The Back Pages

viewpoint

The RCGP —which path to travel by?

THE impetus for writing this piece came from a discussion that occurred at the recent dinner to celebrate Colin Hunter s tenure as Chairman of Scottish Council RCGP. Everyone agreed that Colin had moved Scottish Council from effectively nowhere to definitely somewhere in a four-year period. But doubts about the overall health of the College were freely expressed.

For many of the GPs, new and non-principals that I meet, the College resembles more an Old Boys Club and is not reflective of the dynamic workforce that is modern-day general practice. They may sit the examination but a significant number do not keep up their membership and, if they do, they rarely become involved in any way. Without their youthful enthusiasm and energy, the College is the poorer.

If one takes a dispassionate view of College activity across the country, one is left with a very uneven picture of a body active nationally, yet largely inert locally. It seems to be caught between two opposing drives: one to be a representative body, and the other to be an academic institution. The problem is that the present structure supports neither of these functions adequately. The Faculty structure is effectively dead. My own Faculty had great difficulty in recruiting an Honorary Secretary, has little profile locally, and does not influence general practice debate to any significant extent. If it did not exist, would it matter? The answer from speaking to colleagues, is that it would not. It is neither representative, nor reflective of the profession. It is not unique; for example, none of the new office bearers of Scottish Council RCGP were elected by the membership and the membership has little idea about the direction they intend to travel. The present structure allows for individuals of creative energy to acquire positions of authority or influence with no popular mandate.

In an age of political modernisation, the College needs to redefine its working processes and structure. The modernisation needs to go deep and to address the big issues. For example, what is the function and purpose of the RCGP and how does it engage its membership? How can an individual member influence change or debate? Why persist with a grossly underfunded Faculty structure that is riddled with patronage and hindered by archaic rituals? Why not devolve the Membership Examination from the political and other functions? (dare I suggest that it may have avoided the conflict with Summative Assessment?). It also needs to address the smaller issues that often have a more visible presence. For example, why does Council meet on a Saturday when most doctors have another life to lead; why are locum expenses, in some form, not reimbursed and how can it continue to justify Fellowship by nomination?

The RCGP seems, at present, to be drifting. What can be done? There are no simple answers but it should consider: an alternative to the Faculty structure; an increase in the number of posts that are directly elected, e.g. Chairman of UK Council and Vice Chairs, as well as those of the other national councils; and developing and expanding its communication with the membership through, for example, an expanded website.

The RCGP needs, in the broadest sense, to regain the interest of its members. It needs to grapple with the requirement to change and override its inherent conservatism. It should have the courage to offer its critics and those who feel excluded the opportunity to define its future.

We were left thinking at the dinner whether the glow that Colin Hunter left on the horizon was in fact the dawn of a new age for the College or the light from a distress flare. The College needs an agenda for change. I am sure I am not alone in hesitating every year when I have to pay my membership fee, wondering if it is money well spent.

The College appears at present to have the vision and energy of an old man. This is no bad thing if one follows the advice given by T S Eliot in *Four Quartets*:

> *Old men ought to be explorers. Here or there does not matter,*
> *They must be still and still moving into another intensity into a further union …*
> *In my end is my beginning*

David Blaney

“New geographical understandings of health and illness are emerging that may help primary care understand its evolving role better...”

New Geographies of Health and Illness
Deborah Sportan, page 158

“The third witch presses the wrong button and inadvertently restarts the pocket game of *Doom* she’d been playing while the others were working hard at toe of frog...”

Macbeth, Medicine, and the Palmtop
Neville Goodman, page 167

contents

The Evaluation of Primary Care Research Networks in Scotland

THE editorial by Carter *et al* in the November issue of *BJGP*[1] called for national evaluation of primary care research networks (PCRNs). This would, it was stated, need to link outcomes to process and process to structure. The article by Griffiths *et al*[2] in the same issue additionally called for any evaluation to consider the complexity of network organisation and the context in which they operate.

Here we briefly describe the approach to evaluation of PCRNs in Scotland. Further details are available at **http://www.sspc.uk.com**.

The Chief Scientist Office (CSO) of the Scottish Executive funds high quality research within the NHS in Scotland. As part of its commitment to promote primary care research it has funded a number of PCRNs over the past three years. The Scottish School of Primary Care is currently in its foundation phase. Its role is to develop a coherent approach to the development of primary care research throughout Scotland.[3] Under the auspices of the Scottish School of Primary Care, the CSO and the Network Directors have undertaken a series of meetings to agree core objectives and evaluation mechanisms.

At the first meeting the group considered core objectives of the ideal PCRN with regard to structure, process, and outcome. A small group to clarify which process and outcome measures should be aligned to which objectives refined the result of this. The paper was circulated for further comment and a final version agreed. The document will be used both for financial accountability of PCRNs to the CSO in annual reports and to evaluate the activity, outputs, and outcomes of Scottish PCRNs over the next three to five years. The panel on the right shows the details of the core objectives, evidence of activity, and outcomes.

It is recognised that the evidence of activity and outcome may require amendment over time. Any changes will be mutually agreed and consistently recorded to maintain ongoing robust evaluation of networks.

Based on the information generated over the next three to five years, a comprehensive longitudinal evaluation of Scottish PCRNs that can examine relationships between structure, process, and outcome should occur. The broader development of networks will also be examined.

This process highlights the value of collaborative working between a funding body and the recipients of its monies. A coherent set of objectives has been agreed that are shared between all stakeholders. Thus the criteria against which PCRNs in Scotland will be evaluated are owned collectively.

Kathy Ryan
Sally Wyke

Evidence of activity and outcome in relation to core activities that will be included in PCRN Reports

1. Multidisciplinary and multiprofessional.

Activity: Description of attempts to reach range of professions
Outcome: PCRN membership broken down according to profession and disciplinary background

2. Identify and provide resources to support R&D activities, or guide practitioners appropriately (e.g. library, access to experienced staff).

Activity: Description of resources and how they are accessed
Outcome: Number of PCRN members guided to resources

3. Clear system of accountability for the use and distribution of funds that are accessible to their membership and to auditors.

Activity: Description of management and accountability structure
Outcome: Proof of audited accounts

4. Membership and their research-related activities.

Activity: Description of approach to recording membership and their activity
Outcome: Number of members and current research activity

5. Collaboration with other local NHS bodies to share resources and meet the need of primary care professionals for R&D support.

Activity: Description of shared activities

6. Clear system to handle raised concerns from network members.

Activity: Description of how system deals with concerns
Outcome: Number of concerns dealt with, what they were and how they were resolved

7. Collaboration in research, and in research training.

Activity: Description of collaborations with other agencies
Outcome: Number of collaborative projects

References
1. Carter YH, Shaw S, Sibbald B. Primary Care Research Networks: an evolving model meriting national evaluation. *Br J Gen Pract* 2000; **50:** 859-860.
2. Griffiths F, Wild A, Harvey J, Fenton E. The productivity of primary care research networks. *Br J Gen Pract* 2000; **50:** 913-915.
3. Wyke S. First programme of research for a Scottish School of Primary Care. *Br J Gen Pract* 2000; **49:** 841.

8. Forum for the local discussion of research ideas.

Activity: Description of how PCRN provides such a forum
Outcome: Number of meetings and attendance.

9. Identify research training needs among its constituency.

Activity: Description of how research training needs were identified
Outcome: Description of what training needs were

10. Organise and/or facilitate access to research training for primary care practitioners.

Activity: Description of research training opportunities provided
Outcome: Numbers attending research training

11. Provide access to and disseminate information on collaboration and training opportunities and how to access academic advice and support.

Activity: Description of how this information is provided
Outcome: Number of members taking up opportunities

12. Coordinate research requests for the area they cover (so that duplication of effort is avoided).

Activity: Description of how research requests are co-ordinated
Outcome: Number and outcome of requests co-ordinated in period of report

13. Establish communication channels leading to primary/secondary, national, and international collaborations (with particular interest being made of opportunities between Networks).

Activity: Description of how collaborations are facilitated
Outcome: Number of collaborations engaged in

14. Assist with submissions to research ethics committees.

Activity: Description of how submissions to research ethics committees are facilitated
Outcome: Number submitted in period of report

15. Assist with the process of submission to grant-awarding bodies.

Activity: Description of how members are supported to submit research proposals to grant-awarding bodies
Outcome: Number of proposals submitted; status of proposals (funded, rejected, in process)

16. Provide support to primary care practitioners who wish to register for higher research-based degrees.

Activity: Description of how support is provided
Outcome: Number of members registered for higher degrees as a result of network activity

17. Promote dissemination of research findings through: presentations at conferences and meetings; publications in peer-reviewed and other journals, magazines or newsletters.

Outcome: list of presentations and publications by network members, description of how network members were actually involved in publication

18. Promote quality research capacity and increased research competence through: actively participating in research; hosting research; and initiating/leading research.

Outcome: Number of research projects currently engaged in by network members at each level

19. Contributed to the increase of evidence-based practice in primary care through publications, other forms of dissemination, and an increased awareness of, and understanding of EBM.

Outcome: Number of publications, talks, etc, and summary of cultural shift with examples or other evidence

20. Evaluating the activities through which they have met their objectives.

Activity: Description of how PCRN audited activity over the period of the report.

In mid-2000, the Home Office issued a consultation paper on proposals to alter the law on manslaughter.[1] Two main proposals were made: the first is to alter the law on involuntary manslaughter (killing someone, but not intending to do so) by introducing two new offences (careless killing and reckless killing) are suggested. Secondly, a proposal is made to introduce a new offence in British law of corporate killing . This article concentrates on the latter.

The new proposal is based on a Law Commission proposal. There is a case for something being done as there have been cases in which disasters, such as shipping and railway accidents, have occurred and it has proved difficult to mount a prosecution for manslaughter. Whether or not the defect justifies the introduction of a new law is, of course, for Parliament to decide.

The Academy of Medical Royal Colleges

The Academy was established in 1976. It is the only organisation that brings the 18 Medical Royal Colleges and Faculties in Great Britain and Ireland together. Unusually, it crosses the Irish Sea as the two Irish Royal Colleges are members. It is a registered charity, a federal body, and the voice of the Medical Royal Colleges and Faculties.

The Academy sometimes leaves action to individual Colleges and sometimes decides to act on a generic issue on behalf of the Colleges and Faculties. The response to the Home Office Consultation paper is an example of a collective response.[2]

In this case it was the Royal College of Physicians of London that proposed a generic response, as several complex issues arise that extend far beyond the Home Office and any single branch of medical practice.

An interesting assumption in the Home Office paper is that legislation and litigation are desirable, in that legislation enforces higher standards and hence is in the public good. The Academy response does not deny this argument, but points out that legislation and litigation are expensive. Regardless of who wins, litigation represents a high opportunity cost for society. The issue for society is the proper balancing of these costs and gains.

Impact on the NHS

The Academy agrees that raising standards is desirable and that any law in society generally should normally apply to the NHS (the largest employer in western Europe). Nevertheless, it deploys the case for delay in any implementation or possible exemption for the NHS.

How can this be? Surely it can never be right to expose vulnerable patients to lower standards than the rest of society?

The case for at least temporary exemption for the NHS

The Academy paper makes three points. All are difficult and controversial, but all deserve thought:

1. The NHS is not an ordinary business, as it attracts no income and cannot close for business.
2. The new law might be reasonable for new NHS buildings equipped with new equipment.
3. The opportunity cost for the service if senior NHS managers and doctors in management are to face charges of corporate killing, and prison if convicted, could be, on balance, against the interests of society.

1. The NHS is not an ordinary business

The proposed law on corporate killing is aimed primarily at commercial organisations, which are usually companies trading for profit. The assumption is that the burden of extra expense laid on such companies through legislation is to be recouped through higher charges from customers.

Alternatively, if the business becomes unprofitable through the new costs, the directors have, in the commercial world, the option of closing the business.

The NHS, however, is not an ordinary business. The directors of trusts or the partners in a general practice are the equivalent of the directors of companies. They have neither the right to raise fees/charges nor the right to close a hospital. They have therefore neither option to cover the costs.

A practical example would bewhat might happen if, say, a fire officer reports that an old hospital is a fire risk. The Department of Health (2000)[3] has stated that the NHS has experienced decades of neglect . Suppose that the capital cost is high or, alternatively, that it is simply not practical to make the buildings comply with modern fire standards? All the hospital directors and NHS managers can then do is apply to the NHS regional office for capital funds. However, regional offices do not have a large supply of capital and in practice have to apply to the NHS at Leeds, and in effect to Ministers, for such allocations. However, in a cash limited and nationally funded Health Service such funds may not be available. Are ministers and civil servants also to be liable for manslaughter? So, the ultimate choice is simply either to close the hospital or keep it open. If it is kept open

References

1. Academy of Medical Royal Colleges. *Evidence to the Home Office on the proposals to alter the law on manslaughter.* London: Academy of Medical Royal Colleges, 2000.
2. Department of Health. [Press release]. London: DoH, 2000.
3. Home Office. *Reforming the law on involuntary manslaughter: the Government's proposals*. London: Home Office, 2000 .

then there is a risk of fire and consequently damage and death, but if the hospital is closed then there is a risk to patients because of all the work it did not do and the ill health and deaths that might be the consequence. These are complicated issues. There are no simple answers. The Academy s point is simply that these difficult questions have to be asked.

2. New institutions could be included
However, if a new hospital is built, if it is properly equipped to modern standards, and if funds are available to maintain both the building and the equipment, and then society decides to introduce an offence of corporate killing on financial grounds, it is not unreasonable to include the hospital.

3. Opportunity costs
There is, however, a further issue, namely the opportunity costs of the new policy. At first sight this appears minimal and the gains in better buildings and systems would be an obvious gain for patients.

However, the cost could be overwhelming. The behaviour of NHS directors and senior managers might indeed be altered, but the consequences could be perverse. If they are made to face a criminal charge and a risk of prison then the incentive to concentrate on safety could become overwhelming and be applied at high, perhaps excessive, cost to ordinary NHS services.

Of great interest are the events on the railways that occurred after the Academy s evidence of September 2000.

Safety was suddenly given a new priority and multiple slowdowns and cancellations resulted. The pattern of spending of public money (about £5 billion of public funds were given to the railway companies) was dramatically distorted. About £1 million is the usual rate of public spending to save a life. Yet the railways, where about 30 deaths a year occur, were suddenly spending far more than road safety authorities, although over 3000 deaths a year occur on the roads.

By analogy, the impact of a corporate killing law could be that substantial NHS spending might be deployed on buildings while medical services, which might be able to save many more lives, might be delayed or stopped as a consequence.

The Academy of Medical Royal Colleges sees no easy answers, but it believes these issues deserve considerable thought and general discussion.

Professor Sir Denis Pereira Gray

Further information and comment are available at **www.aomrc.org.uk**

peter sims

A memorable patient

In 1974 the Luangwa Bridge in Zambia was of great strategic importance. The three countries of Zambia, Mozambique, and what was then Rhodesia met almost at this point and it was the only road access to the Eastern Province of Zambia. The Frelimo freedom fighters were engaged in active warfare from bases in Zambia against the tottering Portuguese regime, the failure of the Pearse Commission had worsened relationships between Zambia and Rhodesia and the borders between the two countries were officially closed.

The bridge was heavily guarded and traffic had to proceed, one vehicle at a time and at a snail s pace. There were often long and frustrating waits in the hot sun, vehicles were extensively searched and, it was not unknown for cars to be fired upon for some breach of regulation.

I was working in a Mission Hospital some 40 miles from the bridge. A young soldier, apparently from the bridge garrison presented with an unusual skin rash. He had a patch of rough skin on his back which was anaesthetic, and not sweating. It is possible, sometimes, to make a diagnosis from the textbook and I decided, with some trepidation in my ignorance, that this was leprosy. I took a small biopsy, talked to the soldier and suggested he start treatment at once. He seemed relieved and went away with dapsone the only effective medication then available and agreed to be seen for follow-up.

Several weeks later we had just crossed the Luangwa Bridge after a tedious delay, we were hot and cross, our child restless; there was a long drive ahead. Suddenly a soldier jumped in front of the car waving a Kalashnikov and indeed pointing it at us. I distinctly heard the safety catch being lifted. He was angry, truculent, and screaming at us to stop and get out of the car.

I got out, frightened but desperately trying to look friendly and reasonable. The soldier suddenly threw aside his weapon, grinned broadly and shook hands with me effusively. This was my leper who came back to give thanks for his cure . I have resonated with that passage in St Matthew ever since.

futurology

Postcards from the 21st Century

Making space for health: new geographies of health and illness

Throughout 2000, our series *Postcards from a New Century* examined issues likely to influence general practice in the opening decade of the new century. Our authors were predominantly practising general practitioners.

For 2001 we continue the series, but will broaden the scope. We have asked non-doctors to identify key areas that may influence our discipline.

We begin, in this issue, with the geographer Deborah Sportan, who examines the emergence and impact of medical geography . Further articles investigate confidentiality and children, living with terminal illness in a child, a user s eye view of drug addiction services, architectural determinalism, supra-practice structures such a PCTs (and their successors?), the evolving human form, insurance in a genetic age, and more.

Remember that feedback is always welcome, by post or via e-mail to journal@rcgp.org.uk

Alec Logan
Deputy Editor, BJGP*, London*

Paul Hodgkin
Primary Care Futures

MANY will remember geography as the capes and bays discipline, the study of the features and places that characterise the Earth s landscape involving the endless pouring over of maps. But GPs may be surprised to know that medical geography has always been a key area of research in higher education. New geographical understandings of health and illness are emerging that may help primary care understand its evolving role better.

Medical geography has traditionally focused on mapping the incidence of disease and illness and their spatial diffusion patterns. To these were added other spatial phenomena such as uptake rates, the location of medical facilities, neighbourhood characteristics and deprivation. New Geographical Information Systems (GIS) technologies and an increase in the availability of spatial data within the Health Service means that geographical research is playing an increasing role in informing our understanding of the determinants of health and assisting planning for health care provision. A good example of this work is the recent study published in the *BMJ* that compared the health effects of poverty in London wards in 1896 and 1991 and found that the relationship between death and material deprivation has changed little over the century.

In recent years a growing dissatisfaction with this type of data-led approach has resulted in new geographies of health and illness emerging which mark a conceptual shift in thinking about the relationship between health and place. These new geographies move beyond the simple spatial distribution of a disease to focus on the lived, subjective experiences of those affected.

Today our understandings of illness are strongly shaped by medicine: people whose bodies are defined as diseased by the medical profession become labelled as socially abnormal. Disabled bodies are inscribed with negative meanings in relation to the able-bodied norm that extend beyond their physical impairment. For example, geographical studies have shown how social labelling affects not just access to social, employment, and leisure opportunities but significantly changes people s experience of different places. In other words, the diagnoses that GPs make may have much wider implications for the everyday lives of their patients than you recognise. A patient s spatial world may be turned upside down by diagnosis just as much as their physical health.

The second dissatisfaction with the data-led approach stems from its rigid conceptualisation of space and place. Much mapping-oriented work sees space as simply a container and places as just locations somewhere that just happens to be host to a disease, or to a certain characteristic such as class, ethnicity or a hospital. Places however are much more than just locations. Homes, neighbourhoods, and the workplace are where we interact with one another, the nexus of activities, social practices, and social relations which shape the experience of illness. It is in places such as the workplace that labels like disabled or chronically ill come alive as people experience and negotiate their embodied identity.

New medical geographies use qualitative methodologies to provide insights into how the experience of illness influences, and is influenced by, the spaces we inhabit and occupy. For example, research on the changing life worlds of women with multiple sclerosis (MS) reveal how their geographical worlds, use of household, neighbourhood, workplace and city spaces were fundamentally changed following diagnosis. For many, MS resulted in a shrinking of their social and geographical worlds which became focused on the private space of the home where they were hidden from view. Some women adopted strategies of resistance to manage their symptoms at work such as scheduling tasks in ways to conceal their fatigue, taking work home to hide their failing handwriting and avoiding standing for long periods, particularly in public. While the physical effects of illness for these women was undeniable, the expectation of normalcy in public spaces, such as the workplace and the street, both fundamentally affected and reduced their access to these spaces and shaped their experience of MS. In this context, these spaces were more than physical entities, locations on a map, they were key sites of social interaction with unwritten rules of social practice and behaviour.

Medical diagnoses create bodies that are socially labelled as healthy or unhealthy, normal or abnormal, and these identities then restrict access to certain spaces and living places. The de-institutionalisation of mental health care and the relocation of mental health patients into the community provide a good example of the ways in which medical diagnoses and health policy combine to determine social space. On the surface we are re-integrating formerly institutionalised patients into everyday life and everyday spaces. In reality, community care restricts patients to places such as sheltered accommodation and day centres and to limited social networks facilitated by carers. The everyday spaces of the street, the residential neighbourhood and the shopping centre are out of bounds as anti-social behaviour frequently associated with psychiatric patients excludes them from such spaces. These examples from disability, chronic illness and mental health care show how GPs diagnoses have much wider ranging and indirect implications for the

References
1. Dorling D, Mitchell R, Shaw M, *et al*. The ghost of Christmas past: health effects of poverty in London in 1896 and 1991. *BMJ* 2000; **321:** 1547-1551.
2. Dyck I. Hidden geographies: the changing lifeworlds of women with multiple sclerosis. *Soc Sci Med* 1995; **40(3):** 307-320.
3. Kearns RA. The place of health in the health of place: The case of the Hokianga Special Medical Area. *Soc Sci Med* 1991; **33(4):** 519-530.

Further reading
Butler R, Parr H (eds). *Mind and body spaces: geographies of illness, impairment and disability*. London: Routledge, 1999.

everyday lives of their patients than have perhaps been previously acknowledged. As such, recent comments by policy-makers suggesting the extended involvement of PCTs in housing and transport provision may have more direct and extensive implications for the medicalisation of the spaces of our everyday lives.

The new medical geographies can also shed light on how and why health services are used. Studies of primary health care provision in New Zealand, for example, have found that, for remote rural communities, clinics provide more than just a medical service and are often the centre of vitality and social interaction for the local community. The closure of such facilities on the grounds of efficiency or cost can profoundly affect the non-medical wellbeing of a place. By moving beyond the analysis of medical provision to examining the experiences of, and meanings associated with these spaces of provision geographers can help to inform and improve the uptake of health services. For example, studies of the micro-geographies of the GP s surgery have found the experience of health care to be influenced by the nature of that space and the power relationship between the lay patient and the expert doctor within it. What does this mean for GPs?

The layout of the surgery, the positioning of furniture, the relationship between doctor and patient (sex, age, dress, class, ethnicity) and the language of the encounter (medicalised or lay terminology) will affect an individual s experience and uptake of health care). Similarly, hospitals have been found to constitute neutral elements in our everyday geographies before an accident or major surgery turns them into spaces of fear. The public space of the hospital, the sanitised impersonal environment as well as the medical encounter have affected, for many, the decision to seek treatment where possible within the community. This was particularly found to be the case for home births where the non-medicalised, private space of the home creates an environment of familiarity and security.

These examples of new geographies of health and illness move beyond the analysis of the incidence of disease to understanding the experiences of health and illness. What they show is that the consequences of the medical encounter between doctor and patient go beyond the simple diagnosis and prescription of treatment. Rather, they highlight how these brief encounters may profoundly shape the everyday life-worlds of those leaving the surgery. As such, GPs need to appreciate the wider social and geographical consequences of their diagnoses.

Deborah Sporton

Mapping the private life of organisations

We all think we know our own organisations — but do we? As practices and PCTs take on ever more tasks, just knowing who is doing what becomes increasingly difficult. A new sort of organisational map, devised by physicists running multi-centre projects, sheds new light on this problem.

People in any organisation create a web of communication. Previously this web was unseen and unknowable. The new programmes map every person in an electronic system as one cell in a map — people you communicate with most are shown closest to you and the more intense (i.e. more alterations, more active comments) the communication the darker are your mutual cells. At a glance you can tell who is communicating with whom — and who is not. View the whole organisation and you see dark islands of intensely communicating groups interlaced by grey bridges of weak traffic. Stark white barriers indicate complete silence.

These maps change surprisingly little over time — people prefer to talk to the same colleagues regardless of the task. Planning, implementing, researching — it does not matter what stage a project is at, we choose to talk to people they already know rather than investing time in new relationships.

You can also look at how different documents are handled as they travel the organisation. Who are the completer-finishers who correct every last typo? And who are the creative types who fundamentally change the course of projects or plans? Useful for putting balanced teams together, or monitoring who has done the work.

In 2006 a PCT might use these maps to see where a developing guideline is at — or who is using an established one. Look at electronic patient records and maybe you could map the weak spots where communication tended to fail. Too much like Big Brother? New tools always create new powers and new possibilities. The issue is how they are used.

Paul Hodgkin

From *The Economist*; 6 January 2001.
hodgkin@primarycarefutures.org

Writing about general practice ...

Four months ago, the *BJGP* asked for volunteers for the regular slot on the back page of the *Journal*. The response has been gratifying all sorts of doctors, from New Zealand, Nuneaton, and Newfoundland have responded. We printed some of their articles last month, and do so again this month. General practice is alive and well, and elegantly described. To put things down on paper and send them to journals is hard work and courageous, and every contestant deserves a small comemorative silver quaich, but they won t get one, because the College can t afford it. They do, however, earn our grateful thanks.

To the results ... **Saul Miller** and **Jill Thistlethwaite** join our team. We have had to lose two columnists in the process, and that was far trickier.

How could such delicate decisions be made? Clearly legislation must be taken into account. European Union law now clearly states that no peer reviewed journal of general practice/family medicine can be published without a regular contribution from **James Willis**. So James is safe for posterity.

But to gain two we must still lose two, as my statistical advisers insist. So, Farewell **Bruce Charlton**! But welcome again. A man who has defined the pernicious influence of managerialism cannot be lost entirely from our pages, so we en-**Goodman** him, and look forward to refreshment on an almost monthly basis if Bruce isn t too busy.

And that leaves the Celts **Munro** and **Farrell.** One has to be sacrificed for the common good, and that one shall be Farrell. Liam has provided most of the gut laughs in the *BJGP* in the past three years, but can still be accessed by enthusiasts in *Doctor,* and more respectably, in the *BMJ,* not to mention several Irish newspapers and the BBC.

Finally we introduce another unexpected treat, regular contributions from **Graham Worrall**, in Newfoundland.

Enjoy!

Back to the coalface

So you have been doing a bit of lecturing Doctor , said my next patient. Well, sort of , I replied. It had been over 10 years since I had left a partnership in a rural area of south-west Scotland to take up a Chair of General Practice. It had been an exciting opportunity to build up an Institute of General Practice in Primary Care from what was virtually a one-person sub-department of public health. Looking back it seemed a rollercoaster ride of initiating self-directed problem-based learning for a new curriculum, developing research in general practice, and starting a masters course in primary care.

At the same time there were pressures from organisational changes, arising from the new contract in the inner-city practice where I worked part time; and in the university where there were pressures from research and teaching assessment. Both these changes depended upon the information technology of computers and the management ideology of politicians. It is difficult to believe that, in the early 1980s very few practices had computers, whereas now it would be difficult to practise without one.

If information technology was the means then the aims became mediated by the language of management. In common with public services there had to be purchasers and providers, competition, quality, and customers. The resulting bandwagon of change paid little heed to stability or human relationships. No distinction was made between the valuable techniques of management and the ideology of management for which ends justified means whatever the cost.

One of the differences between inner-city and rural practice is that in the former, doctors often parachute in from owner-occupied suburbs where they have little contact with their patients. In rural areas, doctors are constantly meeting patients in everyday social life and therefore GPs have multiple roles. Some find this uncomfortable, whereas others find it adds to the fascination of general practice.

But there have been changes too in rural areas, of which three struck me in particular. First, there are now well-trained paramedics in place of often voluntary ambulance crews. Secondly, there is a growing problem of drug addiction, mainly affecting the young, owing to boredom and a lack of job prospects. Thirdly, a large proportion of the population seem to be on warfarin.

Another change is the mobility of doctors. Of the 10 GPs in the area when I left, only two now remained. The problems of recruitment and retention have much to do with the demography of medical schools, where around half of medical students are now women and so are half of general practice registrars. Traditionally, male doctors in rural areas would not usually have wives or partners expecting a job. If half the potential pool of rural GPs are women then there is little prospect of work for their husbands or partners in a rural area with high unemployment. The problem of dual careers should now be recognised by all employers, but sadly the medical profession has been slow to do so. Recently, rural economies have been battered by BSE, high petrol prices, and a lack of tourists. And as farming declines so the knock-on affects become evident in rising unemployment, especially for men.

I wonder if you would look at this list of side-effects of the drug you prescribed last week. I was startled from my daydream by an internet print-out offered by the patient. I remembered his father when I was last in practice here, who when asked about any side-effects from a newly prescribed anti-hypertensive, replied that this was none of his business and that it was up to the doctor.

It is technology that forces changes in society and not the other way round. We are all partners now, but is it still the same coal face of personal relationships that are the core of general practice?

David Hannay

Departure

So, you re leaving us, then? a patient asks. It sounds as much of an accusation as an enquiry. Five years as a partner in general practice and I am about to move on. Some of my patients are curious, some are anxious and others are probably relieved (those that say, How will I manage without you, doctor? helpfully justify my decision to leave.) Our therapeutic journeys together are coming to an end.

I am left wondering whether I am letting the side down. Isn t general practice supposed to be about continuity of care through the years? Am I not supposed to deliver the babies of the children I ve seen in this morning s child health surveillance clinic?

The truth is that it is impossible to know whether cradle-to-grave care by the same doctor is of any benefit for patients. I know that general practice is a bit like being part of a family. We all muddle along together through the ups and downs of life.

Nevertheless, I ve long thought that family life does not conform to the idealistic model suggested by the media and by the advertising industry in particular. I fondly remember the last family wedding I attended, particularly because of the fight between two uncles in the hotel car park. In families it is easy to stereotype each other and to dismiss unusual behaviour because, Oh (groaning with eye-rolling sigh!), Auntie Beattie is just like that! It is almost as if our familiarity with our nearest and dearest blinds us to who they really are.

If this attitude is translated into general practice then we risk making assumptions about our patients and the symptoms that they present with. And if we are honest with ourselves, which GP doesn t feel a tingle of enthusiasm when they spot an unknown name on their surgery list?

Being a family doctor makes you feel old. Babies grow up and go to school. Couples separate. People who were healthy last year and the year before, this year have to be told they have cancer. My patients are ageing, are changing, are dying. And I look on, casting the occasional glance at my own mortality in the mirror. How often should I change the picture of me on the staff photo board that greets patients as they enter the health centre? The Queen probably has the same dilemma about her stamps.

Please don t misunderstand me: general practice is a great way to earn a living. Offering continuity of care for an individual and their family through an illness or a phase of life is beneficial for patients and rewarding for us.

But, for all our sakes, it doesn t have to be a life sentence!

David Mazza

Candidates for the dustbin of history

Medical practice without IT is inconceivable, whether for foaming zealot or hairy nonconformist. A frustration, common to all, is the immaturity of the technology exemplified by the proliferation of standards, the rapid obsolescence of hardware and software, the uneven progress toward universal electronic records, and the non-intuitive nature of the interface between user and machine.

Numerous suppliers, platforms, operating systems, software packages, and different functions requiring different levels of access to perform specific actions (often in duplication) would comprise a sufficient problem before the exponential development of hardware and software was added. In the foreseeable future lie optical and quantum computing devices of mind-melting power, sophistication, and speed as well as implantable or wearable computers, electro-biological interface devices and much else that will change the landscape faster than the changes that have occured so far. Reliable voice activation and synthesis combined with Turing test-capable machines will represent the first pause in the present helter-skelter of development but, until that time, some interim waypoints can be defined.

Establishing a common goal, not expressed in terms of hardware or software or user type but, rather, in terms of functionality, would seem a reasonable first step. Any universal health information network should first be comprehensible and accessible to healthcare professionals and patients alike. The factor least likely to change is us; our physical, psychological and social parameters are the common anchors upon which any system should be predicated. Our sensory, communication and information handling characteristics will not change soon.

The first waypoint should be a single standard national clinical database for all citizens. Without this, all attempts at paperless practice are noble but nugatory. I despair when I receive a new patient s notes for reviewing when they come from a paperless practice. They are invariably grossly wasteful of paper and largely incomprehensible. The patient s basic dataset and its form can surely be defined names, date of birth, gender, ethnicity, residence, occupation, social status, growth and development (conception onwards), immunisations, operations, illnesses (current and past), accidents, medication, sensitivity, screening data, etc, with space for free text.

How blissful it would be to not have to enter the details of a child s immunisation in the hard copy notes, the patient-held notes, the Health Authority sheet, the health visitor s notes, and the computer. One entry in one record, stunning in its simplicity and yet a goal that has eluded us all so far. Shunting lorryloads of shabby folders around the UK should join cupping and bleeding in the dustbin of history now.

Wireless computing, using WAP or similar technology, will give physical mobility soon. Direct retinal, cochlear, and even cortical projection will occur in due course and obviate the need for display devices of discernible bulk, even wearable head-up displays. Until then, in offices, large screens with graphical user interfaces, graphics tablets, and character recognition software would do much to improve usability and intuitive use.

Current primary care software may be powerful and flexible in the hands of the adepts but for normal people it is a pain, especially in its abysmal presentation of data to the user in quirky listings and language on tiny screens. Only those with the most severely anally retentive natures have any interest in Read codes on the screen. The basic dataset suggested above, in chronological normal language lists, can all be accommodated on a 22-inch display along with medical and pharmaceutical expert systems windows. Prompts for action required and data entry areas should form the centerpiece of the display. Entering data can readily be made more like natural writing on hard copy with a templated graphics tablet a system that even the most technophobic non-typist could manage after a few seconds.

Keyboards should join hard copy with the cupping and bleeding in the dustbin.

Steven Ford

Christmas presents

As Christmas approached last year I found myself struggling once again with one of life s difficult problems. What present should I buy for my wife?

I have just reached that transitional stage in my life when, sucked into practice meetings on coronary heart disease, PCG meetings on clinical governance, and cross-city meetings on how to make the other meetings more effective, my wife is left to make the really important decisions. It now falls to her to make sure holiday details are sorted out. She is the one who now keeps up to date with relatives birthdays, and she tries to ensure that our children s present list for Father Christmas remains manageable for him to carry.

I have mastered the art of delegation when it is possible, but the one thing I simply dared not ask my secretary to do was to buy a present for my wife. It simply would not do. So I was left pondering what I should buy for the woman who wanted a surprise . Where should one turn to? The RCGP gift catalogue of course where else?

Among the pictures of cufflinks, ties, and tiepins for the old boys of the College, a picture of something that was described as an oval gold perfume atomiser struck me. Not only was it gold but it also carried the initials RCGP on the lid. Should oval not be to your liking, you could also get a square one. What more could any woman want?

I knew what would happen to me if my wife found one wrapped up under the Christmas tree; in fact, I had been struggling to think of anyone I knew who would be delighted to find such a present at the bottom of their stocking. Now, it is obvious that we are all different, thank goodness. We all have our own likes and dislikes, looks and styles, and yet I did wonder whether the image portrayed by an emphasis on tiepins, cufflinks, and the inclusion of a token female item of a perfume atomiser was the one the College should be promoting. What sort of picture did it give of GPs in the 21st century?

Instead, let me offer a few suggestions that the modern College member would surely love to unwrap next Christmas Day.

How about jumpers or socks with health promotion messages sewn into them? Instead of the words Sweater Shop on the front you could have messages like Viral sore throats don t need antibiotics , or Have you had a smear recently? across your chest. Socks could carry any number of key messages or images such as Diabetics love chiropodists or Ask your GP about foot pulses.

For the car enthusiast, a series of car stickers could be produced with messages like Don t clamp me I m a doctor , and sun visors with the message Beware skin cancer .

For the keen gardener, a book on how to grow plants for medicinal use and avoid being arrested. And for those who like Christmas to smell nice, a specially decorated pack of air fresheners to be used after those slightly more nasally challenging consultations.

I am sure the gift catalogue could be revolutionised over night with such a useful array of attractive gifts. However, I am still not certain that I would survive to eat my Christmas pudding should I succumb to the temptation to buy.

Perhaps I ll ask my secretary after all.

Richard Vautrey

Patient-centredness and the politics of change: A day in the life of academic practice
John Howie
1999, The Nuffield Trust
HB, 160pp, £15, 1 902008940 5

If you can negotiate the title, you've done the hard part. This compact volume might be considered as the swansong of one of our discipline's leaders, who retired from the oldest Chair of general practice in the world in Edinburgh last year. His contribution to clinical and academic spheres is difficult to underestimate and has influenced us all, even if we have not read him directly. As he approached retirement, the Nuffield Trust had the vision to invite him to undertake the 1999 John Fry Fellowship, affording the opportunity to create a narrative of a lifetime's thought. It seems entirely appropriate that the memory of one great general practitioner should be commemorated in such a way by another.

The title that was originally suggested to him was 'Empowerment and Quality', and it is a testament both to Howie's dislike of fashionable jargon and to his instinct to think laterally that he chose instead the direction he did. He sets out to explore his views on patient-centredness in medical practice, covering a wide range of related themes, from the philosophy of the discipline of general practice, through the structures required to teach and practice, to the ability to judge the quality of that practice. At all times the linking theme is the need to hold the patient at the centre of medical thinking.

He acknowledges near the beginning, indeed proclaiming it as an objective of the book, that his treatment of the theme is essentially autobiographical, and this Howie-centredness is what gives the book its character and content. There are two main strands to his story, though other subplots emerge. The first tells the long, frustrating, but ultimately successful tale of his negotiations with government to achieve proper funding and infrastructure for university departments of general practice. The current health of general practice as an academic and clinical discipline owes much to his efforts, and the tale is fascinating. Given his later thoughts about the role of general practice, the success of the negotiations can be seen not only as a coup for medical education and research, but also as a triumph for patient-centredness. This chapter is more a historical record than normal bedside reading, but if we persist we learn important lessons about persistence itself, and about negotiation.

The second strand tells the tale of his important research career. Always with its root in important clinical questions or matters of daily relevance to practitioners, this covers much that is now so familiar to us that we may have forgotten how new the ideas were at the time. Antibiotic prescribing in URTI, work stress and consultation length, defining and exploring quality of care and, ultimately, the production of a sophisticated method for its measurement, are wrought elegantly into a continuous and logical story. The pursuit of the last of these can be seen as something of a Holy Grail, but Howie remains realistic enough to keep his achievements in context, keen to acknowledge the collaborative input of his colleagues, and uses the endstage as a platform from which to launch a challenging research agenda for the new century.

The writer Alan Massie, in a recent interview on Radio Scotland, argued that writing non-fiction, especially biography, represented a greater challenge than fiction. This is because in real life there are no natural beginnings, endings or conclusions, and these must therefore be artificially or arbitrarily imposed. In John Howie's book, there is a natural beginning, and, more importantly, a natural and satisfying conclusion to both his research and his political stories. This is, I am sure, no accident, but a reflection of one of his most important qualities – his long-term vision. When acting out these stories, I am sure he will have had a constant eye on his likely retirement date and the writing of this treatise, and wonder at which stage he began to construct the content of his final chapters. It is certainly this completeness that makes the book successful – this, and the magnitude of the achievements, the tenacity with which he set about them, and the lessons he leaves for the aims and conduct of our own stories.

Blair H Smith

Is Menstruation Obsolete?
Elsimar M Coutinho and Sheldon J Segal
1999, Oxford University Press
HB, 208 pp, £15.95, 0 19513021 9

Given the limitations on the average GP's reading time, there are some books which, on balance, are better left on the shelf. This is one of them. First, it is really impossible to agree with the claim made in this book with its catchy title, *Is Menstruation Obsolete?*, that regular monthly bleeding is not the natural state of women but actually places them at risk of several medical conditions of varying severity, and that having periods is not medically meaningful even if they are culturally significant.

You may now want to read no further; however, there are occasional redeeming factors. There is an interesting historical skip through menstruation in Western civilisation from pre-history through Hippocrates, who concluded that the bleeding was nature's way of getting rid of the bad humours responsible for premenstrual headaches, swelling, and nervousness, and on through Pliny who asserted that sexual

intercourse with a menstruating woman could be fatal to man, by way of Leonardo de Vinci, who drew the uterus with veins connecting it directly to the breast in his belief that breast milk was derived from menstrual blood; finally to the present author s view that menstruation should be done away with all together.

Basically, the author argues that menstruation should be suppressed by the continuous use of oral contraception to produce health advantages. Even if oral contraceptives do have a place in the management of certain menstrual problems, they also have their side-effects and disadvantages which are not dealt with in this book, on an equal playing field with the disadvantages of menstruation itself.

The book really polarises the issue between the naturalists at one extreme who believe that no medical intervention should be undertaken in the normal functioning of women s bodies, to the other extreme, in which medicine is the answer to manipulating away any undesirable effects of any kind. In this argument in the book, there is real confusion as to what is natural or normal . The fact that women used to live shorter lives resulting in a fewer number of periods along with a greater number of pregnancies compared with now, does not mean that what is happening now is an unnatural state .

Overall, the makers of tampons and sanitary towels have little to worry about here!

Anne McPherson

Did Adam and Eve Have Navels?
Martin Gardner
2000, W W Norton & Company
HB, 344 pp, £18.95, 0 39304963 9

MARTIN Gardner is an American journalist, now fairly senior, who has published a formidable amount during his life. The present volume is a selection of his contributions to *Skeptical Inquirer*, the official organ for the Committee for the Scientific Investigation of Claims of the Paranormal. In as much as it deals with matters contingent upon health, it is the American equivalent of our own *Health Watch*.

Gardner would describe himself as a professional debunker, and in this book he debunks reflexology and urine therapy under the broad title Medical Matters . His other broad titles include Evolution versus Creationism , Astronomy , Psychology , and Religion . The dust jacket quotes high praise from both Stephen Jay Gould and Noam Chomsky.

He is extremely well read and has taken the trouble to read much of what those he attacks has written: a very tedious ask, I would imagine. He writes well and is attempting to tackle the important and necessary difference between science and nonsense.

Bertolt Brecht s Galileo remarked that The chief aim of science is not to open a door to infinite wisdom but to set a limit to infinite error . The stance of science is doubting, uncertain and sceptical; it is this that offers the possibility of setting a limit to infinite error . In an age where, at least in a rich world, most children complete secondary level education and many go on to university, it is extraordinary (and depressing) that so many have no notion of the difference between science and belief.

The failure to distinguish those things that are associated from those that are causally related is widespread. It stems in part from our need for explanations. A need that is the *raison d'être* for religions that are attempts to explain our birth, our death, and the pain of the journey in between. It is this failure that underpins the success of alternative or complementary medicine and, in part, explains the strength of the placebo. We do medicine a disservice if we fail to make the distinction between that for which there is good evidence and that which many believe.

The *BMJ* is sometimes worth reading. Fairly recently in its pages I came across this quote from Albert Einstein: Two things are infinite, the universe and human stupidity: I am not sure about the universe .

For those of a sceptical nature this book contains no surprises. It is suggested by one of the contributors to the dust jacket blurb that this should be compulsory reading in every high school and in Congress . It would make a good, but possibly expensive present to teenage children that might diminish infinite stupidity .

Gardner belongs to a small band of articulate sceptics among whom I would remember Petr Skrabanek, John Diamond, and Richard Dawkins. Are they voices crying in the wilderness?

James McCormick

Reflective Practice; Writing and Professional Development
Gillie Bolton
November 2000, Paul Chapman Publishing
PB, 224 pp, £16.99, 0 76196729 X

GILLIE Bolton s workshops in reflective writing are one of the best forms of continuing education that I have experienced. This book describes the theory and practice of creative writing as a form of self-reflection. There are loads of contributions from groups that Gillie has run, many of them both amusing and moving. As well as describing how such groups should be organised, this book conveys some of the fun and vigour that such learning generates.

Reflective writing, as described here, does not consist of staring at a blank sheet of paper waiting for *War and Peace: Part II* to appear. Production of a publishable masterpiece is not the objective. Initially, you write whatever comes to mind. Anything is acceptable! This is then reviewed, with the aid of a group and facilitator, to look for an explanation of why you wrote what you did. This technique allows the practitioner to become aware of what is really on their minds, especially when the focus is turned to professional activities. Underlying anxieties and joys of the job come to light in this way. These can then be addressed or utilised in professional development. Especially as writing is involved this technique lends itself to the production of a learning portfolio that can be kept and reflected upon in the future.

Although the reflective writing workshops do not demand great literary skill several of the extracts from work produced are beautifully written and extremely moving. In particular, Mark Purvis s contribution demands a wide readership a wonderfully moving poem with suitably incisive discussion from the author.

Reflective writing is a must for anyone who needs to show that they are practising reflectively, i.e. everyone! It is even more of a must if you are involved in education at any level the techniques described here could be applied in countless educational settings from undergraduate placements to retirement seminars. A particular strength is a review of educational theory that doesn t sound like it has been produced by HAL-9000. Gillie has a particularly fresh and lively chapter on groups and facilitation that doesn t just rehash all the usual guff but has an original take on this fundamental educational tool.

GP morale is low and many of us have anxieties about the ways in which we will be reaccredited. Gillie suggests a strategy for assessment that we should all be able to endorse; A suggested criterion is evidence of enjoyment My pleasure in marking portfolios is increased when the student s enjoyment oozes off the page. We only learn effectively when we are doing what we want to do. Take note politicos when deciding on how we will be monitored!

This book is useful, informative and fun to read. I ll let Jackie Martyn tell you who should read it:

'There was another more ancient breed of healer who lived in the land. They looked like dwarves but everyone knew they were really of the goblin race. And that is how they were known: the Goblin People, or GPs for short.'

Wayne Lewis

Sexual health promotion — inner-city style

He was from West Africa; Nigeria I think, though I can t be sure. The first time I saw him he looked quite poorly and he had been suffering with a nasty abscess on his back which I treated medically. He appeared to make a full recovery. At the time, something about him made me think about HIV infection and it was not just that he was from Africa. (To place it in context, our practice is very much inner-city with a phenomenally high annual turnover and we see many transient people, including our fair share of asylum-seekers and refugees from many parts of the world.) He was a pleasant man, quiet, thankful for the care he received, someone who did not ask too many questions as if talking would reveal too much. I arranged to see him again but, perhaps inevitably, he did not attend. I duly forgot about him,

And then, one rainy November evening, he showed up again as an emergency case, this time with a nasty bout of shingles. Of course I treated him, explaining what shingles is and how the medicine I was offering ought to work. And just as he left I realised that I hadn t arranged any follow-up.

Unfortunately, that was the last I saw of him.

I made several attempts to see him. There was no phone number, thus I resorted to visiting. The address at which he was registered didn t exist. I was then informed that recent mail had been returned unopened. All my attempts at locating him have subsequently failed, miserably.

What information had I? As far as I knew he was heterosexual, though he was not keen to talk about his private life. When I suggested he have an HIV test following the initial abscess I remember he became quietly distressed before I reassured him that the choice was entirely his.

There is a fascinating debate going on at the moment around sexual health. In essence it is this: to what extent should general practitioners (and presumably the primary care team as well) be proactive in identifying and monitoring risk factors in the sexual lives of their patients? With the epidemic of teenage pregnancies, and the rising tide of sexually transmitted infections as well as HIV infection, I suspect that we, as GPs, have a part to play but what part?

Such monitoring requires a careful balancing act: too proactive and it may give us a bad name (‘*... I only went in with a sore throat and they started asking me about my sex life ...*’). There is also the argument that if there is any more intrusion into the lives of people that social engineering becomes the order of the day.[1]

Of course, to do nothing is merely to sanction the *status quo* and I cannot believe that having the worst record on teenage pregnancies in Europe, to take a previous example, is something to boast about. In the case described above, would it not be appropriate for us to give advice when we believe that HIV infection is a diagnosis worth knowing about? After all there is HIV treatment available now that s the whole point! Doing nothing, which is almost a hands-off approach, is a view I d love to take, except that I think it s ducking the issue big time!

I facilitate a small seminar group of fourth year students at Royal Free and University College Medical School on the challenges and opportunities of applying prevention in primary care. During the 90-minute discussion sexual health promotion nearly always surfaces. General practice is the ideal place to raise awareness around sexual issues, say many of the students. The opposite view how long it takes and how comprehensive it can be are also usually well articulated by the more perceptive undergraduates.

Which brings me back to my patient. I am really not sure that I can do more, or could have done more, for this unknown, unidentifiable, but real person from West Africa. It s a great shame that he had to give us a false address. Perhaps he will return, as he has done before, in times of acute need, and I will have another chance to talk about HIV infection.

What was that my trainer used to say about living with uncertainty ?

Surinder Singh

Reference
1. Fitzpatrick M. It s me orgasms, doctor. *The Spectator*; **28 October 2000**: 20-21.

Canadian winter

EARLY winter here in Newfoundland has already provided me with a couple of cases of frostbite to treat. As usual, the effect of dropping temperatures has been compounded by human folly.

One man had a slightly frostbitten chin. This followed a one-hour snowmobile ride he had taken, with his chin uncovered. Fortunately, the first-degree burn will recover rapidly; I advised him to take pain-killers and stay indoors for a few days.

The second man had been hunting for the local seabird, the turr (the rest of the world calls them murres), on an open lead of water between the shoreline and the bay ice. At this time of the year the severe weather drives the seabirds from their bare island homes inland to sheltered coves. It s easy pickings for hunters in boats, who shoot the turrs as they bob on the waves. Unfortunately, our intrepid sportsman had taken off his woollen mitts when fishing dead birds out of the water. He continued shooting in sub-zero temperatures, with wet hands. He had shot 30 birds before his excitement abated enough for him to notice that his right thumb had turned cold, white and waxy. Although he re-warmed his hand right away, part of the pulp remains necrotic, and it is likely that he will lose part of his thumb over the next two weeks.

***

February and March is the time for swiling , as the seal hunt is known locally. The commercial seal hunt has become almost extinct in recent years, but private hunting is common. This year, as in almost every year, I have seen a patient with swile finger . The patient first notices redness and swelling of an interphalangeal joint, usually on the middle finger of the non-dominant hand. The finger turns purplish-red, shiny, painful, and very tender. If untreated, the pain diminishes in two to three weeks, and the finger heals with ankylosis of the joint. If the ankylosis produced an awkward fixed flexion deformity, the old-time sealers would often ask the physician to amputate that part of the finger, so they could get on with their work the next winter.

Swile finger is caused by infection with *Erysipelothrix rhusiopathiae*, an organism found in the subcutaneous fat of the seal. It is thought to enter the patient s finger through a break in the skin of the finger which holds up the seal so that it can be skinned. The condition is now easily treated with penicillin or erythromycin.

My patient recovered within a week.

Two views on the MRCGP ...

Transcultural medicine and the MRCGP

LIKE the English language, the MRCGP is a living thing subject to constant change with the times not so much by revolution, as by evolution. The RCGP was founded on 28 February 1952 at 7 Mansfield Steet in London, but it was not until the first MRCGP examination, held on 1 March 1965, that the evolutionary process was begun. Five candidates sat the examination, all of whom passed.

The second MRCGP examination was held in May 1966 when there were 15 candidates who all, again, passed. In November 1967 the examination had to be cancelled because of lack of support. However, this temporary setback served as the stimulus to update the various elements of the examination and its methodology. The third MRCGP examination was eventually held in November 1968 and attracted 32 candidates.[1] Ever since, the number of candidates sitting the examination has been increasing steadily and the examiners have continued to debate on how it could be further refined and improved. Now taken by over 2000 candidates every year, the MRCGP examination has become the most important professional qualification for those working in general practice. Since 1998, transcultural medicine has been featured in the MRCGP as part of the evolutionary process of ensuring that the examination remains a true reflection of professional life in general practice.

Transcultural medicine is the knowledge of medical and communication encounters between a doctor or a health worker of one ethnic group and a patient of another ethnic group. It embraces the physical, psychological, and social aspect of care, as well as the scientific aspects of culture, religion, and ethnicity, without becoming involved in the politics of segregation or integration.[2] I have been arguing for a long time that GPs and other health professionals should take into account a patient s culture, religion, and ethnicity as much as they are taught to make allowance for age, sex, social class, and occupation. In my opinion, to regard every patient as English or anglicised and to assume that all patients have similar needs, is a gross error of judgement. Instead of disregarding a patient s culture, religion, and ethnicity we must respect it. Not doing so undermines the doctor patient relationship and the effectiveness of our care. It also breaches the Human Rights Act 1998 (Article 9) which ensures that everyone s right to freedom of thought, conscience, and religion is protected.

I was the first non-European to be nationally elected as a member of Council in 1990 after standing for election for seven consecutive years, unsuccessfully. Since then, I have tried to focus attention on the importance of transcultural medicine and its relevance to general practice and, in particular, to the MRCGP examination. The reasons are twofold. First, British society, for political and economic reasons, is truly multi-ethnic. Secondly, it is generally believed that societal changes should be reflected in the MRCGP examination. After many years of debate, transcultural and ethnic issues have become a formal part of the examination, and long may it continue.

I sincerely hope that now the RCGP Council and the General Medical Council would also consider including transcultural medicine and transcultural issues in their good practice guidelines. This change would not only result in raising the quality of care of all ethnic minorities in Britain but also raise the national and international status of both organisations. Indeed, to deny the importance of culture, religion, and ethnicity in patient care is akin to denying the law of gravity.

Bashir Qureshi

References
1. Fry J, Lord Hunt of Fawley, Pinsent RJFH (eds). *A history of the RCGP: the first 25 years*. London: RCGP, 1983.
2. Qureshi B. *Transcultural medicine: dealing with patients from different cultures, religions and ethnicities*. Reading: Petroc, 1994.

Examiner criteria for the MRCGP

IN its document, *Becoming an examiner for the MRCGP*, the College has set out four absolute criteria that need to be met by any GP being considered for nomination as an examiner. These include obtaining the qualification of MRCGP by examination and being a current subscribing member of the College, with an active commitment to patient contact over the next seven years. These three criteria seem apt and reasonable.

However, the remaining criterion is one that, I feel, is out of date and not relevant to general practice in the 21st century. This final absolute requirement states that examiners must have a minimum of five years experience as a principal in general practice.

This appears to have some flaws.

RCGP Annual General Meeting 2001

The AGM of the Royal College of General Practitioners will be held during the Spring Symposium at 9.30am on Sunday 8 April 2001, at the Waterfront Hall in Belfast

The meeting will include the Presentation of Awards and Fellowships, the annual William Pickles Lecture, an update on revalidation in general practice, and constitutional changes for MRCGP International.

Formal notice of the meeting will be sent with the March 2001 issue of the *BJGP*.

First, it excludes all non-principals. Non-principals are an increasingly important part of the GP workforce and include many mature and dedicated doctors who have either not wished to take up a position as a principal or whose life circumstances have prevented them from taking on a principal post for some part of their career. I would be interested to know what the reasons are for excluding them from becoming examiners. Society, at the moment, is striving to have organisations that are inclusive and embrace diversity and indeed the College itself, in its information pack on how to become an examiner for the MRCGP, states that the Examination Board of Council believes that the composition of the panel of examiners should reflect the range of general practice in the United Kingdom . I would suggest that this restriction against non-principals prevents such a policy functioning. The College has previously looked at the hidden and subtle influences that may disadvantage overseas graduates in the oral examination, but perhaps another factor to consider is the restrictions placed on those who are able to examine. If the examiners are all from the same narrow subset of GPs then they will naturally bring with them a subset of attitudes and values to the examination.

My second point is that by only allowing principals to examine it implies that the knowledge and attitudes that are being tested are those that can only be experienced in or assessed by principals in general practice. This therefore suggests that the examination is a preparation to becoming a principal. As an increasing number of doctors choose different career options the examination should demonstrate a marker of quality appropriate for all careers within general practice. The examination and membership of the College should be seen as a valid and reliable assessment of good practice in all its forms and varieties, including ways of working that do not include being a principal in practice. For the College to remain relevant to the increasing numbers of non-principals in the profession it must be accepting of the importance of the role and demonstrate this by drawing non-principal members into the examining fold.

I would hope that the College, and therefore the examination, is able to reflect the changing and evolving nature of general practice; to achieve this it must have a panel of examiners who reflect the diversity and range of general practioners working within general practice today.

Deborah Clarke

neville goodman

Palmtops

IMAGINE a modern *Macbeth*. The witches still dance around the cauldron, invoking spells with eye of newt. But when they ask, When shall we three meet again? (in suitable managementspeak, of course) they whip out palmtop computers and find a mutually convenient date. Well, two of them do. The third witch presses the wrong button and inadvertently restarts the pocket game of Doom she d been playing while the others were working hard at toe of frog. Or else realises with horror that she (or he, if Equal Opportunities gets a look-in) has completely erased her calendar file.

The palmtop has almost conquered the professional world. They are everywhere in coat pockets, on anaesthetic machines; they appear everywhere certainly at committee meetings and now even when extending dinner invitations. I m not sure what their appeal is. I have a slim diary in my pocket. I write things in it with a pen. I can t overwrite an entry by accident. Its batteries won t run out. It may even remain legible if it falls from the pocket of my operating theatre trousers during a call of nature. Of course I can mislay it, or lose it, but no-one is likely to steal it. I certainly dread losing it, because I don t have a backup which is the only real advantage a palmtop has that I can think of. But I bet most people don t obsessively back up their calendar files.

Palmtops are so fiddly. They re fine for two-finger typists, or those used to typing messages into mobile phones using their thumbs. I don t have a mobile phone and I can type properly. Between school and university I spent a month of mornings in typing college: just me, and 49 girls training to be secretaries. None of the girls ever spoke to me, but I can type with all ten fingers and I don t have to look at the keys (much, and except for the numbers which have never become automatic and symbols). You can tell people who can type properly because they make mistakes such as wrods , hopsital and clinicial (and it s been very difficult to turn my autocorrect facility off to let you know that).

Maybe other people lead more complicated lives than I do, and palmtops are a good way of keeping a log book of cases. They make unnecessary the annual ritual of transferring phone numbers and other information from the old to the new diary, but then where would we be without ritual?

Nev.W.Goodman@bris.ac.uk

our contributors

David Blaney is regional director of postgraduate medical education in Edinburgh, Scotland

Steven Ford is a GP in Haydon Bridge, Northumberland

Professor Sir Denis Pereira Gray is a GP in Exeter. He is an immediate Past President of the RCGP and is presently chairman of the Academy of Medical Royal Colleges

David Hannay is a member of the *BJGP* Editorial Board

Wayne Lewis is a GP in west Wales

David Mazza is presently at the Howden Health Centre in West Lothian

James McCormick has enjoyed an exotic career progression, from rural practice in the Ireland, to professor of community health in Dublin, Dean of the School of Physic at Trinity College, as he has been known to his friends. A veritable Renaissance Man for our 21st Century!

Ann McPherson CBE, FRCGP, is based in Oxford

Saul Miller is a GP in Belford, Northumberland

Joe Neary is Chairman of Clinical and Special Projects Network and is a member of Council representing East Anglia

Bashir Qureshi is a GP in Hounslow, Middlesex. He presently chairs the GP Committee of the Royal Society of Medicine

Kathy Ryan is Primary Care Research Manager at the Chief Scientist Office in Scotland

Peter Sims is a consultant in public health medicine

Surinder Singh is a GP in Lewisham, London. He is a member of the *BJGP* Editorial Board

Blair Smith is a senior lecturer in the Department of General Practice in Aberdeen. He recently enrolled in the Royal Naval Reserve, and is practising his knots

Deborah Sportan is a lecturer in the Department of Geography at the University of Sheffield

Richard Vautrey is a GP in Leeds

Graham Worrall **(gworrall@mun.ca)** practises on the north eastern edge of North America, in Newfoundland, where once ruled the mighty Cod. He is a member of both the UK and Canadian colleges of general practice

Sally Wyke is Foundation Director of the Scottish School of Primary Care

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

saul miller

Does the man from the Pru? And do you?

I have recently seen a few different adverts for insurance companies in which doctors are presented as kind and selfless souls. Rather good-looking ones, in fact, though that is as incidental here as it is untrue in the real world. We are all, so the adverts would have Joe Public believe, motivated purely by the desire to help our fellow citizens in times of distress.

These adverts, I have been reflecting, gave me close to the warmest glow about my choice of career since graduation; or, being more specific still, since I wore my first name badge with Dr on it. However, on further reflection I have begun to realise how shallow I am to be so easily flattered by a few adverts.

The idea is a simple one. First, you show the audience a scene in which a (coincidentally attractive) doctor is being unutterably caring in his or her work. Then you show another scene in which it is your insurance company being caring, perhaps to the selfless doctor who is too busy being selfless to waste time looking for good insurance at the right price. After that, all you do is leave it to the audience to draw the obvious parallel.

Presumably, it does improve insurance companies brand image to screen adverts following this sort of formula because they are willing to spend money filming them. Nevertheless, when I think about it, I really cannot get away from the thought that, after all, however they may try to present themselves, these are insurance companies we are talking about. Surely, no-one really thinks that an insurance company cares? Not in the sense you or I use the word, being selfless doctors. Yes, they may care about money but not about people (except as a means to make money).

Luckily, I can avoid lapsing into anti-capitalist rhetoric here. What follows in my mind as I continue to analyse is that if the adverts are putting a misleading gloss on the motivations of insurance companies, can the same be said about the way they portray doctors too? This is a leading question, of course, and I have already conceded that we (or should I say you) are not all beautiful people as well as doctors. Some of us are downright ugly. More to the point though, most of us are motivated by things like money and status, not just the welfare of our patients. We are not so selfless as we might like to think.

Interestingly, in this context Chaucer presents the doctor in *The Canterbury Tales* as a man intent primarily on self-aggrandisement. The sort of qualities we might normally associate with insurance companies he associates with a doctor, and he was writing in the Middle Ages. Some might find it shocking to think that not only does this cynical view of doctors motivations exists, it has had currency since at least that far back in time. In a way, I think I find this revelation reassuring, because it suggests that Joe Public is more insightful than he is often credited with being.

Having said that, it is amazing to me how many patients tell me how busy I am and how many very sick people I must be tending. In retrospect, comments along these lines seem often to be attempts to cast me in the role of selfless and caring doctor, much as the insurance companies adverts try to do for all good-looking doctors.

I think it works like this: the selfless doctor is the ideal of whom patients really want to look after them when they get ill. That is, someone unlike all the rest in the medical profession, who have baser motives and bad skin. While it is nice to be cast as the ideal doctor, therefore, I will be a fool if I ever really believe it. Just as I will be a fool if I ever really believe that an insurance company cares.