The Back Pages

viewpoint

What is a referral? A personal reflection

THE NHS Plan expected that, by April 2001, all PCG/Ts would have a mechanism for monitoring GP referral rates. Referral is one of the possible outcomes from any consultation in general practice. In terms of its impact on the rest of the system it may be the most significant outcome, yet it has been a relatively neglected area of academic inquiry. A flurry of activity in the early 1990s,[1-4] corresponding to the introduction of fundholding, drew the conclusion that there was a wide range of referral rates from primary to secondary care with no convincing explanation.

I was appointed a GP Referrals Adviser in City and Hackney in November 2000, with the task to identify current GP referral habits and facilitate change in the light of best practice, thus keeping inappropriate referrals to a minimum.

The cracks in this model quickly became apparent. Which practices were making inappropriate referrals? Were small, under-resourced and badly organised practices over-referring because they were unable to handle the demands they faced? No: Large and small practices appear to be spread evenly across a spectrum of referral rates. Similarly, practices with large numbers of ancillary staff and well-developed infrastructures are scattered throughout this spectrum. And who were the GPs who made inappropriate referrals? No GP ever believes that it was inappropriate to refer that patient in those circumstances at that time and bearing in mind his own knowledge, experience, and practice capability. He then considers local and national guidance, together with local hospital attitudes and facilities, and all referrals become appropriate.

It is clear that there are as many reasons for referral, as there are consulting styles. One GP's watchful waiting is another's irresponsibility. My borderline decision is someone else's barn door case. Is it just the ability to live with uncertainty? Is the required outcome of the referral clear in the GP's mind, and how often is that outcome delivered? How often during a consultation is a referral considered and then rejected?

We need to consider when a referral opens the door to the range of expertise and facilities available in our hospitals and when it only succeeds in exposing the patient to additional anxiety, resulting in care which could, ideally, be provided outside the hospital setting. The model we use for referring patients dates back, at least, to the inception of the NHS in 1948. GPs, who were mainly single-handed with no practice facilities, referred to consultants who had access to staff and resources. Of course general practice and primary care today has changed dramatically since 1948. The advent of NHS Direct and Walk-in Centres means that general practice is not the first point of contact for all patients. GPs will find themselves receiving referrals from other professionals, as well as making them. Within practices, the development of primary health care teams means that much chronic disease management is now referred to other practice members. The advent of GP specialists, nurse specialists, and extended scope physiotherapists opens up the opportunity for an intermediate level of care between primary and secondary care. Additionally, the growth in subspecialties within the hospital has resulted in the loss of the secondary care generalist. Will GPs fill this role as physicians who take a holistic approach? Will GPs become as familiar with referrals from one primary care setting to another as across the primary–secondary interface?

Referrals remain at the heart of the GP consultation. They influence clinical decision making and are a fundamental part of the clinical governance agenda. However, changes in referral practice are also the key to successful modernisation and redesign within the NHS.

GPs are in a unique position to influence this debate. Definitions about what is a referral will determine the role and influence of Referrals Advisers. As primary care continues to develop, referrals will be seen as part of the continuum of care, with outcomes measured in terms of quality of life, rather than referral rates or waiting times.

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"Only in Macedonia have I been thanked at the end of an interview for giving all applicants an equal chance!"

Primary Care in Eastern Europe, Peter Toon, page 74

"They disparaged French wines apart from Bordeaux, though admitted to drinking champagne 'but only if unwell'"

On entertaining the Bordelais, Stefan Cembrowicz, page 78

"The images are seared into our collective memory — airliners coming out of a clear blue sky ... But, in every sense except the literal, the sky was anything but clear and blue. The backdrop to the outrage was black with hatred, green with dollar bills, blood-red with history ... "

Behind the Lines, Roger Neighbour, page 83

contents

Trainee GPs from overseas to get NHS funding

Overseas doctors will receive NHS funding to train to become GPs for the first time since the mid-1980s. Under the current system overseas doctors only get finding if they are training to become hospital doctors (trainee GPs are excluded). This has put potential trainees off pursuing a career in general practice and it is thought that only a handful are paying to put themselves through training.

Applicants for posts will be subject to the national recruitment and selection procedures for GP training. Directors of Postgraduate GP Education in the postgraduate medical Deaneries will advise potential applicants on the arrangements. As an immediate step, they will be running a one-off recruitment exercise to fill existing training vacancies and posts starting in February next year.

Overseas doctors currently paying for themselves to go through GP training rely on permits issued under the Training and Work Experience Scheme that require them to leave the UK at the end of training. The Department of Health is currently consulting with the Home Office with a view to amending the Immigration Rules, to bring general practice training within the permit-free arrangements that currently extend to doctors training in the hospital and community health services. In the interim period, the requirement to leave the UK at the end of GP training will be relaxed for these doctors.

First Primary Care Sciences Week

More than 1000 primary care physicians and nurses are expected to attend the first Primary Care Sciences Week which will take place in Birmingham from 3–6 July 2002.

The conference, organised by the new Federation of British Primary Care Societies (FBPCS), will be the largest clinical meeting specifically for primary care ever organised in the UK.

The agenda will include clinical sessions reviewing recent developments in the management of cardiovascular diseases; respiratory illnesses, including asthma; metabolic disorders, including diabetes and lipid abnormalities; gastroenterology; rheumatology; oncology, and mental health.

The agenda has been developed by a consortium of representatives from the major primary care groups participating in the FBPCS including:

- Association of Community Cancer Care
- British Cardiac Patients' Association
- British Hyperlipidaemia Association
- General Practice Airways Group
- Primary Care Cardiovascular Society
- Primary Care Mental Health Education/Mental Health Research Group
- Primary Care Rheumatology Society
- Primary Care Society of Gastroenterology

The conference will also incorporate the Annual Meeting of the Association of University Departments of General Practice (AUDGP - see *BJGP*s *passim*), representing the clinical academics in every university department of primary care in Great Britain and Ireland.

Full accreditation for PGEA, CPD and PLPP is being sought.

Under the theme *Quality Care Through Clinical Evidence*, the conference will be held at the International Convention Centre, Birmingham. Registration will be £120.00 (plus VAT) for delegates booking before 30 April 2002 and £150.00 (plus VAT) for delegates booking thereafter.

Abstracts and proceedings will be published in a peer reviewed journal.

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The image most people have of someone researching their family tree is of a bespectacled spinster grubbing around in a graveyard, trying to decipher a weathered inscription on a badly tended grave. Such family research also used to require many trips to local authority archives and parish churches to leaf through dusty volumes of births, marriages, and deaths. An ability to read Latin was useful for research before 1750. Like all things involving large amounts of information, computerisation has altered the process beyond recognition. The Church of Jesus Christ of the Latter Day Saints, more commonly known as the Mormons, have been building up archives of information about past generations since the end of the 19th century. In the past ten years this has increasingly become computerised and it is now all available online at **www.familysearch.org**. Like most things on the net it is free, and there is plenty of help available. If you're lucky enough to have a slightly unusual surname and a family that moved around very little, it may only take a couple of hours to trace your family back to about 1650.

Information for the last century is patchy but, provided you know the name and approximate birthplace of family members born before 1890, you can usually follow the trail backwards. Other useful sites are **GENUKI.org.uk**, the home of the Genealogy Societies of Great Britain and Ireland. The site has detailed information contributed by individuals all over the country on structure of parishes, the dates of Censuses and current location of the parish records. Links are given to each local authority who all have information departments where the archives are kept. If you get stuck trying to work out relationships you can ask the archivist by e-mail to do a quick search for the presence or absence of a marriage or birth certificate in a particular parish. Many local authorities, such as Cheshire, have been working with their local genealogists to put as much of their information online as possible. Much of one branch of my family comes from Cheshire and I can search for both marriage and death registration in the 18th and 19th century online at **www.chesirefamilyhistorygettheurl.org**

There is also a large online community of people doing similar searches, as well as professionals engaged in genealogy full-time. Bulletin boards, such as **www.ancestry.com** can put you in touch with fellow enthusiasts all over the world. Many enthusiastic amateurs have built up websites with thousands of names interlinked, the largest collection of such links are to be found at **www.cyndislist.com**, which is rather American-orientated but still very useful. Alternatively, a quick search in Google (**www.google.co.uk**) for your surname and the word 'genealogy' will usually be useful, unless your name is Smith. Even then, if you put the surname and a county you could well strike lucky. I have also found it useful to put the parish names into a modern-day mapping site, such as **www.multimap.com**, which will give you a detailed map of the area, allowing you to look up the names of adjoining parishes to find out if your relatives moved down the road from generation to generation. Even if, like my forebears, they were very mobile (one branch moving from Exmouth to Croydon and on to Rochdale!) The family search site allows you to look for all people with the same name in the UK born or married within a few years.

Be warned however, like many aspects of the internet, this can become rather addictive and you can easily spend hours wandering down the highways and by-ways of your long-dead relatives!

It is easy for those within the UK's strong tradition of general practice to assume that this is how primary care is delivered. (though for how much longer even here looks increasingly uncertain). The Communist world approached health care very differently, and visiting Eastern Europe challenges many such assumptions.

These countries cover a quarter of the globe, and each is different. There has been little systematic study and interventions are often unevaluated. In some places things are developing rapidly, while elsewhere change is slow, and not always for the better. Our generalisations are based largely on personal and partial impressions and must therefore be viewed with caution, but perhaps they will give some idea of the problems doctors in these countries face.

The Former Soviet Union

The FSU had distinct health care systems for children and adults, with separate training from medical school onwards. The socialist desire to provide accessible primary care to everyone was met in the 1920s in typical communist fashion by dividing the country into 'territories', each with its local polyclinic, often numbered rather than named. District specialists in internal medicine, paediatrics, and obstetrics and gynaecology replaced the former *zemsskii vrach* (analogous to general practitioners). The initial idea was that 'home care is carried out by a single physician' but the 'territorial doctor' responsible for those living in part of a district did not have a gatekeeper function, and patients could and did access specialists directly. In a technologically-oriented society, specialisation was valued and the holistic values of generalism overlooked. In time, polyclinic specialists in psychiatry, venereology, and psychoneurology were introduced, more recently joined by cardiologists, endocrinologists, and neuropathologists. While the training and expertise of these specialists grew, the territorial physicians — seen, as Lord Moran viewed British GPs — to be 'those who have fallen off the ladder',[1] remained without postgraduate training. Many came to be triagers, dealing only with minor, self-limiting illnesses themselves. Half of their contacts led to specialist referral (compared with about 10% from UK GPs).

One Russian doctor commented that 'a person is cut into pieces for different specialists. The authority of the primary physician was lost, and the patient did not know who was responsible for his health-care. The patient himself had to decide what specialists would take care of him, finding his own way through the medical Minos labyrinth, or finding himself pushed into it by the territorial doctor.'[2]

The Stampar Model

Most Warsaw Pact countries copied the FSU system with minor modifications. In Yugoslavia, however, Andrija Stampar, public health guru and founder of the World Health Organization, developed a slightly different model. His vision was a 'hospital without walls', a multidisciplinary primary health care team of specialists in internal medicine, paediatrics, gynaecology, school medicine (caring for all in full-time education up to university level) and occupational or labour medicine.

The reality was unfortunately often rather different. All doctors had a common basic training, but this was usually more theoretical and less practical than in the Soviet Union or Western Europe. After this they became 'general practitioners' and could work in primary care. Postgraduate training was often secondary care-oriented, unpaid, involving few duties and little practical experience, and funded by their health authority, as a reward after several years service rather than as a preparation for work. Many primary care doctors had no specialist training; for example, 40% of doctors are still caring for children in Macedonia. As usual, the inverse care law applies, and they were more likely to work in remote areas or with deprived populations. Although continuing education programmes are now being introduced, the limited appropriate postgraduate training that there was — such as the pioneering family medicine scheme in Zagreb — was struggling for lack of funds. With such limited educational provision and problems of drug and equipment supply, the doctors faced, and still face, huge obstacles to providing a good service.

Country doctors

Under either system, in rural areas the population does not justify such overblown collections of specialists and primary care doctoring is closer to the traditional rural model. As in remote and unpopular areas everywhere, you will sometimes find inexperienced, incompetent or drunken practititioners in villages, but there are also committed, caring doctors doing their best for their community — truly fortunate men[3] (or more often women, as doctors in communist countries tend to be female, except in the more prestigious and powerful positions!)

Out-of-hours care

Communist philosophy viewed illness

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mechanistically and saw clinicians as interchangeable units of labour. Doctors worked in shifts, and 24-hour responsibility was rare. The doctor–patient relationship is undermined, rather than supported by this system. So strong, however, is the need of patients for personal doctoring, and so rewarding is it for the doctor, that despite these antagonistic institutional arrangements such relationships do develop.

In Russian towns there are two emergency services, one for urgent problems in people's homes and the other for emergencies that arise in the street — akin to GP deputising and ambulance services, but with slightly different boundaries. In both services teams consisting of a doctor, nurse, and driver go out (since few doctors drive and the role of our paramedics, like those of many 'professions allied to medicine'), is performed by doctors. Services for minor trauma and acute illnesses are separate from major accident and emergency units run by specialists in intensive care. This is rather more logical than the UK system, where 'minors' may be dealt with badly and grudgingly by A&E doctors whose interest is life and death emergencies.

In contrast, in Yugoslavia the emergency service was part of primary care, again often staffed by inexperienced doctors without postgraduate training. This dealt with all problems out of hours, from a febrile child to a ruptured aortic aneurysm.

The social position of doctors

To Western doctors, used even now to a good income and respected social position, one of the most striking features in many Communist and post-Communist countries is the low pay and popular esteem of doctors. Incomes are, of course, generally lower in these countries, but even in relative terms doctors are badly paid. Their commitment in these circumstances is extraordinary. For instance, one paediatric surgeon in St Petersburg moonlights as a taxi driver, because the money is better — but still operates when he can.

Networks tend to be even more important than in the UK, promotion often depending more on who you know than what you know. In some countries, medicine is a 'family business' and the most important criterion for entry to medical school is to be the daughter of a professor! In Macedonia we were thanked at the end of an interview for giving all applicants an equal chance! Since managerial and ministerial positions are usually held by doctors, and not lay managers or non-medical politicians, the power of patronage is enormous and may be unjustly used.

The post-Communist world

Following the collapse of Communism, plans for health service reform were made as the countries entered 'transition'. Like all countries, they faced escalating health care costs, while social upheaval created new health problems, and economic collapse destroyed the scanty information sources — such as journals and books — that they had had previously.

In both the Soviet and and Stampar systems, the large number of primary care and hospital specialists, general practitioners or territorial doctors, coupled with an employment philosophy of 'we pretend to work and they pretend to pay us' had led to a vastly overstaffed health service, with huge bed numbers and long stays in hospital. Costs were therefore high, despite low wages. As one Russian doctor put it 'our health service is obese!'

'Experts' from abroad were asked for advice and key figures from ex-Communist countries taken on study tours to Western countries, from which they often came back full of enthusiasm for what they had seen. Reforms were introduced, often hastily and piecemeal, importing Western models without considering a different society's needs, or how systems, institutions, and cultural values interrelate in a complex web.

It was common to see the future of primary care as generic family medicine (just as we seem poised to abandon it). A few pioneers were sent on study tours to Western Europe or the USA, returning to work in 'model practices' often glistening with Western money. This was understandably resented by doctors working in crumbling buildings under the old system. Primary care specialists, some with a low level and small range of skills, were deeply threatened by these ideas. Impotent to achieve their vision, these disillusioned pioneers often emigrated to the countries they had previously visited or moved to the private sector, caring for wealthy 'New Russians', or analogous *nouveau riche* groups.

Privatisation and compulsory insurance systems were widely implemented, often at the behest of institutions, such as the International Monetary Fund and the World Bank, without the cultural or regulatory changes needed for accountability. Thus in parts of Croatia primary care doctors were made independent contractors, but 'medical directors' were retained from the previous hierarchical system, though they now had no clear role. There was no educational underpinning to the financial reform, so doctors tended to work as before, caring for the same groups of patients, so they had all the disadvantages of isolated single-handed practice with none of the initiative and autonomy that it can offer.

In other places, such as St Petersburg and Macedonia, education without organisational or managerial change led to frustration, as doctors could not implement the changes they saw were needed. In many countries the nettle of unemployment — which any serious health service reform would generate — has proved too hard to grasp, even after ten years.

The extent of the cultural and legal changes and the time needed for health care reform were often underestimated by both locals and foreign advisors. One advisor was reported to us as expecting that the Russian health service could be changed in six months! Both East and West saw democracy as a political system, but it is also a state of mind. Changes tend to have gone better in countries such as Poland, Hungary, and the Baltic states, who saw Communism as externally imposed, than in Russia where reform was associated with loss of empire. In some parts of the Balkans, wars, ethnic hatred and 'Yugostalgia' — a nostalgic mourning for the past — have hindered change.

What of the future?

One thing is clear — in many of these countries, change will take a generation. Power still lies largely with those whose thinking was formed under Communism, and autocracy and bureaucracy is second nature to them. There are encouraging signs of openness to new ideas among the young, fuelled by the most powerful engine for change in the 21st century: the Internet. 'Grand plans' are unlikely to succeed in countries still ambivalent about democracy and capitalism and where the basic concepts underlying them are not widely understood. It is more likely that change will be incremental, an accumulation of small advances. Personal friendships between people from East and West which introduce individuals from both sides of the former Iron Curtain to new ideas seem to be the most powerful promoter of change. It will be ironic if these succeed in helping them achieve a health service based on personal doctoring, just as we lose it in a flurry of walk-in centres, primary care specialists, and telephone triage systems.

Peter D Toon
Yvan Fontanel

The personal experience of a British GP teaching doctors on a CPD course to 'establish a comprehensive family medicine service' (WHO, 1999) in Kosovo

The CPD Course in Family Medicine
Against the background of the history of the previous 10 years, it was clear that a completely new professional medical register was needed with a policy on educational needs and an approach to continuing professional development, both for the doctors already working in Kosovo and for future doctors.

The doctors who had trained and worked during the 1990s providing primary care in the 'parallel system' needed to adapt and develop their knowledge and skills to practice family medicine in the new health service.

By February 2000, the World Health Organisation had responded to this need by proposing a CPD course designed for the situation.

In the situation in Kosovo, as it was in the Spring of 2000, only a year after the war, these were brave aims with a remarkable vision and much to ask of one course.

I joined the course as an international clinical supervisor at the end of September 2000 when it had been running for three months. The mood was high and both staff and participant doctors were full of energy and enthusiasm for this major new initiative and venture. I committed myself to stay until the end of the first phase of the course (June 2001) as I felt from the beginning that continuity for the participants doctors was going to be an important factor for a people who had lived through many extremely unstable years, both personally and professionally.

Experience
My personal experience has been twofold; first, the opportunity and luxury to work full-time with mature doctors developing their professional futures over an extended period; and secondly an opportunity to live and work abroad with my partner in another culture at the edge of the Europe I thought I knew.

Inevitably, the whole experience has been dominated by being in Kosovo at a time when some two million people are recovering from the horrors of a civil war. The professional development of the doctors has been part of their recovery from a prolonged period of ethnic and professional repression and also to recover from their own personal bereavements. I have been living and working in a predominantly Albanian town, Gjakova, in the far west of Kosovo. Eighty per cent of the old town was destroyed in a few unimaginably violent days and nights soon after the NATO bombing campaign started. Serb soldiers and police reduced houses and shops to burning rubble, while NATO bombs picked out and destroyed Serb military targets from the air. Thousands of people escaped over the border into Albania but every family has experienced the death of close family members or friends. Hundreds, particularly young men, are still 'missing', possibly alive in Serbian prisons but more probably now dead.

Everyone has their own story to tell and memories to learn to live with, somehow, each in their own time.

During my time there, people had only just been able to enjoy their first celebrations; a birthday perhaps, weddings too, and the return of 150 prisoners of war to a small town where everyone had personal connections, either of family ties or close friendships.

The speed and energy of the physical rebuilding of the old town has been remarkable, with new houses and shops appearing and opening every day.

However, the fragile infrastructure of transport and power supply has made day-to-day living and working difficult at times, particularly during the long winter of cold nights and snowfalls. One snowfall lasted two days, and movement within Gjakova almost came to a standstill. In our apartment, we had a wood burning stove for heating and cooking and a gas bottle heater, as well electricity, and we often used candles and portable electric storage lamps during the frequent power cuts. We were relatively independent of electric power for our comfort but for others who could not afford these extras, and at the teaching centre, life was more difficult.

Teaching and learning
I worked as a full-time teacher, planning ahead but also responding to issues and problems of the moment — very much like day-to-day general practice! This experience seemed very luxurious compared with all the teaching I have done in the past, which has been 'fitted in' to days of full service

commitment as well. However, towards the end of my time I realised that I needed to get back to practice myself, to keep in touch with the reality of general practice and to maintain my credibility.

The doctors were very good at learning from lectures and were used to having very little access to textbooks. The course text was basic and there was a hunger for new books and journals after the years of deprivation. Over the year, ways of teaching appropriate for experienced adult learners were introduced — learning new ways of learning. It took time to convince the doctors that their level of knowledge was very good and to have the confidence to spend more time on exploring ways of applying their knowledge. The value of asking questions and problem solving in peer groups was stressed. The tools needed for problem solving, such as consultation technique and basic clinical skills, were identified and learned about.

By the end of the year, the doctors were developing their own lecture sessions and running their own groups. Clinical skills were exchanged and improved among the doctors themselves.

Earlier in the year I had set my own goal, which was to make my supervisory role in the teaching/learning process redundant. By the end I really felt that I had achieved this. I spent more and more time in the last weeks silently watching from the sidelines!

Progress and achievements

The initial excitement of a new future promised by the course inevitably went through highs and lows. At the six month stage, in the depths of the winter with the added logistic problems, morale was so low at times that participants often talked of leaving. At this time too the course had still not been accredited towards achieving specialist status in family medicine by the Kosovo Ministry of Health. The doctors were still working with low professional status and for only 350 Deutsche Marks a month (about £120 sterling) with little belief in a future for themselves in the new primary care health service. We clinical supervisors spent time and energy working on this, both with the participants and by stressing the importance of accreditation to the doctors working with the Ministry of Health. By the end of the year the course had become officially recognised and accredited. In addition, the doctors with more than ten years previous experience were to receive full recognition as specialist GPs, without having to participate in further CPD. Morale finally rose to a realistic and optimistic level.

For me, one of the best achievements was to see and participate in the development of an active local branch of the Kosovo Family Doctors Association. Centrally, this embryo organisation seemed rather quiescent but, in Gjakova at least, an increasingly confident group of doctors decided to move forwards. They developed their own aims and objectives and a programme of meetings. They addressed both professional contractual issues about terms and conditions, and strategies for promoting and developing the role of family medicine in their own municipality. The group were truly building a base from which to participate in the future health service. They had gained self-value and confidence from the course and had become innovators and leaders in their speciality and among their professional colleagues, both in primary care and in the secondary hospital services.

Personal reflections

My partner and I have had the privilege and pleasure of living and working completely immersed in another culture in the very Albanian town of Gjakova. We have lived with a people who are recovering from a horrific civil war and an extreme apartheid policy of ethnic cleansing. Even if we can not quite imagine what recent life had been like, we were received there with great warmth and trust and perhaps shared some of the grief. We lived there long enough to observe some remarkable recovery, both materially in the rebuilding of the old town and also more subtly and movingly, in the rebuilding of individual lives and the future of families.

We marked our time in Gjakova and our departure by giving a dinner party for 30 Albanian friends. It was an evening full of joy, laughter, and indeed love. I did not understand the words of much of the conversation (although some of the talk was in English!) but I certainly understood and experienced the mood and feelings. My partner and I were truly privileged to be so accepted and included by a people whose culture and history are both physically so near and yet also so different. We all live in geographical Europe but have far to go to understand each other.

Robert MacGibbon

Recent History of Kosovo

During the 1990s the political apartheid policy of Yugoslavia in Kosovo led to increasing economic and cultural decline. In a well-established town, such as Gjakova in the west of the province, factories fell into disuse, vineyards were left untended, and sports facilities and cultural centres deteriorated with lack of maintenance. During the civil war that culminated with the intervention and bombing by NATO in March 1999, major installations of the infrastructure were finally destroyed and even the land itself became unusable because of the extensive laying of land mines.

At the same time the health service, particularly for Albanians, declined because of lack of funding, and also because Albanian staff were progressively removed from working in the service and denied training in undergraduate or postgraduate institutions. Hospitals were not maintained; windows were not repaired, light bulbs not replaced, heating systems and plumbing were left leaking.

In response to this, Albanian doctors organised the 'parallel' system for medical education and primary care which developed without state funding or support and it was subjected to intermittent harassment by the police. Many doctors trained during the 1990s in back rooms and without official access to patients. By March 1999, despite this remarkable response, very little was left of a Yugoslavian health service which, 20 years before, had been comparable and reciprocal with the British NHS.

At this stage the United Nations and NATO intervened, and when KFOR troops secured the province in June 1999 the United Nations Mission in Kosovo (UNMIK) was set up to re-establish all levels of civil life, such as a legal system, a police force, and a municipal structure to organise local services. Recreating a health service was also a priority.

By October 1999, UNMIK had developed an 'Interim health policy guidelines and six-month action plan' (UNMIK, 2000) as their official strategy for health in Kosovo. The policy was built on 'European Health 21' developed by the World Health Organisation (WHO, 1998) and the key aspect was to re-orientate what had been a hospital and specialist driven system, to one more focused on family medicine and prevention in primary care.

With an estimated population of about 2 000 000, at least 700 family doctors were going to be needed to establish the base of family medicine as soon as possible, before a mixture of private and public specialist-orientated health services grew irrevocably.

How to set up an international exchange group

GENERAL practice is an international phenomenon. Although 'doctors of first contact' overseas have different working conditions from GPs in the UK, there is always common ground — as well as contrast — to be found in other people's systems.

A group of Bristol GPs assembled 12 years ago to visit a similar group of French doctors in Bordeaux for a week. One of us had a friend in Bordeaux, and since the two cities are twinned, it enabled us to gain support from our City Council.

Our first exchange started with a home fixture. Our guests stayed in our houses, and shadowed us at work. Their programme included visits to different aspects of primary care and there was plenty of emphasis on the social side.

The Bristol–Bordeaux link smoothed the way to a reception with the Mayor of Bristol at his official residence (impressing our guests, whose mayor — controversial resistance warlord and politician Chalbon Delmas — was far less accessible) and drug companies helped sponsor evening meetings. Rather a mistake, though, was a wine tasting; our guests were gravely disconcerted to be presented with powerful Californian and Australian wines, let alone a Chinese Riesling. At home they disparaged French wines apart from Bordeaux, though they admitted to drinking champagne 'but only if unwell'.

Bordeaux group, visiting in Bristol.

Dr Vaclav Smattah with his nurse, in Prague

On the return leg our hosts were not to be outdone. The French generally entertain away from home and we were clearly guests of honour to be staying in our hosts' houses.

Shadowing our French colleagues we saw how the open-ended French system catered for citizens' wishes. Doctors were paid per consultation, partly reimbursed by the state. Record keeping was minimal and medicolegal problems seemed rare, as the doctor–patient relationship was courteous and dignified and patients had free choice of doctor. Our Republican colleagues were certainly not going to be ruled by the centre, and freedom of the individual was central to their culture. Doctors had higher incomes but less holiday; this might be funded by *les laboratoires*. Multiple prescribing was prevalent, and less work was delegated to non-doctors.

Perhaps the contrast between English and French cuisine is an analogy; in England you get sound, if unpalatable, nutrition; in France, every nuance of your palate would be catered for. Since our visit the Ministry of Health has tried to curb expenses, with a national record system and complex penalties for over-investigating, overdiagnosing or overtreating, to prevent overclaiming. However, our French colleagues remain very independent practitioners. Our exchange was great fun, and led to persisting friendships and family contacts.

Our Prague exchange was quite different. A reliable personal contact in Prague recommended her two young family doctors. They turned out, fortuitously, to be President and Treasurer of the fledgling Czech Association of GPs. We got on well, and planned a group exchange visit.

Family medicine in the Czech Republic was then being reborn. Under the Soviet regime, GPs had been replaced with deskilled street doctors working in large polyclinics, to whom patients were allocated. Ambitious doctors specialised and general practice was

described as a dumping ground for the politically unreliable and alcoholic.

From beneath these ashes, diamonds emerged. When the Communist regime fell in Havel's velvet revolution, the intelligentsia emerged from the prisons and boiler rooms where thay had been shelved, and started to rebuild democracy. Free choice of an independent, trustworthy doctor was one aspect of this, and a part of Czech culture that had not been forgotten.

Shortage of up-to-date medical information was a problem — it was not so long ago that state paranoia had placed an armed guard by each photocopier. With help from the (then) Knowhow fund, the British Council, and the British Embassy, we presented a seed-library of current GP-related books. Our hosts fell hungrily upon these well-produced and illustrated textbooks. This was a salutory reminder of the value of knowledge. When I got home I arranged for my copy of the *BMJ* to be diverted to my friend's Prague address.

One scene comes to mind; the new Polyclinic Director saying goodbye to his ousted boss from the former regime, who had been relocated to 'the countryside near the cement works, where he will be able to keep a pig — if he wishes' (his expression implied that he wouldn't wish ...)

As Czech salaries were a few dollars a week at that time, we raised funds from pharmaceutical reps for our group of doctors to come over. Our groups have kept in touch by e-mail, letters, and visits, and family exchanges have taken place.

We subsequently made contacts with family doctors in Denver, Colorado, and Odense in Denmark, and further exchanges ensued. More (Cuba and Turkey) have been mooted, though progress has been slow. Successful exchanges seem to depend on a single dependable contact abroad, a language in common, and a coherent group.

General practice is a culture-bound phenomenon. GPs are deep inside each country's culture, a very central part of it. High-tech hospital medicine is much the same around the world, but each country's family doctors relate to the public on most intimate terms.

Seeing others working lives and health systems helped us reflect on the strengths and weaknesses, challenges and rewards of our own.

Stefan Cembrowicz

Medicine and Humanity
Edited by Marshall Marinker
King's Fund Publishing, 2001
PB, 152pp, £14.99, 1 85717441 0

MEDICINE is a science, or art, or craft, or profession, practised principally by human beings called doctors. It is practised on, or with, other human beings. They may be called patients, clients, consumers or co-producers of health. The acts and transactions of medicine take place in consulting rooms, clinics and hospitals in the context of local communities and nation-states. This happens in a world where virtually any medical technology is available to those who can pay for it. The science of medicine changes by the day — more is always becoming possible; human beings and their societies, however, adapt more slowly. This book is about the interstices between medicine and humanity, and the ambiguities and uncertainties of the relationship.

It is no small subject. As medicine expands from its traditional territory of treating disease to include the treatment of risk factors (raised blood pressure, cholesterol, glucose) and the expansion of human choice and possibility (contraception, *in vitro* fertilisation, foetal selection), the issues become even bigger. Even the quiet backwater of public health has become a battleground between those who argue that we are autonomous individuals free to choose what we think is best for ourselves and our children, and those who believe that immunisations such as the MMR should be obligatory. How do we proceed? Who makes the rules? Who enforces them? Who decides what medicine is for?

There are no simple answers in this book, but most of the right questions are there. Marshall Marinker has been imploring us to look up from our prescription pads and management meetings for many years now, and this, his edited collection of 12 essays, is based on a series of lectures and debates held in London last year to celebrate the Millennium. The lectures covered 'health and justice', 'staying human', 'personal freedom or public health?', 'culture, conformity and mental health', 'living well and dying well', and 'health in the city'. There is a spread of perspectives from religious, academic, medical, economic, and ethicist authors. Many, such as Tudor Hart, Robert Winston, and Richard Harries, are very well known. Marinker bravely provides an excellent introductory essay in which he links the themes together.

Over the past year, I have been involved in a series of meetings in Scotland with a group exploring some issues concerning medicine and society. One remark that was made early on was to the effect that 'medicine is not merely a form of self-expression for doctors.' This is a kinder way of stating what Ian Kennedy suggested in his Reith lectures of 1980, entitled 'Unmasking Medicine', that 'we [the public] must become the masters of medicine, not its servants.' Many essays in this book develop this direction of travel. Bruce Charlton suggests making psychotropic drugs such as antidepressants freely available to the public, as alcohol is. This is autonomy writ large, in capital letters. Bert Keizer writes movingly of his father's 'management' as a bag of diseased organs and rampantly abnormal biochemistry in a teaching hospital, and his eventual rescue by his family doctor to a low technology, morphine-assisted peaceful death. Not much, he suggests, has changed since Byron was bled and clystered to death in Greece in 1836 by his doctors.

On public health, it's not insignificant that the UK perspective on public health is that it has too much power, and the US perspective is that it is too weak. In the market-obsessed USA health care system, it is hard for public health to find a place. The continuing inter-necine warfare between communitarian values and individualism is reflected in the pieces on health and justice given by Tudor Hart and Kenneth Minogue.

If you feel uneasy about the former Home Secretary's wish to lock up individuals with 'antisocial personality disorder' read Jonathon Glover's essay on 'Culture, conformity and mental health'. You will feel even more uneasy. If you feel that it's the

HAIKU[1] GP[2]

50 million patients
30 000 GPs
30 professors
The numbers do not
Add up

Amanda Howe

1. HAIKU — a Japanese poem of 17–25 syllables, usually referring to nature, or the nature of life
2 HAIKUGP–- 'Heads of Academic Institutes for Knowledge and Understanding of General Practice'

right thing to do, there is even more reason to read it. Kay Redfield Jamison has a brave and honest piece on life as a psychiatrist with manic depression. I may be wrong, but I can't imagine a British psychiatrist writing such a piece. Are American doctors more honest and less covert about their disorders than we are?

I would have liked to see a debate on medicine and the media in this volume. The media are central to public perceptions of medicine and increasingly shape Government policy. An essay on medicine and the media would certainly have raised controversial issues and perhaps cast some light as well. Developing world issues, increasingly important in our shrinking world, are given only a brief mention in Peter Budetti's essay.

However, any of these essays would make for a stimulating and fruitful GP registrar workshop, perhaps to discuss both the goals and the limits of medicine. Illich revisited, but with less polemic and more substance.

A few years ago, the term 'post-modernist' would have hung over this collection of essays, but I can't recall seeing the term anywhere and was glad not to. What it does illustrate, however, is what Alasdair MacIntyre describes as the impossibility of securing moral agreement in our culture, or the interminable character of contemporary moral discourse. Marinker accepts this in his introduction in saying that the purpose of the exercise is to initiate a debate, and frame the questions in a way that allows illumination of the issues. Moral certainty in the 21st century, it seems, is only given, or taken by those such as Osama bin Laden.

I go fishing with a friend who tells me that one of his main aims in life is the avoidance of dullness. A good way of achieving that is to read and argue about this book.

John Gillies

Racism in medicine: an agenda for change
Edited by Naaz Coker
King's Fund Publishing, 2001
PB, 241pp, £15.99 1 85717407 0

THIS is a book that needed to be written. As Rabbi Julia Neuberger states in the introduction, 'Racism is one of the most difficult and painful words in the English language. It both describes and creates barriers between people. Not surprisingly, then, it is a word that gets a great deal of use but which is rarely discussed openly, dispassionately and with neither malice nor dismissiveness.'

This book does discuss racism in medicine openly, dispassionately, without malice or dismissiveness. It weaves together discussions of concepts, descriptions of the current state of institutionalised racism, and suggestions for practice. You might think that starting the book with a discussion of the concept of race and racism is superfluous, since anyone bothering to read the book would be aware of these issues. But Shahid Dadabhoy's personal account demonstrates that such self-assurance is unjustified. His perspective on how of the College's 1999 discussion document, *Tackling discrimination in general practice*, read much more like a defence than an agenda for change, holds up a mirror — not only to the health service generally but also, and more importantly for us, to the RCGP in particular.

Personal accounts such as this and the one by Aneez Esmail, who describes the early controversial work that he and Sam Everington published on discrimination in selection for medical school places, make this a highly readable book. However, facts and proof of discrimination at all levels of training and career progression are provided too and the book contains a substantial body of evidence.

The second part of the book is titled, 'Agenda for action'. Disappointingly, it starts with a very short description of the inequality of health service provision experienced by minorities. This was out of place in the section and would have benefited from a chapter of its own. Practical suggestions are given for policy development, such as assessing needs of hard-to-reach groups, enhancing communication, recruitment of doctors, and harassment policies. They are good starting points for organisations, such as PCGs and Trusts which do not yet have policies; given the evidence in the book, they are the majority.

Kevork Hopayian

graham worrall

Atlantic crossing

YET another intrepid team of voyagers has failed to complete the journey from Newfoundland to the Old World. Two young Americans, in a boat not much longer than a bath tub, had to give up their journey two days out of St John's, because of high seas and unfavourable winds. Their unsuccessful fate was the same as that of the balloonists who attempted the trek in summer 2000, only to be fished out of the water by a fishing boat on the Grand Banks.

Because eastern Newfoundland is the nearest part of North America to Europe, it has often been the start of voyages. For example, when in 1913 Lord Northcliffe of the Daily Mail offered £10 000 for the first continuous non-stop transatlantic flight, the island became abuzz with hopeful aviators (in addition to the proximity, they hoped that the prevailing easterly winds would help them along).

In April 1919, the British aviation team of Woods and Wylie attempted a western crossing from Kent, but their plane crashed in the Irish Sea. By the following year, several groups were hard at work clearing ground and assembling their crated aircraft in fields near St John's. By that time an additional 2000 guineas prize had been added by the Ardath Tobacco Company (sport sponsorship by ciggies has a long history) and a gentleman by the name of Lawrence R Phillips Esq donated a further £1000.

Two flights took off on 18 May, 1919. A Sopwith piloted by Hawker and Grieve managed to fly 1050 miles, before it was forced by engine failure to ditch into the Atlantic. The Martynsyde of Raynham and Morgan has even less luck; it crashed in the same field it was taking off from!

Three weeks later, on June 14, John Alcock and Arthur Brown in their Vickers-Vimy took off from Lester's Field on the outskirts of St John's. Like the other aviators, they had no reliable weather forecast and their navigation and in-flight instruments were very simple. When ice and snow began to obscure the fuel gauges and clog the engine air intake valves, Brown had to climb out on the wing of their mile-high plane and scrape them clear by hand. After 16 hours and 57 minutes flying, mostly navigating by the stars (when these could be seen), they arrived near Clifden on the West Coast of Ireland. They selected a flat green field for their landing, and were soon nose down in a bog! Fortunately, they were not hurt, they claimed the cash prizes, and both were knighted by King George V.

The Sopranos
Channel 4, Thursday evenings

The Sopranos is challenging drama and takes Mafia fantasy to an altogether deeper level.

Interpenetrating themes have been the stuff of psychoanalysis and phenomenology since the early 20th century. Here the themes are Tony Soprano's family life, his Mob life, and his psyche. The integrating element is his psychotherapy, through which we gradually come to comprehend the strands holding him together. And, by implication, holding us together.

Even for an antihero, Tony is pretty repelling. Racist, unforgiving, callous, disloyal, self-indulgent, and plain homicidal, he has few redeeming characteristics. But we like him, and are encouraged to support him against the serried ranks of envious and devious mobsters, and incompetent and injudicious federal agents. The ambiguity is discomforting, and consciously made more so by the writers avoiding every chance at cliché. Tony, for example, is virulently racist towards his daughter's black boyfriend. In any normal drama, the boy would be a paragon of rectitude, but, in *The Sopranos*, he is a complete jerk.

So, against our better judgement — and, we presume, our finer natures — we find ourselves very much on Tony's side. Partly, we know his weaknesses which, of course, makes brave men of us all. Mainly, we are encouraged to see in Tony that part of ourselves rendered dormant by our upbringing, our education, and our socialisation.

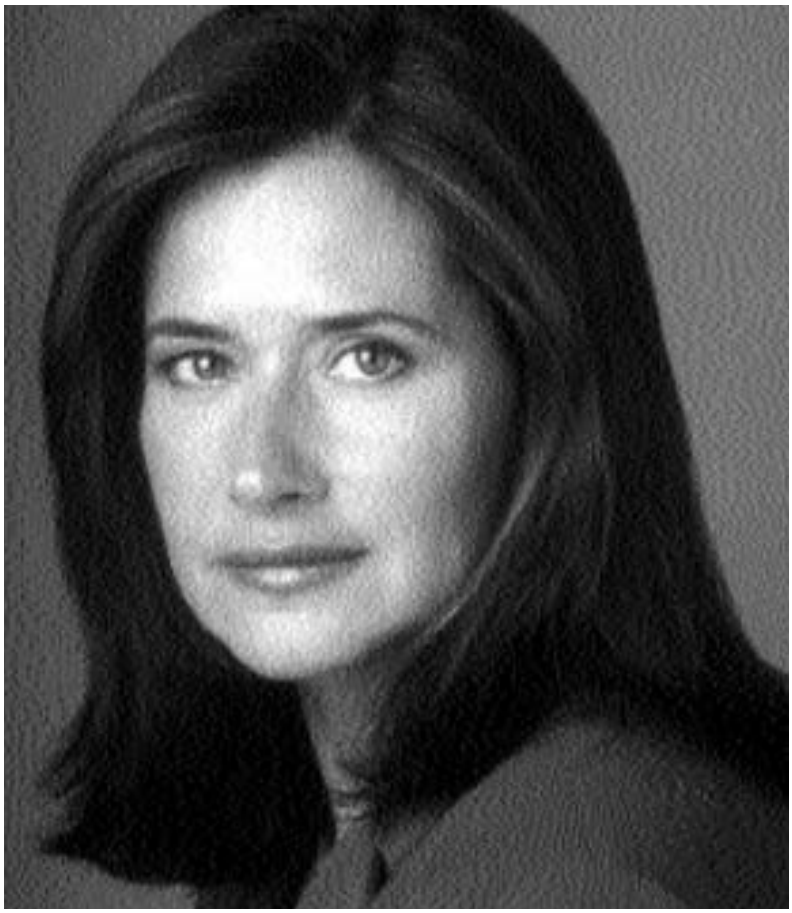
Even his psychiatrist is an ambiguous figure. Played by Lorraine Bracco, Dr Jennifer Melfi's own (as yet unrevealed) demons lead her to some dissolution, particularly dependence on alcohol and 'prescription' drugs. Her therapy is similarly ambiguous, from a school reviewed elsewhere as 'eclectic':. "here comes the Prozac" says Tony, as it is prescribed (unlicensed) for his panic disorder. At her best when sticking to conventional, focused psychodynamics, she meanders through cognitive therapy and even threatens Tony with referral to a behaviourist if he doesn't improve, as if that were punishment.

And punishment it would be. Tony has wet dreams about Dr Melfi, something he delights in telling her, 'like throwing a rock at me', she pertinently observes. Many male viewers will sympathise. Bracco was house model at Gaultier, and dresses that part, something arguably unwise with a patient she describes as a 'charming psychopath'. Her consulting style is an understandable mixture of cool disregard and mild terror, and her consulting room is clinical, minimalist, and contains a double psychiatrist's couch, an elementary piece of symbolism if ever there was one.

Nevertheless, the therapy is the vector for our understanding of Tony, and of ourselves. In recent episodes, we have come to learn that his neurosis has its seat in his revulsion as a child at his father's business. His own son is gently going off the rails. Like *The Godfather*, *The Sopranos* may well turn out to be rather more about the son than the father. We may be more what we become than what we were. Tony is no more a psychopath than the rest of us.

To do justice to the form is almost impossible. The creator, David Chase, is a major student of film and television, and it shows. Virtually no reference is missed, no connection unmade. Tony, for instance, sings along in the car to Steely Dan's 'Dirty Work'. Occasionally, that can be off-putting, and the art can intrude on the narrative, but mostly it works perfectly, and the show is a dream for amateur film and TV critics, and all deconstructionists. The style can vary, as different episodes have different authors, and there are times when it has difficulty making up its mind. Is it satire, a Lynchian comedy, or a send up of suburbia? Sometimes it is vain and a real show-off. The third series is half-way through and there are promises for at least two more. So far, there are no signs it is running out of steam. Tony's fate awaits, and with it, our own.

Stephen Hunter



Dr Jennifer Melfi (played by Lorraine Bracco). *Courtesy of Channel 4 Television*

Handbook of Women's Health: an evidence-based approach
Edited byJo Ann Rosenfeld
Cambridge University Press, 2001
HB, 631pp, £47.50, 0 52178833 1

THIS is a comprehensive, well-referenced text written almost exclusively by women for use in primary care. The authors' aim is to 'provide a clear and comprehensive evidence-based primary care guide to the care of women in ambulatory practice — intended for GPs, nurses and all those who practice primary care of women', with an emphasis on prevention and screening. They partially succeed. The book is handsomely presented in a logical fashion, with recommendations easily identifiable and small summaries of important points highlighted throughout the test. The subject matter is presented as a series of lists and tables which makes the text easily accessible.

There is one excellent chapter on 'Woman battering', which gives a full and detailed account of this difficult subject, including rigorous forensic examination techniques — likewise for sexual assault and rape.

But after that things go downhill. The emphasis is so dominated by American models that one wonders why Cambridge University Press bothered to bring it out on this side of the Atlantic. Take, for example, Chapter 2 and recommendations for annual smear tests and vaginal examination for all women between 21 and 70, annual breast examination by a clinician, annual mammography for all women between 40 and 75, and annual blood pressure screening for all women over 40. The authors have the good grace to admit that there is little evidence to support such zealotry, so why do it? Why medicalise life to this extent?

And a further recommendation — again without evidence — that 'all women of child-bearing age should take a daily multivitamin' (in the richest nation on earth!) is simply absurd.

Moeover, there is little discussion of the well-known discrepancies in health care provision across the social divide in America. And why is there almost no mention of termination of pregnancy? Politically incorrect, or just too dangerous?

I began reading *Handbook of Women's Health* anticipating a medical textbook from a feminist perspective, but I was disappointed — the largely female authorship seems, ultimately, coincidental. The most interesting aspect is the different social and cultural attitudes in the USA, highlighted as much by what is not discussed as what is. I am not convinced this will add anything more to already available texts in UK practice.

Linsey Semple

roger neighbour — behind the lines

COFFEE poured, I'm ready to begin what was once called 'writing'. An intimidating white screen, labelled 'New Blank Document' and destined to become this, my inaugural column for Back Pages, is mouse-clicked into existence. Inconsequential thoughts arise, tantalise, evaporate — 'In the beginning was Microsoft Word …'

Some good advice comes to mind — 'Write about what matters to you.' OK, so what matters? Revalidation? The College's Working Party on cradle cap? No; since the cataclysmic events of 11 September, hardly anything has seemed to matter as much as the concatenation of atrocity that began that day in New York and Washington.

The images are seared into our collective memory — airliners coming out of a clear blue sky and bringing down the emblems of America's domination of the world's agenda. But, in every sense except the literal, the sky was anything but clear and blue. The backdrop to the outrage was black with hatred, green with dollar bills, blood-red with history.

Hollywood knows that, for a movie to feel like it matters, the characters, even the bad guys, must have a back-story — a past that makes sense of their behaviour — and the Act III climax must catapult them into an unseen but all-too-imaginable future. It's drummed into every aspiring screenwriter: 'Think the big picture before you write the small one'. That is (or should be) what President Bush's friends are telling him now. We have little to send but love to those who grieve amidst the rubble of Manhattan. Instead, our contribution to the healing process should be informed with the best thoughtfulness we can muster, and that means thinking the big picture.

Some commentators on both sides of the Atlantic have found the courage to wonder why the USA — land of the free, the self-fulfilled and the self-obsessed — should find itself so violently loathed. And if there is to be any healing power in friendship, America's friends should help her dare to see a picture big enough to contain the answer. It will have to be done gently yet insistently; for any answer will come in terms of that nation's reputation as a bully and a know-all — cosmopolitan, vibrant and creative by all means, but, at least as far its conduct abroad is concerned, a bully and a know-all nevertheless.

It is, I suppose, progress that the definition of 'enemy' has been expanded beyond particular individuals. I suppose it makes a bigger picture for the war to be against an abstract noun, 'terrorism'. Yet the dead in America and Afghanistan surely deserve better than to be thought of just as ideological casualties, collateral damage in a philosophical war-game. These particular dead should not have needed to die at all. In a war between abstractions, better weapons than airliners, B-52s, and smart bombs would be other abstractions — listening, humility, generosity, mutual regard, and even the apparently forgotten religious virtues of compassion and forgiveness.

'Only connect …' wrote E M Forster. I'm afraid talk of bullies and know-alls inescapably reminds me of the present British government, and indeed of all our recent governments. For if sabotage and subversion are the politics of the powerless, the extremities to which the unheard and the desperate are driven when their aspirations are overridden by a complacent Establishment, then maybe some of our own institutions, notably the NHS, are at risk of catastrophic attack out of a seemingly clear blue sky.

Doctors and patients alike know to their cost that the shameful inadequacy of Britain's health service has not been cured by cosmetic surgery to its management structure or by homeopathic doses of money. They also know that their protestations are systematically ignored, denied, belittled, and dismissed by our bullying know-all governments.

General practice has been called 'the art of managing uncertainty'. If only it were that simple. In the consulting room and in our wider professional lives we are having to acquire a new skill — managing disappointment and desperation: our patients' and our own. And with that new skill may have to come a new role — the GP, if not as social terrorist, then as freedom fighter.

The College, like the NHS, is in danger of withering for lack of resources. Many young doctors who pass the MRCGP exam don't continue as fee-paying members. Why? Because they don't see the College as standing for the things that really matter. And what matters supremely, I believe, is that the impoverishment of Britain's emasculated health service is, on behalf of its consumers and its providers, exposed and rammed home to Government before damagingly confrontational tactics become the only option for the disillusioned. The College has the people and organisation to lead creative protest. Has it the nerve?

We are in the early months of David Haslam's Chairmanship of Council. David is my good friend, and I know him to be a man of unsurpassed compassion, energy and common sense. So, David — let's make sure the College is seen to stand for the things that matter. Let's think the big picture.

uk council, december 2001

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Dr Iona Heath
Chairman of Patients' Liaison Group (PLG)
Mrs Eileen Hutton

As you know, these Council summaries now appear in the open area of the Website (**http://www.rcgp.org.uk/rcgp/corporate/council/coun_index.asp**). We are now putting on the website a list of the College responses to consultation documents on a monthly basis (**http://www.rcgp.org.uk/rcgp/corporate/viewpoint.asp**). This links the relevant College web pages and website across the four UK countries.

Chairman of Council
Council paid warm tribute to the huge achievements and contribution made to the College by Mike Pringle, who handed over the Chair of UK Council to Professor David Haslam at the beginning of our meeting. Mike's energy and productivity have been truly amazing and the College has a very great deal to thank him for. His influence on the College will last, as we are in a better position than ever before to influence the primary health care agenda and with a much-improved profile.

50th Anniversary of the College
The AGM marked the start of the 50th Anniversary of the RCGP. This will be an opportunity not only to celebrate the past but how we can support members effectively through the many changes and challenges that are being presented to them. See **http://www.rcgp.org.uk/50th/index.asp**

Simulated surgery and MRCGP
A motion from the North East London Faculty on this subject was debated, and will be considered by our Quality Network, looking at the feasibility and resource implications of offering candidates a choice of using video or simulated surgery. The Network will report back to Council in due course. Comments welcome.

Chairman's strategy
David Haslam brought a paper to Council, explaining his two main themes. First the greater support for and *involvement of members in the work of the College*. This will be demonstrated by a number of ideas to be developed over the coming months. The second plank of his strategy is to look at how even more effective *involvement of public and patients* in the work of the College, with GPs and in primary care can be achieved. Council offered David Haslam many ideas and aspects which could be woven into these themes.

Other activities and papers before Council are linked with these themes.

Council was pleased to support the concept proposed by David Haslam of developing a virtual e-mail discussion group alongside the existing routes for feedback and ideas through faculties. Council, guided and supported by CEC, will of course remain the College's policy-making body. The concept of a virtual discussion group will be developed and we shall advertise for volunteers in the *BJGP* soon.

There was a paper from David Haslam and the Chair of our Patients' Liaison Group (PLG), Eileen Hutton, looking at the way that patients and the public could be more effectively involved in the work of the College. Already, as the first College to introduce a PLG from 1983, we have lay involvement not only at Council and at Executive Committee level but also on many groups and working parties. Additionally, lay members of the PLG are invited to contribute their views and comments on responses to consultation documents, which we prepare, and to be involved in developing policy. This work is all done voluntarily and we are grateful for the huge amount of effort and time that lay members of PLG in particular put into this work. David will be looking at how best we might be able to support and develop this work in the coming months. Council was also keen to explore how more explicit involvement of the public, as opposed to patients, might be taken forward.

Modernising the NHS
At Council we had the usual updates on the modernisation process across the UK which as ever shows the diversity of the NHS as well as the common themes in the four UK countries. In England, the introduction to Parliament of the NHS Reform Bill sees the proposals for restructuring the NHS given legislative shape. The strength in the College in having firmly established bases in the country capitals is again being demonstrated by the information we glean and can discuss by means of these reports.

Workforce and morale
A recent survey by the GPC and the Department of Health's General Practitioner Recruitment, Retention and Vacancy Survey set out very clearly the difficulties of attracting doctors to work in general practice, retaining them in active and effective service, morale problems, and avoiding undue early retirement, as well as the problem of the growing number of GP vacancies.

These are all alarming signs. Our debate focused on the issues to which we have drawn attention over the last few years. We have repeatedly pointed out to the Departments of Health the folly of failing to continue to build the training numbers for the GPs, to recognise the way the GP workforce is changing, and the need for an effective and comprehensive training regime for GPs. While announced increases in GP numbers and training places are welcome, these will all take time to feed through.

We have particular concerns that when the Medical Practitioners' Committee ceases to function, from April 2002, there will be no body with the responsibility to ensure equitable distribution of the workforce on a national basis. This is likely to reinforce existing health inequalities, as areas of greatest deprivation already have the greatest difficulties in recruiting and retaining GPs. In Sunderland — the most understaffed PCTs in England — there are only 30 GPs per 100 000 patients — compare and contrast with Hounslow in Middlesex, where there are 70 GPs per 100 000. In Liverpool alone, 84 additional GPs are required to bring the area up to

national averages.

Workforce and morale need to be central issues to changes we expect to see in the future, such as the SHO Review, the Medical Education Standards Board, and the emerging primary care structures across the UK. 'Quick wins' were unlikely to be possible and stop gap measures, such as bringing in GPs from Spain to North West England, were inevitable provided that standards are not compromised and the doctors are effectively inducted to the NHS.

Revalidation and appraisal
We had further updates on the introduction of revalidation across the UK countries and how appraisal is being developed. The final form of appraisal across the UK is still uncertain, with different models being proposed and tested. The School of Health and Related Research (of the University Sheffield) (ScHARR) had produce a report commissioned by the DoH in England on appraisal. This is a formative approach to appraisal and was generally supported by Council. It remains to be seen if it will be accepted by Government.

Reforming emergency care
The DoH in England has issued *Reforming Emergency Care*, which looks at the spread of activity across primary and accident and emergency care and asks how admissions and management of those processes can be better controlled. Council expressed a wide range of views about the interface between primary care and A&E services and the way in which these services were used by patients. We discussed the tensions that exist between the greater use that could be made of primary care services and the capacity to provide such services. Vice-Chair, Tina Ambury, has been asked to lead a small group looking at these issues.

eBJGP
It has long been a wish of the College to have an online version of the *BJGP* and fresh proposals came before Council which appear to offer a good value way of achieving this. Council was happy to support the proposal, which will now go forward to be considered alongside other demands on our limited resources during our forthcoming College 'budget round'.

Next Meeting of Council
UK Council next meets on Friday, 25 January 2002 at Princes Gate. Also, the next John Hunt Lecture will be held on the evening of 24 January 2002. The speaker will be Sir Alan Langlands. Details are available via **courses@rcgp.org.uk**. If you require any further information on the issues above or on other matters discussed by Council, please contact the Honorary Treasurer at **honsec@rcgp.org.uk**.

Maureen Baker

neville goodman

NICE

THE House of Commons' Health Committee is undertaking an inquiry. It is asking whether NICE is doing its stuff. I really don't know whether to laugh or cry.

Since Clinical Governance was introduced in 1998 as the way to save the NHS for the nation and from itself, scarcely a week has gone by without one of the big boys (Blair, Brown or Milburn) announcing another reform, review, reorganisation or modernisation. I've lost count. Derek Wanless (surrogate for Brown) is the latest. He's decided that the underfunding is worse than anyone thought and that general taxation remains the most effective way to pay for health. But there's another review (for Blair this time) in the pipeline, so that may change.

An editorial in the *BMJ* gives the clue to the Government's difficulty with the NHS. Nicely understating, Smith, Walshe and Hunter (*BMJ* 2001; **323:** 1262-1263) wrote: 'Governments often regard a degree of medical disapprobation as a sign that their NHS policies are generally heading in the right direction.' It's the Government's difficulty with everything: transport, crime and education, as well as the NHS. The government believes it knows more and cares more about everything than anyone else. Anyone else includes not just those who actually run the service, but particularly and especially those who run the service. Unlike politicians, whose every thought and deed is altruistic, railways workers, policemen, teachers, doctors and nurses serve merely their vested interests. This has now come to include NHS managers who, according to Alan Milburn, have 'never saved a life'. It would be churlish to say that this cheap jibe is even more true of Mr Milburn.

But where does NICE fit into all this? It fits because all the problems with NICE that the Health Committee will uncover were foreseen. They were discussed at a conference in 1999, which — whaddya know? — no-one from NICE was able to attend. Take the myth that NICE could end postcode prescribing: if health authorities are forced to buy expensive cancer drugs from a limited budget, then some other drug, operation or service has to go. Different health authorities will restrict different things (remember devolution from the centre?), so access to treatments will still depend on where you live; the restrictions will simply be less obvious. And if the government resists special interest groups as feebly as it resisted the multiple sclerosis lobby over β-interferon, then NICE might as well shut up shop. To set up a flawed review or committee and then ignore it is throwing out the baby but keeping the bathwater.

Miles A, Hurwitz B, Bentley P. (eds). *NICE, CHI and the NHS reforms: enabling excellence or imposing control?* London: Aesculapius Medical

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saul miller

Democracy

ASIDE from the irony of the current anthrax scare in the USA (the citizens of that fine country freely stockpiling their own personal supplies of the wonder-drug, ciprofloxacin, while here in Blighty my practice faces penalty if we prescribe more than a handful of the stuff in a year). Aside from that, yet another example of America failing to take note of Northumbrian health policy, the main disquiet I feel about current world events is that democracy should be the concept our armed forces are claimed to be defending in the Afghan offensive.

I could cope with freedom, I can understand why it isn't capitalism, but I do have my doubts about citing democracy as the concept in need of such a defence. Bear in mind that it was less than a year ago that George W Bush himself made it to the White House, the legal victor in a presidential election despite polling fewer votes than his opponent. Note too that our own parliament has not been allowed the opportunity to debate the War on Terrorism before it was launched.

Perhaps such inconsistencies as these merely serve to show that translating the democratic ideal into practice is not easy. No doubt a part of the Queen's security of tenure rests on the fears of the British populace as to just who they might end up with as head of state if democracy were introduced.

But I should come clean here and admit that my difficulty about what democracy really is, also stems from events much closer to home; closer, even, than what goes on in London. It is to do with all of the consultation exercises we are currently having to endure.

The local primary care group is about to become a Trust. The local health authority is about to amalgamate with others and become even less local. And all stakeholders have to be consulted about every such change (if I am a stakeholder at all, it is only in respect of a long pointed stick I carry in the hope of violence). Democracy in action.

Consultation exercises when I was a boy took the form of my mother asking me what I wanted for pudding before she had decided. Consultation exercises were not, of course, a daily occurrence (far from it, if anyone is interested in my heart-rending stories of a deprived childhood) but when they did occur I invariably got the pudding I wanted. If I were to relive my childhood under the current system, my mother would decide, canvass my opinion, and then produce a big glossy brochure at tea-time to inform me that what she has chosen for my pudding is what everyone wants for pudding.

More fundamentally still, the one question never asked in any of these consultation exercises is 'should we be doing this at all?'. Which sounds suspiciously like the question that the House of Commons debate on the War on Terrorism will be too late to consider if such a debate ever takes place.

I am not a great believer in direct action. Bit of a wimp really, if the truth be told. I have thoughts like these without ever actually doing anything about them. Although lately I do find 'ciprofloxacin' on more prescriptions than perhaps I ought.