemopoietic organ in the human adult, but the ancient Chinese knew better.

I know that these ridiculous statements are not the product of Stephen Russell s fertile imagination because I checked them in a book about Chinese medicine. His imagination is actually severely limited, because he is more prepared to accept ideas of how the body works and diseases affect it from a time when no one really had a clue and thought that the heart was the seat of memory. When he writes about the ancient Taoist view of the common cold virus he is repeating nonsense: viruses were unknown to the ancient Chinese.

This is all the more depressing for three reasons. First, judging from the Barefoot Doctors general statements about health, he writes sensibly, has a good sense of humour, and probably helps many people. Second, the *Observer* is a quality broadsheet but nonetheless prints this nonsense.

Which is a shame because, third, after the further denting of public confidence in science caused by the Phillips report into the BSE affair, we need all the help we can get if people are not going to revert to seeking fortunes in tea leaves, diagnosing their illnesses by pendulum, and demanding eye of newt on the NHS.

Nev.W.Goodman@bris.ac.uk

our contributors

Gillie Bolton has a terraced house next to the British Museum, and shoots to the top of the Deputy Editor s Christmas card list

Edward Ernest (Ted) Cockayne was a GP in Woolpit for 33 years. He is unsure why doctors are so fond of sheep, but points out that unlike most pets, sheep are also rather good to eat

Columnists come and go, but not Neville Goodman, primary care s favourite anaesthetist

Dougal Jeffries has been a GP in Salisbury, Wiltshire for the past 13 years, where he set up his practice from scratch..

David Kernick would like to reassure readers that he does keep his feet firmly on the ground as medical officer to Exeter City Football Club, where he can be found every Saturday supporting them in their eternal struggle against relegation from Division 3. Only rarely is he flown to California to discuss knee reconstructive surgery

Michael Lasserson is a GP in Guildford, Surrey, and Arts Editor (it says here) to *London Calling*, the renowned magazine of several London RCGP faculties (and why not all of them?)

Saul Miller is a GP in Belford, Northumberland

Alan Munro is presently on holiday in New Zealand

Jill Murie has been a GP and police casualty surgeon in Lanark, Scotland for 15 years. She is obsessed with patient participation through community based health promotion, and in the last month her work in this field has been recognised both by th eRCGP and at the Doctor of the Year awards.

Boyd Peters is an Ulsterman domiciled in.Scotland. He trains his border collies to work as search dogs for mountain rescue and is keen to hear from volunteers who would enjoy being buried under several feet of snow for two to three hours at a time.

Tomi Spenser doesn t know how he ever had time to see patients and teach students and trainees before he retired from being a rural GP in the Upper Galilee, Israel and head of the Department of Family Health Care, Faculty of Medicine, Haifa. He can be contacted at **tomi@sasa.org.il**

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alan munro

Dread Titres

I knew it was my liver that was out of order, because I had just been reading a patent liver pill circular, in which were detailed various symptoms by which a man could tell when his liver was out of order. I had them all . So begins Jerome K Jerome s *Three Men in a Boat.*

I might have been the fourth man. I too, once upon a time, had all the symptoms of harbouring a liver like a wallnut. Long after a brush with viral hepatitis temporarily turned me a colour deeply incompatible with red hair, so out of sorts was I as to spend dark hours interminably checking my urine for deadly excess of urobilinogen. This involved the addition of someone or other s reagent, since found to be carcinogenic in Armadillos and withdrawn, but which in another century was an essential tool in the tireless, physicianly pursuit of the untreatable. The addition of a little acetone was supposed to extract a nice pink colour if the test was positive. A dire circumstance this, for a chap with fulminating cirrhosis anxiety, allied to hilariously incapacitating colour blindness (can t tell cyanosis from sunburn, far less port from starboard).

Tired all the time, I divided what little time I thought I had left between fainting in operating theatres and hovering disconsolately on the periphery of life clutching a pint glass of orange juice. Had a solemn counsellor explained that not cirrhosis, but post viral syndrome was the thief of my vigour, and that it might last many years, and through it I might struggle heroically only with unremitting, skilled, professional support and encouragement, I should certainly have been sunk.

I was lucky. I was saved from my obsessive imaginings by a wise doctor. A short waspish professor of liverish things told me to go away, drink what I liked, and never, ever let anyone check my LFTs again. Soon I felt much better.

Jerome and his friends self-prescribed a boating trip. They soon felt less liverish too.

Though I am a little on the long side, I have diligently practised short waspishness in front of the mirror ever since. There are still patients who are tired all the time and who need what I needed: to be demedicalised, to have their imaginations re-routed, to be inspired, somehow, to believe that they can take part in life to the full. But I m no good at it. Viral titres are the rolled up newspaper with which my emergent short waspishness is mercilessly and invariably swatted to death. You are our servant, the columns of figures seem to leer at me. Ours is the power of science, do not challenge us. Like a fool I rise to it every time: I won t be a party to creating invalidism out of incidents of immunological history. I won t be stuck in the medical model, I ll contextualise in the great sweep of life and the universe. But the titres get me every time. Patients know about blood tests for viruses. It s hard, I reckon, to demedicalise, and yet arrive at a shared understanding with a patient whom every medium of mass communication is hell-bent upon medicalising.

But there are occasional surprises, mercifully. Jock is a sprightly old guy, with a firm stride and quick smile.

Tired all the time, he said, loud and clear. Nothing much emerged from a quick sift through the usual symptomatic stuff. Then, into the silence popped a clue!

It s aye worse at the weekends.

Uh-huh?

Ah ve a wee job wi one of the hotels so ah'm sometimes up late wi that. And there s the dancing, ballroom dancing. Used to be pretty good still no bad. And there s the widows. Five auld wifies, their husbands a deid. They keep me at it pretty late. But there s five o them, ken, and they a want tae dance wi me. D ye think ah m just getting a bit auld fur it?

We agreed he should spread the widows more evenly through the week. I suggested that to be on the safe side I d like to check a couple of blood tests, if that was okay with him. I skipped the viral titres.

He d be a fine man in whose company to row up a river.