# The Back Pages

## viewpoint

**EBM and the future general practitioner**

EVER since evidence-based medicine (EBM) erupted onto the scene in the mid-1990s it has evoked strong passions, both for and against. Among general practitioners, there are enthusiasts (with whom I unashamedly identify)[1,2] and sceptics (with whom I am happy to debate).[3,4] The resulting dialogue has played an important part in moving forward ideas about how to integrate the process of EBM into our practice while preserving a humane, patient-centred approach.[5-7] For enthusiasts, the integration of EBM into general practice now seems essential for its future development.[8] Yet, sceptics sometimes seem to reject the idea that any good can come of it at all.

I agree unreservedly that the doctor patient relationship and the art of medicine are essential components of good general practice. I also agree that it would be a disaster if clinical practice was reduced to ... a mechanistic rulebook [following] evidence-based guidelines .[9] However I profoundly disagree with the conclusion that the practice of EBM by GPs would lead to such a dire outcome.

EBM at the individual patient level is a process in which ... knowledge of epidemiological principles [sheds] light both on the illnesses of patients and on the diagnostic and management behaviour of their clinicians [and that] applying these epidemiological principles ... to the beliefs, judgements, and intuitions that comprise the art of medicine might substantially improve [clinical management and the teaching of medicine] .[10] In other words, it is an addition to our established clinical skills, not a replacement for them. There remains, of course, much work to be done on how to integrate these new skills into the consultation, but that would be so for any innovation.

Nevertheless, Charlton s nightmare scenario[9] is by no means a figment of his imagination. There is currently a plethora of top-down guidelines imposed upon GPs by expert groups and organisations, such as the National Institute for Clinical Excellence (NICE). The fiasco of the zanamivir (Relenza) guideline is a demonstration of what the editor of the *BMJ* called the corruption of EBM .[11] The appropriation of EBM by such groups, that take a population rather than an individual patient view of clinical effectiveness, is a real threat to humane clinical practice, as it puts pressure on clinicians to fit patients into predetermined categories rather than listening to them to take account of their unique needs and values.

The necessary (but probably not sufficient) condition to protect patients from impersonal, bureaucratic, clinical management is for clinicians to learn the skills of EBM themselves rather than leaving it to the experts . This is partly a matter of using evidence in such a way as to make better and more focused clinical decisions in the context of the patient s needs and values ( bespoke rather than off-the-peg medicine), but it is also a matter of power. The ability of GPs to practice EBM represents an enhancement of their expert power relative to guideline-generating bureaucracies , and thus their ability to act as advocates for their patients and practice *Cum Scientia Caritas*.[2,12]

**Toby Lipman**


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**"The central idea of an ecosystem is that organisms living in an area ... should be considered together with other organisms and their environment as an integrated interacting system of co-evolving elements."**

*The NHS as an ecosystem*
**Peter Dick**, page 248

**"what ten non-medical books (to) recommend to aspiring GPs today?..."**

*Osler's Books*
**John Gillies**, page 251

**"an indispensable information source for the cultured traveller"**

**Benny Sweeney** finds solace, page 252

## contents

## Pesticide-related ill health

A seminar for general practitioners on the diagnosis and treatment of pesticide-related ill health was organised last year by the Pesticide Action Network UK, a non-profit-making group. The seminar, which was held in London in September, was borne out of frustration.

The Chief Medical Officer issues reminders at regular intervals that GPs should report any exposures to pesticides and veterinary medicines. However, both the Department of Health and the Royal Colleges have acknowledged that GPs are not well equipped either to investigate or to diagnose pesticide cases. Training for doctors on organophosphate poisoning was a recommendation in the 1998 report by the Joint Working Party of the Royal College of Physicians and the Royal College of Psychiatrists. However, this has been ignored.

And what of the centres of expertise for supporting doctors that the Royal Colleges also acknowledged were needed? The Department of Health has now cut the funding of the only existing institution that might have formed the basis of such a network: the National Poisons Information Service (NPIS).

Whether the NPIS fulfills the expert role envisaged is in any case questionable. Long-term effects of exposure can only be assessed if toxicovigilance is carried out: NPIS London itself admits that this is a much neglected area. Emerging epidemiological evidence about pesticides is not being effectively disseminated to the profession.

The argument that doctors rarely see cases of pesticide poisoning was not accepted by delegates. In fact, as Dr Vyvyan Howard (Foetal and Infant Toxicopathologist at the University of Liverpool) described at the seminar, every patient a GP sees has been exposed. Pesticides are used, not just on farms, but in homes and gardens and by local authorities.

Dr Howard s main concern was that chemical combinations and their effects are not being tested for in the regulatory control systems, based as they largely are on the conventional model of toxicology in which a single linear dose-response effect is measured.

Dr Howard then described how organochlorines, the class of chemical that was first widely used as a pesticide in the 1940s, now contaminate every point in the globe, including our own bodies. In doing so, he described the context in which family doctors now work:

Persistent chemicals have a half-life in our body, which means that we metabolise them more slowly than we take them in, so that the body burden increases as we get older. The body is able to get rid of other chemicals, such as organophosphates and carbamates, relatively quickly, within about 72 hours. We come across them every day through a variety of routes, primarily food.

Whether or not children, in particular, are at risk from the deliberate routine use of endocrine-disrupting pesticides in the food chain must be considered , said Dr Howard. He reminded delegates of the government guidance to parents to peel fruit and vegetables, to reduce children s exposure. It was based on work carried out by the Pesticides Safety Directorate which found that the acute reference dose (the safe dose for one meal or one day) could be grossly underestimated because of variations of particular pesticides found on different individual items of produce. Children could receive six or seven times the acute reference dose if they ate the wrong sort of fruit on the wrong sort of day .

Professor Andrew Watterson, of Stirling University s Occupational and Environmental Health Research Group, argued for better occupational health surveillance systems to be embedded in forthcoming Health Improvement Programmes. He drew attention to the Ministry of Agriculture s Pesticide Usage Survey, from which information on the pesticides used in a particular area is available. This could be useful to GPs if they are seeing many cases of, for example, breast cancer .

More courses and materials are planned which can be used by individual Primary Care Groups and other health professionals within the Health Improvement Programme framework.

**Alison Craig**

*If you would like more information about pesticide use in your area, contact Pesticide Action Network UK, tel 020 7274 6611; URL:* ***www.pan-uk.org***

## Intercollegiate Course on Human Nutrition

In 1996, an Intercollegiate Working Group was set up to address the perceived need for postgraduate training, primarily for medical practitioners, in the broad discipline of nutrition. Over the past four years, representatives from 11 medical Royal Colleges, with financial support from Rank Prize Funds and other sponsors, have participated in developing an intercollegiate course on human nutrition.

It has been a substantial challenge to produce such a course for an interdisciplinary group drawn from many medical specialties. The emphasis of the course has been on basic principles of nutrition that have common elements across the life-cycle, across the range of disease states, and in both primary and secondary health care settings. The topics covered include the assessment of nutritional status, nutritional requirements in health and in prevention and treatment of disease, the assessment and management of nutritional abnormalities, and ethical and psychological issues, using an evidence-based approach.

Two courses were held in 1999 and three were held in 2000, in Southampton, Dunkeld, and Nottingham. A further three are planned for 2001, using the same five-day residential course format which has proved very popular. Twenty to 30 participants attend each course.

The Intercollegiate Group on Nutrition and delegated College representatives have played a key role in the development and delivery of the course, with valuable extra input from a dietician, a pharmacist, and a nurse. There is now an experienced cohort of College-approved trainers. Ongoing support for new trainers has enabled the course to be franchised to each site, with virtually the same course being given on each occasion. For this, universal take-home messages has been prepared. A course management team that includes an experienced medical educationalist has been established to review the programme, the materials, and the details of the course administration.

Participants receive a certificate of attendance, and where relevant, CPD/CME credits. There are, as yet, no formal arrangements for an intercollegiate qualification, although there have been some preliminary discussions regarding how attendance at the intercollegiate course might contribute towards a diploma qualification in certain areas of nutrition.

Further information regarding future courses can be obtained from the website **www.icgnutrition.org.uk**. This site also carries links to other nutrition sites, as well as to the websites of participating colleges.

**Colin Waine**

## Belfast hosts RCGP Spring Meeting 2001

The Waterfront Hall in Belfast is the venue for the Royal College of General Practitioners Spring Meeting, to be held in April this year. This is the first time that Northern Ireland has hosted the event, and preparations are well underway for what promises to be a spectacular event. Between Friday 6 and Sunday 8 April around 500 delegates are expected to enjoy a very full programme of academic and practical interest, with an imaginative social component.

Taking Pride in Primary Care is the theme of the conference, and an internationally renowned list of speakers has been called together to help accentuate the positive. Professor Chris Van Weel of the University of Nijmegen will look at the impact of science on the future of medicine. An American flavour will be given by Professor Larry Culpepper of Boston, with a response from RCGP Chairman Professor Mike Pringle. A host of local speakers will also be present, speaking on subjects as diverse as telemedicine, conflict resolution (a local speciality), sports medicine, emergency care, joint injections, and rural medicine.

*The Waterfront Hall, venue of the Spring Symposium in Belfast.*

Among the highlights: Liam Farrell will give his recipe for how to make a fortune and kill the cat if he doesn t suffer from writer s cramp beforehand! Dr Michael Boland, president elect of WONCA, will gaze into his crystal ball with a look at the future world of medical education. Revalidation inevitably gets a mention, and Ann-Louise Kinmonth will be delivering the William Pickles Lecture.

The social programme will include a tour of the Stormont Parliament buildings, now used for the new Assembly, and there will be a grand banquet in the City Hall, preceded by a civic reception. Trips have been organised to some of the many rich cultural, heritage, and natural history sites for those overwhelmed by the academic programme, including the Giant s Causeway, and the famous Bushmills Distillery.

Valerie Fiddis, Norther Ireland Regional Manager for the RCGP, has been involved in organising the conference and seen the efforts of the Symposium Committee and the professional conference planners, Project Planning International, come together in the past 18 months. Following the success of the last RCGP Spring Symposium in Crieff, Scotland, delegates are expected to attend the Belfast meeting from all over the UK, and also from Denmark, Sweden, Canada, and the United States.

The Waterfront Hall, situated alongside the River Lagan, has plenty of excellent hotel accommodation within easy walking distance of the venue. Two international airports and several ferry terminals are close by for easy access. Project Planning International have already negotiated discount rates for travel.

*Brochures and registration forms can be obtained from Project Planning International, by writing to them at Montalto Estate, Spa Road, Ballynahinch, Northern Ireland BT24 8PT, or telephone +44 (0)28 9756 1993; fax +44 (0)289756 5073; E-mail: catherine@project-planning.com; URL:* ***www.rcgp2001.com****.*

**Barry Mitchell**

### RCGP Annual Meeting — a correction

In last month s issue of the *BJGP* (page 166) we announced that the RCGP AGM would be held at the Spring Symposium on 8 April in Belfast. We would like to point out that this announcement referred to the Spring General Meeting, and *not* the Annual General Meeting, which will be held at the normal time in November. For more details of the formal events during the Spring General Meeting, please turn to the Diary on page 255.

# A day in the life of a Cuban family doctor

IMAGINE what would life be like if you only had 600 patients? Yolaynee Deliz doesn t have to, because that is roughly how many patients she, and another 20 000 Cuban family doctors like her, have to care for.

At eight o clock in the morning she leaves her flat, which has been provided by the Ministry of Health, and goes downstairs to her consulting room. Like most of her colleagues she lives above her job, often in purpose-built accommodation. The advertised surgery hours are from 8.00 am to 12 00 pm, Monday to Saturday; for one day a week there is a late afternoon/early evening surgery for people who work full time, though workers may also visit a family doctor near, or even at, their workplace. In this four-hour period she will see 10 to 15 patients in consultations averaging about 10 minutes each. There is no receptionist and no appointments. Patients drop in as they please and regulate their own queue, which is rarely more than one or two people. They can always drop back later since in this city practice, they all live with five minutes walk.

The clinical workload would be familiar to any British GP, since Cubans suffer from much the same illnesses as British people; however, the style is somewhat different. Yolaynee is focused and business-like, but not pressured for time. The patients are relaxed, acting as if they are in the house of a friend. She has worked there for five years and knows them all very well.

One old man walks in and gives his young doctor an affectionate kiss patient-initiated physical contact is not uncommon. Another woman arrives, initially angry and agitated, but calms down during the consultation and eventually departs with a hug and kiss. A mother consults about her nine-year-old daughter. Mother and doctor sit in classic positions around the table, but the girl wanders round and leans on the doctor s shoulder to see what she s writing about her.

Confidentiality? Yolaynee routinely reminds her patients to close the door behind them, and they routinely ignore her. A woman pops in during a consultation to remind the doctor that she has to visit her mother later. Nobody bothers about my presence, not even the teenage girl with an unwanted pregnancy. Compared with the British way of life, Cubans live their lives in public.

There s no computer. Yolaynee fills in the patient s clinical record, which is in book form, and also a workload sheet. At lunchtime she takes this sheet to the polyclinic a few blocks away where the workload data will be entered onto computer. The data set is small but is collected in the same way by every family doctor everywhere in Cuba.

Yolaynee writes scripts, laboratory tests requests, and referral letters in a similar manner to British GPs. The scripts are normally taken by the patients to the neighbourhood state pharmacy. Sometimes the patient will come back with a note saying that the drug is not available, or that the pharmacy have substituted for a similar drug. Cuba is a Third World country trying to run a First World health service, and some medicines are expensive under foreign exchange. Others are simply unavailable because they are produced by US multinational drug companies, and for them to sell even an aspirin to socialist Cuba is illegal under the US trading with the enemy act.

However, there are always alternatives. The pharmacy has herbal medicines and Yolaynee has had training in their use, but when in doubt she refers to the specialists in alternative (principally Chinese) medicine at the polyclinic.

Laboratory tests? The patient takes along a note from the doctor and visits the polyclinic between eight o clock and 11 o clock in the morning. Once there, the technicians do the test or tests, 95% of which are analysed on-site the rest go to a hospital.

Outpatient referrals? Once again the patient takes along a note from the doctor to the polyclinic reception and receives a booked morning appointment for some time within the next seven days! Most specialties run outpatient clinics weekly at the polyclinic. Gynaecologists, obstetricians, paediatricians, and specialists in general medicine are based permanently there. For a few specialties it may be necessary to go to hospital; however, the principal of weekly appointments is the same. In this case, the patient would drop by the surgery before the appointed time, to collect his or her clinical history and the referral letter to take to the specialist. Occasionally, Yolaynee will go for a joint consultation, which is often a learning experience for the family doctor.

So, what kind of beast is a polyclinic? It is something with its origins in Eastern Europe but with a distinctive Cuban flavouring. Serving 30 000 people, it combines the resources we would expect in a large general practice with hospital outpatients, community health clinics, dentists, opticians, alternative practitioners, social workers, and environmental health. All under one roof, one management and all free to the patient. It is invariably managed by senior doctors their technical management skills are variable but their commitment to the service is unquestioned.

Yolaynee, meanwhile, is salaried and doesn t have to employ anybody. She only has with her a practice nurse who does similar work to British practice nurses of five to 10 years ago vaccinations, smears, diabetes, hypertension, sterilising equipment, and ordering supplies generally within strict protocols and limited clinical autonomy.

**Useful Information about Cuba**
The best source of information directly from Cuba is the website of Granma International **www.granma.cu**

**For information from the Cuban Ministry of Health** go to **www.infomed.sld.cu** This Spanish language site is linked to the English language US Infomed site

**For two opposing sources in Britain contact**
Cuba Solidarity Campaign, 129 Seven Sisters Road, London N7 7QG
020 7263 6452,
**www.cuba-solidarity.org.uk**
US Embassy, 5 Upper Grosvenor Street, London W1A 2JB
020 7499 9000.

**Further reading about Cuba's Health Service**
Waller J. *Cuba - health for all - what difference does a revolution make?* London: Cuba Solidarity Campaign, Oct 2000.
Theodore MacDonald. *A developmental analysis of Cuba's health care system since 1959*. New York, NY: Edwin Mellon Press, 2000.

**Reference**
1. *Washington on trial - the people of Cuba versus the US government*. Melbourne: Ocean Press, 1999 (Dengue fever and the CIA)

Targets? Financially, they don t have any. In any case this is not an issue, since smear and vaccination rates are usually in the 99% region. Members of the neighbourhood associations and the local Women s Association are involved in encouraging uptake. You can refuse, and some do, but you have to be pretty strong to resist the combined medical and peer group pressure. People here trust their doctors.

A husband and wife couple enter the surgery, to be seen in turn. The woman mentions that, earlier that same morning, the polyclinic fumigation team had visited to spray for the mosquito that carries dengue fever (introduced into Cuba by the CIA in 1982, killing 150 Cubans in the process[1]). Yolaynee explains for my benefit that collaboration with this eradication programme is compulsory. Quite right too, says the husband. In Cuba there is no freedom to breed mosquitoes on your property.

The afternoon is for home visits, but acute visits are the exception. Mothers and new-borns get regular visits from the doctor or nurse (there are no community midwives or health visitors), as do patients discharged under the hospital-at-home scheme. There are no district nurses either. Since people often live in three-generation extended families, much basic nursing care is undertaken by the family or, more correctly, the women in the family. Other visits are for routine three-monthly checks on, for example, diabetics. Patients who haven t been seen for a year get a visit too.

The style is casual. Yolaynee dispenses health promotion advice as she goes and receives not so healthy but delicious Cuban coffee in return. Occasionally she pays an early morning visit to the grandparents circle a t half-past eight in the morning, in parks and squares across Cuba, groups of elderly women, and some men, do physical exercises. Sometimes this is followed by a celebration of somebody s birthday or maybe a minibus visit to a place of interest. It boosts their well being and lowers the incidence of chronic disease and the prescription budget. Can we have some please?

Night calls? In principle she is permanently on call all the time. In practice, out-of-hours work is fairly rare people look after their friend the doctor. The polyclinic runs a 24-hour casualty unit and all family doctors do an all-night turn roughly every three weeks. Holidays are four weeks a year. Family doctors are teamed up in groups of three, so for eight weeks a year you have to help cover for a colleague.

Fancy the job? The wages are very poor but costs are low and the free flat is a big perk. The job satisfaction is high, the patients adoring and the weather wonderful!

**John Waller**

**Learning from Cuba ...**

The Cuban family doctor system has been the subject of increasing UK interest in the past few years, partly because Cuba has become easier to visit but mainly because of the achievements of the Cuban health care system, boasting the best health statistics, including infant mortality and life expectancy, of any Third World country and putting its plutocratic and hostile neighbour, the United States, to shame.[1]

In Wim Wenders film, *Buena Vista Social Club*, Ibrahim Ferrer comments that the achievement of the Cuban revolution has been to protect its population both from having too little and having too much. As such, their impressive health gains may be similar in nature to those achieved in the UK during World War II when most commodities were rationed.

It s not clear to what extent the Cuban health care system is responsible for improvements in public health, but their investment in maternal and child health has been substantial and comprehensive. Such early benefits were not enjoyed by most Cubans born before the 1959 revolution, however, and perhaps this group has had most to gain from socialised health care.

The quality of the primary care system is hard to judge, but lists are low (about 600 per GP), home visiting rates are high, protocols abound, what we would call significant event auditing is standard, and there is strong local support from specialists.[2] The system lacks resources, particularly since the US economic embargo began in the early 1990s, but is rich in people.

Modelled on British general practice and starting from scratch less than 20 years ago, the 30 000-strong Cuban family doctor system is a huge achievement, matched by an equivalent number of practice nurses. With monthly salaries of $26, the system is hardly transportable, nor is the extent to which doctors and nurses are distributed evenly throughout the country, or the readiness of Cuban family doctors to accept prevention and public health responsibilities as key aspects of their role.

Perhaps the most impressive aspect of the system is the extent to which shared social values supersede the usual medical interest in specialisation, centralisation, and commercialisation. This is achieved largely via the political system, but another factor may be the rigorous selection system for 15 medical schools, in which evidence of a commitment to community service and values is based on school reports over many years.

Cuba is no utopia its lack of democracy remains a blight, and there are uncertainties about what will happen after Castro s death but its survival so far, unlike the rest of the communist world, and its health prosperity, compared with countries following the model of development favoured by the World Bank, suggest that the Cuban example is important. In its social values, systems approaches, and investment in people, Cuba provides a rare, important, defiant, and successful alternative to the American way.

**Graham Watt**

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**Yolaynee on a home visit**

futurology

# Postcards from the 21st Century

## At the end of the tunnel

*This is the second article in our continuing series, Postcards from the 21st Century, commissioned and edited by Alec Logan (Deputy Editor,* BJGP*, London) and Paul Hodgkin (Primary Care Futures).*

At a recent workshop for members of Primary Care Group (PCG) boards in south London, the first speaker began with a reference to the Scottish decision to do away with Primary Care Trusts (PCTs) as separate corporate entities, and locate the public accountabilities for health and health care, not now residing with the new national parliament, at future supra-district levels (e.g. NHS Grampian). He went on to mention that, in Wales, the Cardiff-based Assembly has also indicated its intention not to pursue the PCT path and that its Local Health Groups, with their co-terminous NHS and local authority boundaries, are already well placed to become among the early versions of integrated health and social care organisations in the UK

The response was dramatic. The shocked expressions on some of the faces of the primary care professionals attending the workshop are now firmly logged in the memory, if not quite to be cherished there was too strong a sense of pathos for that then certainly to be retained as a cautionary reminder of the continuing distance between central policy and local practice when it comes to contemporary primary care organisational developments. Several GPs in particular simply could not credit the implication that, in setting up their own new PCT, they may once again be putting their (considerable) energies into an organisational structure pre-destined to self-destruct.

The reaction of GPs at this PCG, which is an event typical of many others now taking place around the country, mirrors that of local counterparts across the UK as the process of continuous organisational development in primary care continues apace. Despite their awareness that the likes of Total Purchasing Pilots, multi-funds, GP commissioning groups, and consortia not to mention GP fundholding itself have already come and gone, the workshop participants could scarcely believe that NHS Primary Care Trusts might represent yet another passing phase. A little over a year ago they were having to adjust in similar learning events to the dawning awareness that Primary Care Groups were organisations in transition. Now, as their response to the speaker illustrated so vividly, the prospect of a further novel collective identity just seemed too much.

Historically, GPs have been used to a stable, and sometimes static, form of organisation. They have also expected to control its fortunes, determining its shape and strategies.

The legal partnership has been both a simple and single form of organisation. The imperative in modern care systems, however, is for complex and, above all, genuinely dynamic organisational types. The inexorable and global policy pressures for both effective resource management and public health improvement require as much. The British General Medical Practitioner is having to recognise that organisational change is a legitimate tactic for modern health policy development and implementation; even to the extent that such change may take statutory form.

It is, of course, what is commonly felt to be the bewildering speed of such organisational change that has affected the morale of not just GPs, but also many other health care professionals more than any other factor over the past decade. The NHS itself has not kept up with progress in organisational theory and practice. Its reliance on such simple, closed organisational forms as the hospital institution, the unidisciplinary profession, and the administrative bureaucracy, now seems suddenly and quaintly outmoded. Conceptually modern organisations are adaptive socio-technical systems. Practically, their informal relationships are as significant as their formal structures. This is the age of the Virgin-style virtual organisation, the stakeholder enterprise (in Manchester United s image), and, above all for primary care, the multi-membership National Trust - type community organisation.

Each of these three terms virtual, stakeholder and community are now in common parlance among PCG/T members, each one acquiring a currency in different territories.

In those parts of the country, such as the Shire counties, where the individual practice is still sovereign, the virtual organisation holds sway. Its theory of a brand name organisation comprising many, disparate semi-autonomous units with their own operational styles and strengths, all signed up to a (very) few overarching and highly visible goals (or slogans), seems ideally suited at this stage of their development to those PCG/Ts where subsidiarity is the principle and a federal approach is required.

In many of the more affluent suburban areas outside our larger cities it is the stakeholder model that is preferred. It fits well with the local cultures of commuting, competitive sport, and consumerism. Here, the primary care organisation represents a new opportunity for mixed investment. The theory is that its accountability, scope and, above all, resource base will each be increased by its multiple interests. Manchester United is as important to clothing manufacturers and the media as it is to the Stock Exchange and its soccer supporters.

Similarly, the future Primary Care Trust can prospectively draw on a wide range of local

and external contributions, in addition to the public purse.

Finally, especially around inner-city areas there is the community organisation. The fundamental concern of GPs and others in these parts is local, neighbourhood-level legitimacy very often among socially and ethnically mixed populations for their own roles and responsibilities, for their services, and, most important, for the difficult decisions on resource usage priorities that lie ahead. These PCGs operate as communities themselves in their relationships and focus externally on the maintenance of as much interest and support from other community organisations as possible.

General practitioners have had tunnel vision when it comes to NHS organisational development in England. Internationally, of course, the opposite has often been true, Inter-sectoral alliances remain one of the World Health Organisation s key principles in its promotion of primary health care. Many developing countries have developed their equivalents to the NHS applying this tenet.

In the UK, the days when general practice was the name of the building, the profession, the organisation, as well as the service and the clinical discipline are fast coming to an end. For the last two those that GPs really care about this is good news. Their whole-person principles mean that they have long been used to operating effectively across boundaries. Each of the new primary care organisational types transcend past conventions of public and independent roles, and provide them with fresh opportunities for demonstrating anew the service value of their clinical discipline.

There is positive evidence of these opportunities being taken. The networks nurtured and developed by the first wave of Personal Medical Service pilot sites, serving people with with problems such as drugs misuse, homelessness and mental illness, grow ever more impressive as time passes. In one, the GP s count of his 17 primary care team members now includes hostel, hospital, and health centre staff. In another it is the parallel church charity which is co-ordinating with the GPs the primary care team s training programme. Above all, at several sites new nursing specialisms are releasing general medical inputs by GPs, rather than replacing them.

It is an encouraging picture. The organisational change is clearly favouring modern general medical practice. Perhaps there is a light at the end of the tunnel.

**Geoff Meads**
**Anthony Riley**

**Trust us — we're just doctors!**

Shipman — Bristol — Alder Hey. Whatever next? More of the same, clearly, for the world has shifted and being a doctor no longer of itself commands confidence. Instead, patients' trust is becoming conditional, contingent on our performance.

When we trust someone we understand both that their actions may have an impact on us and are not under our control. Trust also implies a degree of choice — too ill and I become dependent, not trusting. Finally trust implies risk — if the outcome is already assured the relationship is mundane, not fiduciary. In most situations — relationships, business, sport — trust is also mutual. In medicine it is peculiarly asymmetrical: patients have to trust me, but in what sense do I trust patients? In what sense do their actions put me at risk? In health care, trust has other dimensions too: that doctors act in patients' best interests, are competent, command the resources necessary to do good medicine, maintain confidentiality, and disclose all relevant information.

Dissect trust in this way and it is immediately clear that patients have good cause to trust us less: at times we all place the good of the balanced budget above their needs, frequently we cannot command adequate resources, and daily we fail to be honest about these compromises. Given the asymmetry of trust to start with, it is hardly surprising that patients reach for their lawyers.

So what can be done? Firstly we might be less dewy-eyed about trust. Perhaps it is a good thing that patients trust us less — standing on a pedestal for 30 years not only makes for pomposity, it is also damn uncomfortable. Next we could get much better at disclosing all that relevant information: We need to be comfortable about discussing the costs of treatment, and about when and why we are not doing certain things even though they may be indicated. And while we are getting used to doing these big, difficult things, we can make a start by disclosing the easy, cost-free things — routinely dictating referral letters with the patient, displaying the monthly practice drug budget in the waiting room. Finally we could increase patient choice by being more transparent about who we are and what we are proficient at: video clips of the partners in the waiting room might sound far-fetched but quick summaries of what we are good at, and what we are less confident about would help patients select who is right for them. Deteriorating trust leads to a vicious circle of defensiveness. Paradoxically, restoring trust demands openness and vulnerability.

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A fuller annotated bibliography on the application of a complex dynamic systems perspective to organisations is available from the author at:
**peter.dick@doh.gsi.gov.uk**

*This paper expresses the personal views of the author and should not be taken as representing the position of the Department of Health.*

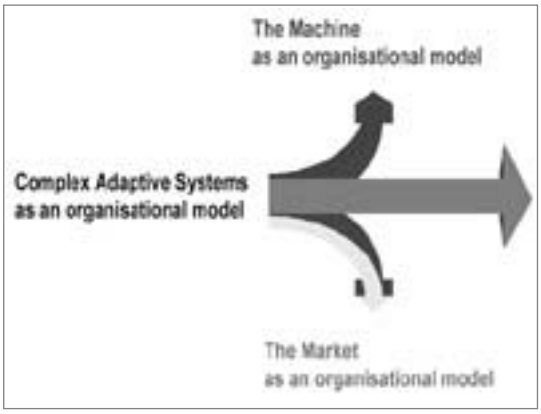
*'The real significance of the metaphor: "Life's … a tale told by an idiot", is that, in getting us to try to understand how it could be true, it makes possible a new understanding…'.*[1]

THIS essay very briefly explores a metaphor. As with all metaphors, it results from the bringing together of two distinct areas of experience and of treating one such area of experience as if some of the characteristics and features of the other applied to it. The metaphor considered here is that which results from applying ideas about natural ecosystems to primary care organisations, their staff and patients, and collaborative communities of such organisations and individuals.

Our thinking is essentially metaphorical in nature. We form our ideas within a framework, model or picture of the world about us and, since we then often act on our ideas, these frameworks are a significant, although often hidden, part of our lives. In particular, the ability to use novel or different frameworks or metaphors allows us the freedom to act differently. Twenty-five centuries ago, the Greek philosopher Aristotle wrote that ordinary words convey only what we know already; it is from metaphor that we can best get hold of something fresh .[2]

Since even before the time of Aristotle, the question of how we should organise ourselves and our activities so that we can most effectively live and work together has occupied the minds of our greatest thinkers. We know that, at our best, we can achieve much more by working with our fellow men and women rather than in competition with them or in isolation from them. The difficult question is how best to co-ordinate our collective life as a society so that we are more than simply a vast collection of more or less isolated individuals.

The answers given by the philosophers to this question have been diverse, often very dependent upon the focus of the collective achievement and the interests of the philosopher. Political thinkers seeking a moral society have suggested that power be held and exercised by wise guardians and that the rest of us are organised to serve their interests. Revolutionaries seeking a just society have put everyone and no-one in charge. Military men seeking a victorious society have emphasised rigorous training, specialist tasks, and obedience to orders. Economists seeking efficiency have tried to organise us so that we mirror the workings of the market-place. Each of these has had its successes and failures; each has its advantages and disadvantages.




Medical men and women have for the most part not played this game. A focus on the individual relationship with one s patient, a lack of interest in and a scepticism about grand social schemes and often a rather low social status yielding a lack of power or influence over fellow members of society has meant than those in the health professions are more likely to be victims of organisational schemes than to be initiators. This is particularly true of those working outside the more formal institutional structures of university hospitals. The appearance of Primary Care Groups, Primary Care Trusts, and Local Health Care Co-operatives however seems likely to change this.

The dominant metaphors of social organisation in the 20th century have been that of the machine and the market place. Following the model of the machine is seen as a route to efficiency and effectiveness: each part has a pre-defined function which contributes to the overall purpose of the machine. The parts relate to one another in well-defined ways and it is thought possible to pull a lever in one part of the machine and the whole machine will respond in the intended manner .[3] Much of our language about organising uses terms implicitly or explicitly taken from descriptions of how machines operate. Central government is seen as, and sees itself operating as, a vast, complicated but ultimately feasible machine. Laws are proposed and enacted and in some distant part of the machine behaviour is expected to change in the predicted manner.

The metaphor of the market place where goods and services are bought and sold is a more recently prominent model; however, it too underlies much of our discussion about how we should co-ordinate our activities. Important relationships should be based on (usually short term) contracts to buy and sell services or to provide labour because, it is believed, in the absence of such legal contracts nothing will be achieved.

Within the health service in the UK and in other countries, these models or metaphors continue to affect the way we think of our work and our professional relationships.

However another organisational model has recently been given some prominence in scientific and business circles and some discussion of the application of this model to public organisations such as the NHS has taken place.[4] This is the biological metaphor of an ecology or an ecosystem. Ecosystem is a relatively recent idea used in studying the natural world that emphasises the inter-connected and dynamic aspects of the living world and its environment.[5] The central idea of an ecosystem is that organisms living in an area cannot be understood as isolated elements but should be considered together with other

organisms and their environment as an integrated, interacting system of co-evolving elements.

Systems with properties like those of ecosystems are of a particular type, known in the scientific literature as complex adaptive systems.[6] These have been extensively studied in recent years in the developing sciences of complexity with applications to ecology, biology and, importantly for our purpose, to organisations.[7-9] Examples in the natural world include not only ecosystems but also the immune system, the central nervous system, and communities of social insects, such as ants or bees. Human organisations which may be regarded as complex adaptive systems include villages, towns and cities, or firms, industries, and national economies. Markets themselves are complex adaptive systems of a limited kind. Such systems are highly dynamic, continually developing in the way in which they are structured internally and in the ways they interact with their environment.

As an organisational model, the significant features of ecosystems and other complex adaptive systems are that: they emphasise a systemic perspective where the effectiveness of complex, rich, and dynamic relationships are as important as the performance of individuals or individual institutions; they are open to the environment; they evolve and learn through interaction between the elements of the system and with the environment; a rich diversity of elements, of relationships, and of processes is important to sustain the ecosystem ; no-one is in charge, and power and influence are distributed throughout the system; and finally the organisational focus is long-term and strategic rather than short-term and tactical.

The operational implications of a change in perspective towards such a biological model could be extensive.

The dynamic system perspective implies that attention be paid to relationships and the management of relationships. Machines are simple systems whose parts have fixed, pre-set relationships with one another. Once the machine is up and running there is no need to be concerned with how the parts fit together, unless the machine stops working properly. In an ecosystem, however, maintenance of effective relationships, the monitoring of changing relationships, and the encouragement of a diversity of types of relationships are central tasks for all the living creatures concerned. The need to avoid locking oneself in to any sort of rigid structure and to look out for and exploit emerging sets of relationships is important. A similar dynamic perspective applies in markets; however, since the relationships are relatively simple, always based on contracts, and often short-term, the strategic implications are often not emphasised.

Ecosystems are always embedded within wider environments with which resources are exchanged, and an ecosystem perspective draws attention to these exchanges. Often the ecosystem and its environment can be thought of as a larger ecosystem itself and so the ideas of ecosystems within larger ecosystems, of ecosystems having sustainable sub-systems, and of hierarchies of ecosystems, become part of a useful complex of concepts drawn from discussions of natural ecosystems. Social organisations need to recognise that the working environment is often a complex set of embedded, overlapping networks each with their own functions and purposes. Any one system or network needs to remain aware of changes in these other systems and be flexible enough to respond.

An important feature of complex adaptive systems and a productive way of viewing ecosystems, both natural and health ecosystems, is to see them as learning systems, adapting to and co-evolving with their environments and each other. To be more precise, ecosystems are embedded hierarchies of learning systems in which individuals, groups of individuals, organisations, and groups of organisations develop by learning what works and what doesn t work.

Successful open systems must be learning systems. Closed systems (such as machines or unresponsive bureaucracies) can be designed to cope with well-defined and foreseen problems. The intelligence of the designer is incorporated into the structure of the machine. In contrast, open systems that interact with their environment cannot anticipate the range of problems with which they will be required to deal. They must, therefore, evolve solutions on the basis of experience; that is, they must learn. In open systems, the intelligence resides, not in the machine structure, but in the individuals and groups that make up the ecosystem and that must respond to changing contexts.

Machines may be complicated and ingenious but any diversity they have is static and designed in to the machine. Fast moving markets may surprise us with their offerings but the structure of the market or the processes of buying and selling remain very much the same. In the natural world, however, the diversity of the living and non-living parts, of the multitude of ways these relate together and of the processes of exchanging food, shelter, protection, and other necessities is critical. Organisational ecosystems need to encourage, monitor, and work with a diversity of people, structures, processes, skills, and ways of working if they are to be effective.

In a market, power accrues to the larger players and, in general, power and influence are responsive to the magnitude of resources, financial or otherwise. For a machine, the power resided with the designer, and the machine responds only as it was designed to do. Neither of these models is appropriate to situations, such as a local health economy, where no one person or institution can be thought of as being in control , which is held together by a framework of common values, and which seeks to be responsive to individuals and at a very local level. Local health ecosystems have multiple goals and objectives, some of which are long term and some short term. They therefore need to include a long-term focus and this puts a premium on strategic management (management across the ecosystem and into the longer term future) at all levels of the local health and social care economy.

The ubiquitous nature, the complexity and the rapidity of change itself, driven by the opportunities presented by new technology and the expectations that these opportunities be seized form the staple diet of many management books. The general-purpose nature of the industries changing most rapidly (computing, telecommunications, finance) means that such rapid change is not restricted to these industries. The complexity of change means that past change often becomes embedded in the system structure and thus lives on, while expectations of future change affect the current performance of these same systems.

Increasing interdependencies and connectivity in physical form (from inexpensive, fast telecommunications), in functional and problematic terms (from the overlap of boundaries of responsibilities and problem areas), and in moral terms (from knowledge of interdependencies and sensitivity to the consequences of them) combine to produce a more complex situation than previously existed for organisations inside and outside the health sector.

A new (or newly acknowledged) diversity, both of the workforce and of the attitudes and expectations of patients and the public, present novel management problems for those with responsibility for managing a local health economy.

For government and the public, limited resources and a general unease about public spending, increasing demand in part driven by demographic factors, the complex nature of seemingly intractable public problems, and an expectation that the user-friendly services provided outside of the public sector will be matched inside, together lead to a degree of difficulty and complexity for public services not often seen elsewhere. The problems of public sector management are often highly context-dependent, requiring specific solutions for specific situations.

All these factors suggest that a conceptual framework different from that embodied in either the machine or the market place metaphors may be productive. To look at the way nature organises herself may be a useful first step in the creation of a framework and even make possible a new understanding .[1]

**Peter Dick**

## in brief...

On-call GPs, late on Sunday afternoons, have never enjoyed memorable radio. **Radio 4** loses all direction, and listeners to **Radio 5 Live** are becoming jaded, as a six-man Manchester United win again with a last-minute disputed penalty after being encouragingly 8-0 down at half-time. Meanwhile, on **Classic FM** someone called Natalie Wheen is advertising urostomy accessories, for all I know. Then, out of the blue, **Radio 3** comes up trumps. You leave your car listening to the end of *Un Ballo in maschera*, dispatch an obvious case of necrotising fasciitis to an emergency tabloid exposØ, and come back to find wait for it **Bob Dylan** neck and neck with **John Keats** (**Dylan Among the Poets**, Christopher Ricks) as a seminal influence. A son and I, dodging Old Firm fans sword-fighting on the dual carriageway, career towards the local emergency on-call Primary Care carry-out curry facility. We re hollering **Isabella; Or, The Pot of Basil** to a strident FM beat. Enough to restore your faith in publicly funded broadcasting, I can tell you.

Then homewards, to salute **Ellen MacArthur's** astonishing performance in the Vendee Globe. The *BJGP* can now exclusively reveal that we knew all about Ellen MacArthur back in November (Deputy Editor meets man-in-the-know at Edinburgh dinner party), and that we predicted she would come second. Delays with peer review hampered our telling readers about how much we admired her until the race has finished. But better late than never. She is a star! Her uncle s a GP, by the way.

**Next month** How concise is the **Concise Oxford Textbook of Medicine**? Fabulous book, but why does it split in two when you open it ...?

***Alec Logan***

### Love

Within your eyes
There is a light
Which age shall never fade

Within your kiss
There is a truth
Which time shall never falsify

***Colin Ian Jeffrey***

**What are you feeling Doctor?**
**Identifying and avoiding defensive patterns in the consultation**
**John Salinsky, Paul Sackin, Marie Campkin, Michael Courtenay and Lesley Southgate**
Radcliffe Medical Press, 2000
PB, 174pp, £19.95, 1 85775407 7)

THERE is a contradiction at the heart of Michael Balint s teaching. The original aim of the Balint seminar was to reveal the doctor s emotional reaction to the patient and work with it in the service of his or her professional endeavours. The focus was explicitly on the relationship, not on the source of the doctor s emotions in his or her personal life. Many group leaders steered the discussion away from any exploration of the doctor s personal history, and in the course of time such an exploration has become a taboo. At the same time, Balint taught that, to achieve the objectives of the seminar, the members would need to undergo a change in personality, a heightened self-awareness providing insight into their own defence mechanisms, negative emotions, and stereotyped responses to patients. How could this occur, unless there was some explanation by the group of the doctor s defences? The fear was always that the group might become therapy for the doctor. Was it not possible that a group could contribute to a member s self-knowledge without becoming involved in therapy for his or her pathological traits?

This book has broken the taboo. It describes and evaluates the experience of a group of doctors that deliberately set out to explore their own defensive reactions in responses to patients. The members of the group were all seasoned members of Balint groups, and all had at times been group leaders. All of them were GPs, including the two leaders. The group followed the Balint procedure, starting with the verbal presentation of a case that had upset the doctor. Rather than presenting cases recognisably difficult by all physicians, members tried to select those that were upsetting for them, but would probably not have been difficult for other doctors.

To focus the discussion, the group developed a series of questions about the reasons for the doctor s distress, the nature of his or her defences, and how self-awareness might have changed the outcome. Like Balint s original group, this one was conceived as a ground-breaking research project.

Discussion of the cases provides interesting reflections on achieving a balance between avoidance of sensitive issues and undue intrusiveness, and on dealing with the temptation to offer comfort rather than challenge. After some initial hesitancy, one case proved to be a significant event in enabling the group to be more open about the possibility of a defensive reaction having roots in the doctor s personal history. The level of trust in the group was obviously an important factor in this breakthrough. The book goes on to look more closely at the defences deployed by the doctors, coming to see them as patterns of avoidance that may have a basis in the doctor s personal self, but not necessarily so.

One chapter is devoted to the hard question of time. How can we attend to patients in this way when we are under such time pressure? Unfortunately, this chapter has some major factual errors. The NHS is not the only health care system where family doctors see their patients free of charge at the point of contact. Time is a problem for doctors in North America. Consultation times cited for GPs in Canada are not correct. No references are given for these statements, and there is no thought for the hazards of comparing consultation times arrived at by different methods. Having said this, the chapter does offer some wise counsel on the time problem. As they observe, there is a subjective aspect to time. Time pressure is much greater if we are already emotionally upset. They suggest that we keep calm and not let time frighten us too much .

The project was evaluated by one of the group using participant observation, based on an interview with each group member, and a focus group to discuss the observer s findings. Interviewing patients was considered, but reluctantly rejected as impractical. Given the exploratory nature of the project, a relatively limited qualitative method was appropriate. Building on the experience of this ground-breaking group, the path is now open for more research using ethnographic methods and an external observer, and including patients as well as doctors.

In the interviews, doctors spoke of a new-found curiosity about their own reactions, a greater tolerance of patients feelings, and especially a new way of listening to patients. For Balint listening was the key skill and required a personal change in the doctor. I might have been surprised that these very experienced doctors were so late in learning how to listen, but I was not. It exactly mirrors my own experience. Is this because the ability to listen comes only with age? I think not. It comes, as the authors maintain in their final chapter, from an education that does not neglect the emotions. This book is a notable contribution.

***Ian McWhinney***

**General Practice: Demanding Work**
**Understanding patterns of work in primary care**
**John Waller and Paul Hodgkin**
Radcliffe Medical Press, 2000
PB, 177pp, £17.95, 1 85775447 6

THIS is a little gem! Subtitled Understanding patterns of work in primary care it weaves a story in three parts: first, it uses data from a study of workload and morbidity to address questions often asked about why general practice seems so busy and demand so difficult to manage; secondly, it subtly persuades the reader to question some of the traditional assumptions about how work is patterned; and lastly, it puts the earlier issues into a reflective and philosophical framework. The success of the authors lies in their being able to present the three themes in a single continuous narrative, that is easy to read, and manages to make statistics and ideas seem comfortable bedfellows.

The main content of the book is derived from the Sheffield Practice Data Comparison Project, which collected information from 33 practices in the late 1990s and had available continuous data from 17 practices for three years and from four practices for five years. The 16 core chapters are all short and start with the kind of everyday question practice staff ask about their work. An engaging introduction leads on to analysis of the relevant Sheffield data (generalisable within the limits the authors set themselves). A focused discussion stimulates the reader to think both in straight lines and often laterally as well, there is a key points box and finally a what others have found item with references and comment about recent relevant literature. This body of work stands alone in its own right as a good read, offering a starting point to any primary care worker interested in comparing their own working practices and experiences with those of others.

However it was the second of the three strands that marked this text out as something different for me. Whether consciously or not, the core chapters repeatedly question the received wisdom of the general practice culture which says that it is patient demand that makes the job so difficult, and that solving the problems is everybody s responsibility but our own. Waller and Hodgkin note that general practice workload does not in fact appear to be increasing if surgery consultation rates are taken as the yardstick. They note that home visit rates are declining, although they argue correctly that the complexity of consultations is increasing and that expectations of patients and managers are increasing too. They note that the seasonal increase in workload is much less significant than doctors usually think, and find only a modest connection between working in a deprived area and increases in consultation rates. They suggest that the problems of non-attenders and of high attenders pose a problem that is more an irritant than anything worse. As others have found, they conclude that work patterns between and within practices vary widely and with hardly any detectable rhyme or reason . Most importantly, they face up to the reality, that it is supply (how available doctors make themselves to their patients) which is as often the problem underlying perceptions of overload, as is demand and they rightly say that supply is a quality issue.

Paul Hodgkin writes the 20th and penultimate chapter on his own. Sensing admirably the anxieties GPs feel about their roles in a modernised Health Service at the start of the 21st century, he argues that people most want a fast, efficient, courteous service from competent people ... who discuss fully what can be done and why sometimes things will not be done. He suggests that, on the surface, what the generalist does better than the specialist is to diagnose normality. However, he also argues around the importance of holism to patients and describes the kind of concerns that patients want their doctor to answer, pointing out that for many of them there are no easy answers and no guidelines. He finishes by reflecting on what made John Berger s Sassall *A Fortunate Man*, quoting that Sassall is nevertheless a man doing what he wants Sometimes the pursuit involves strain and disappointment. Like anybody who believes that his work justifies his life, Sassall by our society s miserable standards is a fortunate man.

The authors start by suggesting that their book can be used for reference or read from cover to cover. I strongly recommend the second option. Whether for a new registrar, for an established principal, for a nurse, or for a manager at any level, from practice to PCT, the whole tells a better story than the parts do on their own. It is a story that mirrors reality, promotes thought and reflection and, in the end, should provide encouragement and a way forward. What more could we ask?

**John Howie**

## What ten non-medical books would you recommend to aspiring GPs today?

Suggestions to **journal@rcgp.org.uk**. 350 words maximum.
We ll try to rustle up a prize for published entries

## osler s books

WHEN I went to medical school in 1969, a family friend gave me a book of essays by Sir William Osler, BT, MD, FRS (1849 1919),[1] the great Canadian physician, who was successively Professor of Medicine at McGill, Pennsylvania, Johns Hopkins, and Oxford Universities. I never read it at medical school, of course, but it is a handsome volume and lent an Osler-ish *gravitas* to my shelves.

Osler s place as the last guardian of pre-technology, bedside general medicine is analysed by Tauber[2] in his challenging analysis of the dehumanising effect of technology on modern medicine and on doctors, the high priests of the discipline. Osler wrote at the time of the paradigm shift from observational to scientific medicine, and saw the ascendance of the scientific model of practice as potentially sacrificing the important humanistic elements of medical care. He was not opposed to science applied to medicine, but was worried that scientists who learnt medicine in laboratories, not wards, would make poor physicians, orientated to illness alone, unable to understand or relate to patients. His fears were well founded.

At the end of his book, first published in 1904, he put down, as a recommendation for reading for medical students, a list of ten books. He suggested that students should try to get the education, if not of a scholar, at least of a gentleman. Osler s books were:

1. The Old and New Testaments
2. Shakespeare
3. Montaigne
4. *Plutarch's Lives*
5. Marcus Aurelius
6. Epictetus
7. *Religio Medici*
8. *Don Quixote*
9. Emerson
10. Oliver Wendell Holmes *(Breakfast Table* series).

It is easy to mock a selection of books written by dead, white males, who range from 1st century Stoic philosophers to a near forgotten 19th century medical polymath. The list contains not a single scientist. What he was perhaps trying to do was to help his students put their burgeoning scientific knowledge in perspective and, by looking backwards as well as forwards, temper that knowledge with wisdom and judgement.

Perhaps medical teachers might consider this: what ten non-medical books would they recommend to their students today?

**John Gillies**

1. Osler W. *Aequanimitas with other addresses.* London: Lewis & Co, 1941.
2. Tauber AJ. *Confessions of a medicine man.* London: MIT Press, 2000.

**The Genius of Rome 1592–1610**
The Royal Academy, London, 20 January–16 April 2001

As a title, The Genius of Rome doesn t represent fairly the true nature of this show. Had it been christened The Genius of Caravaggio and some OK pictures by some of his contemporaries , it would have been more accurate. Some great names are included here such as Rubens and Adam Elsheimer, for example but the paintings of theirs shown here do not do them justice. Many of the artists are distinctly second rate, and some are so feeble that one is forced to the conclusion that, just as in 1900 , last year s blockbuster in the main Royal Academy galleries, it is now a commonplace of curatorial philosophy that the full range of artistic endeavour must be included if the true nature of a period is to be understood. Of course, some of the paintings were not meant to be looked at close up, but rather to be seen hung high behind an altar: we do not look at them properly if we stand at the same level some few feet away, and one s judgment can accordingly be clouded.

There are, to be fair, a few fine painters here whom one is glad to have encountered for the first time notably Simon Vouet and some whom one is pleased to see again, such as Artemisia Gentileschi, but the works by Caravaggio are absolutely dominant and are what make this exhibition worth coming to see. You may know his works only from the series of sexually uncomfortable depictions of unhappy youths holding bunches of flowers or being bitten by lizards, and rightly, some of these virtuoso works are included here. However, the triumphs are the religious paintings. One is not really prepared for these, even by perhaps the most accessible of Caravaggio s works in the UK, such as the Supper at Emmaus in the National Gallery in London. The John the Baptist from Kansas City is visible at the other end of the gallery from the second room that you enter: as soon as you see it, you want to walk the length of the sequence of rooms to look at it properly, such is its magnetism. Striking as this is, it pales beside the Taking of Christ from Dublin or the Entombment from the Vatican. The latter of these is among the most magnificent paintings I have ever seen, before which even the most non-religious would have to be moved by the Passion of Christ. Once you have seen it, you will be convinced that Caravaggio is one of the greatest masters in the Western canon.

The paintings are hung on deep red walls, suitably enough given the high ecclesiastical patronage that these painters enjoyed, and their insecure and even dangerous relationship with these powerful and capricious figures is well explored. The atmosphere of 17th century Rome persists into the shop outside, where conspicuous consumption on an almost papal scale can be enjoyed by those with the desire to buy a copy of a hat depicted in Caravaggio s Card Sharps for some £1500.

**Frank Minns**

Caravaggio: *The Taking of Christ,* c.1602; oil on canvas 133.5 cm x 169.5cm
National Gallery of Ireland and Jesuit Community, Dublin, who acknowledge the generosity of the late Dr Marie Lea-Wilson. Photo copyright © courtesy of the National Gallery of Ireland, Dublin.

*This exhibition has been organised by the Royal Academy of Arts, London, and the Soprintendenza per i Beni Artistici e Storici di Roma*

**Traveller's Guide to Art Museum Exhibitions 2001**
Abrams, 2000
PB, 500pp, £10.95, 0 81096724 3

THIS book gives details of every exhibition staged this year anywhere in the civilised world, and also in Little Rock, Arkansas. In addition, it describes each gallery s permanent collection: the New Art Gallery in Walsall contains a collection of European Art donated to the people of Walsall by the widow of the sculptor Sir Jacob Epstein.

Major travelling exhibitions are listed, including the somewhat obscure 17th century Dutch landscape artist, Albert Cuyp, coming to the National Gallery London early in 2002, and Old Master Drawings from the National Gallery of Scotland appearing in one of my favourite galleries, the Frick Collection in New York. The Triumph of French Painting: Masterpieces from Ingres to Matisse arrives this summer at the Royal Academy, currently hosting the unmissable The Genius of Rome . Curiously listed in the same section is Yes Yoko Ono , visiting New York, Minneapolis and Houston. Personally, I would not attend were it to arrive tomorrow at the Cambuslang Community Centre.

A delightful essay on smaller European Museums Off the Beaten Path alone justifies purchasing this guide, which is an indispensable information source for the cultured traveller. I know of no British equivalent.

***Benny Sweeney***

**The Diagnosis — Alan Lightman**
Bloomsbury, 2000
HB, 369pp, £16.99. 0 74754932 X

**The Officers' Ward — Marc Dugain**
(trans. Rory Mulholland)
Weidenfield & Nicolson, 2000
HB, 135pp, £16.99, 1 86159176 4

Two very different novels with a common theme: the reaction of men to overwhelming disability and their treatment by healthcare professionals. *The Diagnosis* is set in modern day America, a land of competition, where stability is only achieved by conformity and meeting deadlines. Bill Chalmers, an outwardly successful trader in information, is stricken by a mystery illness that slowly paralyses him. His search for a diagnosis among the nightmare of the American healthcare system becomes increasingly Kafkaesque as he undergoes blood tests, scans, and psychiatric assessment at the hands of seemingly unempathic doctors. The situation is ironic, in that a man whose company s motto is The maximum information in the minimum of time receives no explanation about his tests and treatment, nor recognises that his physicians are reluctant to face uncertainty. They are always confident that modern medicine will triumph in the end. How often have our patients been left floundering after a trip to their doctors, unsure of what has been said and in despair at their helplessness?

The impersonal nature of Chalmers world is highlighted by the fact that one of his main means of communication is e-mail. Even his son, increasingly distressed at his father s condition, talks to him in cyber space more eloquently than he can face-to-face. Bill s story is intercut with that of Socrates. I found this intrusive but I suspect the reader is meant to make comparisons between the lives of the ancient Greeks and their thirst for knowledge, and our own society overloaded with often meaningless facts.

In contrast, Adrien, the narrator of *The Officers' Ward*, knows exactly what is wrong with him. He has suffered mutilating head injuries at the onset of the First World War and spends the next five years in hospital as surgeons attempt to reconstruct his face. The doctors are matter of fact and professional in their approach. It is a time of experiment in plastic surgery and skin grafts; however, many operations are unsuccessful. Adrien eloquently describes a life devoid of the many pleasures that he hitherto took for granted. He feels an outcast, cloistered away from the people for whom he volunteered to fight.

The doctors do not appear to recognise the psychological scars these victims bear. The physical healing process is secondary to the mental recovery that the soldiers gain through contact with each other, an early example of a self-help group. The book encourages the reader to reflect on the nature of disability and our responses to it.

**Jill Thistlethwaite**

**Tantalus**

**Edward Hall, Peter Hall and John Barton**

Salford Quays, The Lowry
27 January–3 February 2001

*Then*: Nottingham, Milton Keynes, Newcastle, Norwich, and The Barbican, London (May)

Icy blasts of late winter turn thoughts to Ionian shimmering sands; very different emotions played through the minds of the Athenian army, camped on the beach before the walls of Troy in *Tantalus*, the gigantic production of John Barton s Greek tragedy now touring the UK (Royal Shakespeare Company information: 01789 403440).

Gigantic is the only word that can describe the scale of the production which, with all three parts lasts ten hours, and took place in the magnificence of the Lowry Centre Salford s answer to the Guggenheim. Fortunately, each part, which each consists of three plays, is self-contained: your reviewer chose Part 2, War , which begins on the last day of the Trojan War. The weariness and pointlessness of this conflict is reminiscent of Vietnam (is the Asian tiger economy really America s Trojan Horse?).

The second play takes the Trojan s view and is dominated by their spindly King Priam, and his prophetess daughter, Cassandra. Despite her warnings, the Trojans bring the legendary horse into the city and their fate is sealed.

The third play which takes place with the gory remains of the previous night s killing strewn about the stage and all over the body of Neoptolemus, the young son of Achilles has all the tribal ingredients of the Balkan conflicts more familiar to contemporary eyes. For all his savagery, Neoptolemus remains the little boy, too small for his armour, as Hecuba, Priam s wife contemptuously remarks; even as he threatens to strip and brand her, a fate which has already befallen the rest of the Trojan women.

In a few minutes the audience became attuned to the features of Greek tragedy; actions taking place offstage enable the drama to explore the dilemmas and emotions of characters heightened by masks. Soon they were roaring at the sometimes contemporary quips of this ironic and witty script supported by a timeless eastern musical accompaniment.

It took $8 million, an 88-year-old Denver philanthropist, the Royal Shakespeare Company, six months of rehearsals, and a mega-row between John Barton and Peter Hall to bring about this production. Only one word describes it tantalising.

**Jim Ford**

## graham worrall

**Yours eponymously**

Which of us does not wish to have a new syndrome named after him?

Imagine my excitement, then, when a middle-aged man came to see me recently, complaining of a bald left leg! Sure enough, examination revealed that his left leg was much less hairy than his right one, and it was completely smooth below the knee. My pulse quickened was I on the threshold of discovering a new disease?

I remembered the bald patch we found last summer on the back of our faithful family pooch s neck caused by friction as he squeezed under our verandah to escape the sunshine. But what could have caused unilateral lower leg friction in a human?

As usual, the patient provided the answer. He told me that he d had deep venous thromboses in that leg about 10 years ago, and ever since then, because of poor venous return in his left leg, his calf is slightly swollen all the time. He also mentioned that his left leg had been as hairy as his right, last summer, when he was wearing shorts most of the time.

Eureka! It was clear that his swollen left leg was tight inside his long trousers in the winter, and the trouser lining was rubbing off the hairs. The exhilaration of making this diagnosis was balanced by the disappointment of not discovering a new disease after all. I kept a straight face, however, and suggested that either he buy baggier pants, or he let the inner seam of his existing ones out an inch or so.

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The school roll calls have been much diminished of late. Many children get an illness which seems more than a cold, and less than true influenza. They stay off school for a few days, apparently recover, go back to school, and then soon fall ill again with what seems to be the same infection. Given that the initial viral infection should have produced immunity, it was difficult to understand what was going on. I weakly explained to the parents of one such child it was possible that, still debilitated from the first infection, he had picked up one of the many other viruses that swarm through our institutes of education at this time of the year. I don t know whether the parents were any more convinced by this explanation than I was.

It was left to my son, then eight years old, to give the definitive name to this puzzling cyclical disease, which he d had himself. I was discussing the sickness with my wife over dinner, when he leaned over his plate and said, Dad, I know what that is it s the Coming and Going Flu! Everyone at school has it.

Can we call it the Worrall Syndrome?

**College Budget 2001-2002 and Annual Subscriptions**
Council agreed that the annual subscription should be set at a new full rate of £321. This represents a 4.9% increase slightly over the rate of inflation in respect of the full subscription rate only - other rates remain unchanged. Fellowship fees will rise from £650 to £670. A detailed budget will come to Council in March.

**Extension of Nurse Prescribing: College Response**
Council discussed this DoH (England) consultation document. While we were supportive of extending nurse prescribing Council expressed some important reservations:

- That nurses permitted to have extended prescribing rights should have been properly trained to prescribe in the therapeutic areas concerned;
- That prescribing was within agreed local guidelines;
- That nurses concerned had the right peer support of professional education to prescribe and to continue to prescribe safely and effectively;
- That appropriate Clinical Governance arrangements and the equivalence of revalidation for doctors should be applied to nurses who have extended prescribing rights;
- That the implications for the workforce and structures need attention before the process is implemented;
- That the safety and clinical governance systems and other necessary controls should exist in the private sector before it is implemented there, and therefore the proposals should be restricted to operation within the NHS;
- That no changes should be made to the prescribing in respect of controlled drugs or those used in palliative care until the outcome of the Shipman inquiry is known.

**National Institute for Clinical Excellence and the Primary Care Calibrating Centre**

The RCGP has secured agreement with NICE to fund support for the appraisal work of the College. We intend to rationalise the College s activities in the area of managing appraisals and other NICE work programmes. In the meantime, work is in progress on establishing a Primary Care Calibrating Centre which NICE has invited the College to continue being the lead organisation.

**Date of next meeting**
Saturday 17 March
Princes Gate, London

**Chairman Elect**
David Haslam was elected Chairman Elect, from November 2001. The Officers of Council look forward to working with him.

**College in Northern Ireland**
Council supported proposals from the Northern Ireland Faculty for moves to establish, in due course, a Northern Ireland Council of the College. Pending amendment to the College constitution, Council approved the creation of a Northern Ireland Committee. Proposed changes to bye laws should be in place for discussion in time for the Belfast Spring Meeting/AGM in April.

**Shipman Public Inquiry**
Following Richard Baker s audit of Harold Shipman s activities, the public enquiry looms. The timetable for producing evidence will be very tight and the College has undertaken to give all support and co-operation possible to the Inquiry.

***Good Medical Practice***
You may know that the GMC has issued for consultation a revised version of *Good Medical Practice* and I am currently conducting a consultation exercise among members to prepare our response. While some of the changes only involve reordering of material, the document has been updated to incorporate various other GMC publications and guidance issued in the interim period. Council was critical of the latest version, and felt that the additional material had not been properly integrated with the existing text. More seriously, many felt the purpose of the document was no longer clear: it contains a number of detailed provisions while purporting to be a principles document. Council was minded to propose to the GMC that it should be recast and revert to its position as a document of principle.

**Appraisal**
This was a major issue for Council and it is well known that it has been one of the significant concerns surrounding the issue of revalidation. We have been at pains to ensure that, when introduced, appraisal is a formative, educational process and at the same time can form part of the five-yearly cycle of revalidation so that GPs should only go through one appraisal process each year, which serves both purposes.

Chairman of Council, Mike Pringle has been in many discussions with ministers and advisers at the Department of Health in England about this. The position is not complicated by an agreement by the consultants to a management style appraisal that appears to be summative in nature. Although the Chief Medical Officers in Wales and Scotland appeared to be supportive of the formative model, that position may be changing. Council found this a complex issue but was supportive of our approach to aim for a single appraisal process, which is the least complex and supports both formative and summative outcomes. It is quite clear that, while there may be progress towards the introduction of a system of appraisal for GPs by this April, it will not be fully in place as was the aim of the NHS Plan for England.

**National Clinical Assessment Authority**
Readers may have heard of the document, *Assuring the Quality of Medical Practice*, a document produced by the CMO (England) following his consultation document *Supporting Doctors, Protecting Patients*. The National Clinical Assessment Authority is one of the key parts of *Assuring the Quality of Medical Practice*. While supportive of the analysis in *Supporting Doctors, Protecting Patients*, our major concern was the proposal for a support and assessment centre. This would have assessed GPs where there were concerns away from their working environment and resulted in a false and inappropriate process. Further, appraisals under these processes would be a managerial rather than a formative tool. While the first issue has been acknowledged the question of appraisal, as above, remains unresolved.

Council s first reaction to *Assuring the Quality of Medical Practice* was very negative in relation to its content and its tone it seemed to perpetuate a blame mentality. We need time to analyse the document, and Council Executive Committee will be asked to do this in February with more detailed comments coming back to Council in March.

**General Practitioners with a Special Interest**
In the NHS Plan for England there was a proposal to create 1000 specialist GPs. This term is not helpful for the College given our wish to maintain the ethos and purpose of the specialism of general practice. We prefer the term general practitioners with a special interest . GPs have of course had special interests in many areas of practice over the years and we are very encouraging of that, but there is a difficult balance to be achieved here between developing special interests and preserving the speciality of generalism. We have been discussing some of these issues with the Royal College of Physicians and we are also looking at the linkages within intermediate care. The first draft paper on these issues from Mike Pringle was debated by Council when the tensions referred to above were evident. Council wanted to be sure that GPs would not be viewed as second class doctors if specialist GPs developed to the detriment of generalists.

The paper will be worked on to take account of these concerns, also working as appropriate with other medical Royal Colleges.

**Modernisation of the NHS**
Council considered a number of papers on the subject of modernisation. The series of papers responding to the English NHS Plan that the College is producing jointly with General

Practitioners Committee (and in some cases other primary care organisations) is nearly completed. These papers will explore some of the issues already referred to including GPs with Special Interests and Intermediate Care. The document on the Primary Care Workforce has already been published.

The NHS Plan for Scotland has already been issued and contains many positive proposals though there are some negative aspects as well. In Wales, the Plan is due to be debated in February. In Northern Ireland, there is no modernisation document planned, although two documents on the future of medical regulation at local level and on primary care have been issued and the Northern Ireland Faculty is responding to them.

**Health and Social Care Bill**
A full brief on the Bill has been prepared by our Information Services section and is available via **info@rcgp.org.uk**.

One clause in the Bill is of concern, not only to the College but to the British Medical Assocoation and others, namely Clause 59 dealing with patient confidentiality. This gives the Secretary of State power to make regulations to prohibit or restrict the use of anonymised data, and also to enable disclosure of patient identifiable information without the patient s consent. Iona Heath pointed out that this infringes overriding principles of the Data Protection Act in some instances and could also infringe Human Rights provisions. Council was keen that the College should be active in trying to amend these provisions or narrow them to specific needs rather than granting wide powers. The bill is having a very rapid progress through Parliament as the Committee stage ends on 8th February after thirteen sittings.

**Out of Hours (OOH) Review: Implications for Primary Care**
Council expressed concerns about the ability of NHS Direct or its counterparts in Scotland and elsewhere to handle all OOH work effectively. The reduction in patient choice was criticised as many patients want to speak directly to their GP or use a well known local OOH service rather than a nationally-based call centre. As the College has representation on the OOH review implementation group, we will press these points during the coming discussions.

Other matters discussed at January Council:

- **NHS Plan for England: Implementing the Performance Improvement Agenda**
- **Winter Pressures 2001–2002**
- **RCGP Network Structures**
- **Advice for Air Travellers**
- **Spring General Meetings 2003–2005**

Full transcript via **honsec@rcgp.org.uk**

**Maureen Baker**

## neville goodman

**Of articles and authors**

It must happen to journalists and novelists all the time, but it s never knowingly happened to me before. The man sitting opposite me on the train was reading an article of mine. I knew he was a doctor from his previous reading matter, but nothing else had kept my eye. His briefcase was stuffed with journals, folders, and files. Some of them had been shuffled over to my side of the table and I d politely but pointedly had to push them back. He d half-smiled apologetically but we d not spoken. Then, he riffled through a section of the case and brought out my article.

I have to admit it was not a Back Pages column. It was a serious article with which people are likely to agree unreservedly or disagree wholeheartedly. He read it very slowly and carefully. Reading the later pages, he turned back on a couple of occasions to earlier sections. I found it difficult to do anything except watch. No real expression crossed his face. He didn t nod, or tut, or look skyward, and he didn t notice that I was taking an interest.

When he d finished, he put it down on the table and looked out of the window for a little while. Then he put it back where it had come from in his case and started reading something else.

Should I speak to him? I couldn t help noticing what you were reading: what did you think of it? Or perhaps I should be more bold. Excuse me, but I wrote the article you ve just read Then again, perhaps I should be more subtle, find something in my briefcase with my name on, put it on the table and sort of slide it across.

But to what gain? If he agreed with me, then I could glow in a self-satisfied way. If he didn t, then there might be an argument its unpleasantness directly proportional to our degree of difference. Even worse would be indifference: not hurrahs of congratulation or outpourings of scorn but the opinion that the article was worthless. And what would happen after this conversation? We were only halfway to our destination and I had plenty to read myself.

So I passed up the opportunity. I then reflected that when I d found myself standing next to Roy Hattersley, and on another occasion Clive James both writers whom I greatly admire I d not said anything. Nor did I say anything to Jean Shrimpton (the 1960s supermodel whom I eventually forgave for marrying fashion photographer David Bailey), when we were standing next to one another in the taxi queue at Paddington, though perhaps for different reasons.

**Nev.W.Goodman@bris.ac.uk**

## our contributors

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Peter Dick has a BSc degree in Mathematical Physics, an MSc in Numerical Analysis and MA in Modern European Thought. In 1998-99, he was Fulbright Fellow at the Humphrey Institute of Public Affairs at the University of Minnesota, Minneapolis, USA where he undertook research into the strategic management and leadership of decentralised organisations, with the aim of learning lessons which might contribute towards improving the performance of the Health Service in the UK. Presently he is a team leader responsible for providing analytical and facilitative support, policy analysis and advice to managers in the NHS Executive, Leeds **peter.dick@doh.gsi.gov.uk**
Jim Ford is a medical civil servant at the Department for Education and Employment, where he is Medical Director of the Job Retention and Rehabilitation Pilots (www.dfee.gov.uk/nddp). He is also still an occasional GP in Bootle
John Gillies is a GP in Selkirk in the Scottish Borders... **j.gillies@rural-health.ac.uk**
Neville Goodman has been writing elegantly to the *Observer* rebuking that normally sensible newspaper s Barefoot Doctor for spouting nonsense. ( The ears are the flowers of the kidneys etc etc etc)
John Howie has recently retired from the chair of general practice in Edinbugh, but isn t short of work, before you ask...
Toby Lipman s talents continue to impress our reviewers. Naval history one month, EBM for the next six or so, and Berlioz to come. Yet another Renaissance Man from Newcastle. You have been warned
Ian McWhinney OC, MD, was until recently director of the Centre for Studies in Family Medicine, at the University of Western Ontario, Canada. He hails originally from the elegant Lanarkshire spa town of Motherwell, Scotland
Geoff Meads is Professor of Health Services Development, Health Management Group, City University, Northampton Square, London, EC1V 0HB
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Graham Watt is professor of general practice in Glasgow
Graham Worrall has been working in rural Newfoundland for 20 years. His major interests are primary care research, single malt scotch, baroque recorder playing and helping his patients, though not necessarily in that order

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

## jill thistlethwaite

**'Is this the beginning of the end, doctor?'**

Now if I were clairvoyant, would I be talking to this 92-year-old lady on the phone? No I would be lying someone warm where the sun shines for more than one hour a day, courtesy of a large lottery win.

It s difficult to know what to answer when the patient is a fairly sprightly nonagenarian with intact intellect and a few months history of (very) intermittent chest pain. Platitudes are the easy option: of course not, you ll live to receive that telegram from the Queen (if she still sends them), see your great-granddaughter married, and celebrate the New Year. You ve only had to use that headache-inducing spray once this week after all. But of course in reality I have no idea. I tussle with the idea of referring her for an exercise ECG, after all we under-investigate our female patients with possible ischaemia, but decide that old ladies on treadmills could be construed as some form of euthanasia if anything were to happen to her. So I reply that I don t know, and she is glad I am honest. As I said, her intellect is intact.

Do the worried elderly well lie awake at night fearing that every breath might be their last? Some of my aged patients, similarly in their nineties, living alone, pottering about managing some housework, watching daytime TV, are just marking time. They tell me they are just waiting to die. There are no stigmata of depression, no sense that this is a morbid fascination, simply the realisation that their work here is done. Death will be welcome, but it will happen when it happens and until then they will continue to potter and make jam and wait for visits from their offspring and have the flu jab.

But other patients cling to an illusion of youth and gasp in amazement when that niggling pain in the knee is diagnosed as osteoarthritis and that loss of hearing is not wax but signifies the necessity of a hearing aid. They take as personal insults the creeping patina of age and vow to carry on as long as possible living life to the full. But then the doubts creep in. Little lapses of memory are seen as the signs of full-blown dementia. God, I don t want to die. I imagine them looking behind the curtains at night, ready to send the Grim Reaper packing. (He will resemble the ghost of Christmas yet to come, as played by Alistair Sim in the film version of *A Christmas Carol*.) But, unless they are obviously dying, I have never asked my patients are you scared of death? I would not know how to carry on the conversation whatever the answer.

Perhaps it is fear of ageing, rather than fear of mortality. I see this in the much younger, middle youth, as some wit has described them. This is the group of adults who wish to be seen as teenagers. They are up on all the latest music, buy clothes from trendy shops, go to the gym to stay lithe and fit, and spend a fortune on retinol and other anti-wrinkle creams. They like the sun, but not its direct rays. Their role models are Mick Jagger or Cliff Richard though they would rather listen to Robbie Williams or Britney Spears. The well-informed woman s panacea is HRT, the well-informed man demanding equality wants testosterone patches, or failing that, Viagra.

It all adds up to that familiar feeling: the inadequacies of 21st century medicine. I cannot keep you young, I cannot predict when you are going to die and I cannot make your hearing aid look any more appealing.