The Back Pages

Viewpoint

Template totalitarianism

THE latest initiative from our local Primary Care Group (PCG) is to promote the care of patients with mental health problems.

The National Service Framework for Mental Health[1] highlights the lack of provision of both structured and emergency care for many people with mental health problems. This group of people may have concurrent physical health problems that are overlooked. Care is often crisis management which does not lend itself either to structured care plans or to opportunistic health promotion. So blood pressures remain unchecked, smears are overlooked, and smoking habits are unchallenged. To maximise both their mental and physical health the PCG suggests that GPs provide protected time for those "who are not sufficiently unwell to require input from Community Mental Health Teams" but who "may require significant input from practices." Each GP "needs to identify ten patients who fall into this 'in-between' category and to see them for about half an hour on a quarterly basis in a dedicated clinic".[2] The carrot is about £100 per patient (over an unspecified time). The practice must demonstrate by means of a completed template that the patients have been seen on a quarterly basis.

My argument is not about the objectives of this practice incentive scheme. It is of course both important and necessary to provide standards of care for people with mental health problems that are at least as good as those of the rest of the population. The argument is with its implementation; there are serious issues about the use of both the patients' and the GPs' time as well as the trend to only validating (and therefore rewarding) care that is 'template-able'.

Mental health clinics

If we are to have specific clinics then which patients are to be included? It would be easy to choose ten house-trained, needy, dependent patients who crave attention, and who would happily spend half an hour with their GP every three months. This would further their dependency and fill the clinic, satisfying the hungry template and the objectives of the PCG. It is also easy to see how a GP may be more reluctant to invite the unpredictable patients who consistently DNA, shout at receptionists, and whose problems may be beyond the reach of any type of input, be it primary, secondary, complementary, psychotherapeutic, or other.

We should also consider the patient's perspective; for, however non-judgemental a health professional's view of mental health may be, and despite the efforts of Mad Pride[3] (cf Gay Pride), there is still, in many people's views, a stigma attached to any diagnosis involving the word 'mental'. Patients may well object to being categorised as having mental health problems and being targeted as special cases. They may be underwhelmed to learn that this process is to earn their doctor financial reward.

Templates

Say 'chronic disease register' with reference to coronary heart disease, diabetes, hypertension, asthma or heart failure, and one is flavour of the month. These templates are structured around measurable, objective data which predict health outcomes and have little or no associated stigma. Say it about mental health and one's heart sinks. Different cultures have different ways of dealing with mental health problems which do not usefully lend themselves to reductive data collection in the way that blood pressure measurements or peak flows do. Will the use of a mental health template improve the delivery of holistic care?

The wider picture

This initiative does not play to the strengths of general practice. While it is right to identify patients with any health need and to stop it developing into a problem, this scheme is a blunt instrument. One of the many advantages of working in general practice is the GP's autonomy in patient care. One can negotiate mutually acceptable, appropriate follow-up and many patients respect this. Whether the problem is deterioration in hypertensive control or exacerbation of anxiety, the intervals between reviews ought to vary to meet the patient's need and not so that the GP can jump through an arbitrarily imposed hoop. People with mental health problems are not a homogeneous mass to be serviced like a car or central heating system. To treat them as such is neither in their interest, nor ours.

Helen Lucas

References

1. Department of Health. *NSF for Mental Health*, 1999.URL: www.doh.gov.uk/nsf/mhexecsum.htm
2. Merton, Sutton and Wandsworth PCG.
3. http://www.ctono.freeserve.co.uk/

"A life-enhancing resource for its local community... all it needs is funding and will. You can't help feeling that somewhere in all this there is a message for our NHS today."

John Allan, on Berthold Lubetkin's Finsbury Health Centre, page 256

"We shape our buildings; thereafter they shape us."

Winston Churchill, quoted by Alexi Marmot, Architectural Determinism, page 252

"'Treatments' such as crystal therapy don't merit regulation. They warrant exposure ..."

Neville Goodman, still having problems with alternative medicine, page 263

contents

Self Care Conference in Manchester

In January, the Department of Health assembled a varied collection of people — policy makers, researchers, workers in the voluntary sector and a few health professionals — to discuss self care, one of the pillars of the NHS Plan. Work done by researchers and voluntary workers emphasised that patients can get a better deal if they take a more active part in their own care.

At the other end, there was much interest in helping patients use resources better; for instance, pharmacists, ambulances, and of course the role of NHS Direct. One of the problems for the Department is that it defies definition, so that when they tried to identify all current activities, they produced two sides of A4 covered in a bewildering range of initiatives.

One group had a discussion about how to make organisations more responsive to self care. Some predictable answers were: training to become expert patients; making sure users are involved when planning changes to services; training professionals in patient-centred interviewing, and patient-held records. I suggested a self care-friendly award, only to be told that it already exists.

Finally we tried to quantify the benefits of this activity. This discussion was upbeat about reducing attendance (and therefore saving money). As I started to worry about whether this managerial approach should be in the same room as the voluntary workers we were brought down with a bump by one of the researchers saying 'You can't do patient-centred interviewing with those algorithms', and Andrew Herxheimer having the last word with 'Those aren't the real benefits of self care'.

In the end, it was agreed that there are potentially huge benefits in encouraging self care, but it is going to take a great deal of effort to make sure the initiatives are driven by patients' needs as much as by managerial imperatives.

David Jewell

The blind leading the blind

It's Monday morning — the first day of the Seventh International Conference for the Deafblind, held last October in New Zealand. We are providing proceedings in English and Spanish, and in New Zealand sign language. Needless to say, the first session starts late as we sort out an amazing array of technology and furniture to meet everyone's requirements. Many interpreters are doing a double translation, from English into, say, Croatian or Japanese, and then into a sign or tactile language. After months of helping to organise the conference I suddenly get my first realisation of the visual impact this group makes. There is every conceivable mode of communication happening: video, personal FM systems, computers, Braille text machines, signers, touch. Many visually impaired require their own interpreter to sit immediately in front and facing them — not easy to arrange in a tiered theatre. A deafblind woman in a wheelchair has two interpreters who are both blind. Amazing.

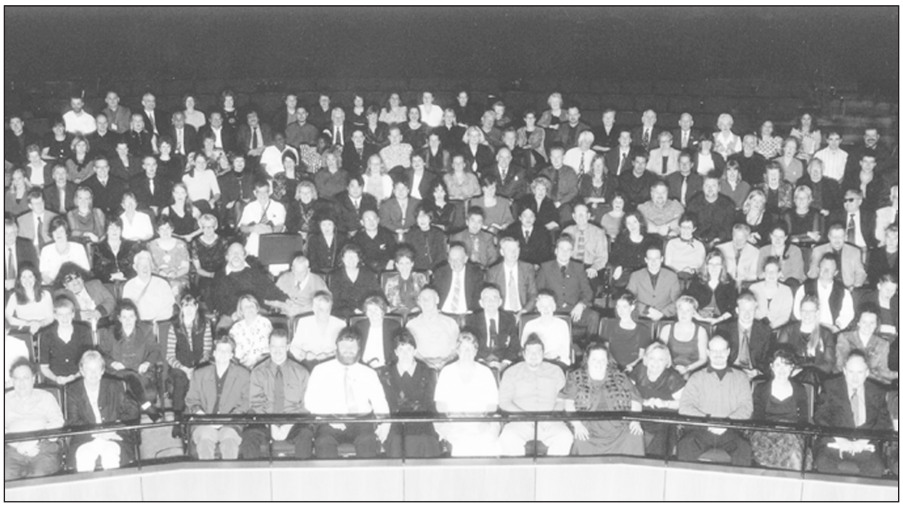
In the beginning it all seemed very straightforward. Becoming the organiser for a conference of the deafblind would have its interesting moments but I was full of confidence. Even if I did not know what to do then someone else would. I knew that as a sighted and hearing person I would make all kinds of assumptions but I was unprepared for just how deep rooted they would be. It is such a natural thing to view the world through one's own lenses.

By mid-September we had 300 registrations from 46 countries. Several groups cancelled after September 11, but final numbers were 320 people from 35 countries. Of these, 155 attendees were deafblind, the rest were interpreters, support people, and a sprinkling of professionals. A group like this will not come together again in New Zealand for a very long time.

Forty Swedes arrived in Auckland a week early, including 20 interpreters. I visited their motel one day and had my first encounter with tactile interpreters, many of whom were young and very attractive Scandinavian women. Fresh from some recent work on sexual harassment my heart sank when I first saw them in a close huddle with older deafblind men. But as I continued to watch from my car I realised that here were very kinaesthetic people, communicating intensely in a strange environment. Yes, the relationship is powerfully intimate, but it is also completely professional.

Registration — and suddenly processing 300 people in three hours seems a huge task, as I learn that communication might take double or triple the usual time. Interpreters take their job seriously and interpret everything exactly as you say it, and then interpret the response exactly. No short cuts, even if the interpreter knows the answer. Rising levels of panic, particularly when I am asked questions like "Who will orientate the guide dogs to this venue?" An obvious question that I am totally unprepared for.

Most of the speakers and workshop presenters are deafblind also, employing whatever mode of communication they need. Sometimes the interpreter verbalises for them, sometimes they do it themselves. I learn fully the vital difference between being born deaf (or going deaf pre-verbally) and going deaf after acquiring verbal skills. I am



Founding General Assembly — 7th Helen Keller World Conference and World Federation of the Deafblind.

Useful websites
www.deafblind.org.nz has the conference proceedings, and **http://www.wfdb.org** is the website of the recently-founded World Federation of Deafblind.

impressed with the confidence and poise of the participants. The majority of interpreters are women, though there are several pairs of an older deafblind man with a younger male interpreter from Eastern Europe — Russia, Poland, Bulgaria. One young woman from the UK — why only one? — communicates through an interpreter from New Zealand whom she met on a UK camp.

I realise I have taken on a camp leader role — making instant decisions, as there isn't time to consult with the rest of the committee. "Can we have Braille signs on the toilets?" Of course (why didn't we think of that beforehand?) "Can someone empty X's catheter bag?" Well, er, try that volunteer in a yellow cap. "I want to put on a stand-up comedy show tomorrow night. Is the theatre free?"

We have organised a recreation day — it is fascinating to see which of Auckland's tourist venues responded positively to the idea of a busload of deafblind visitors, and which of them were very ho-hum. In the end, the Museum came out top, organising a tour focusing on exhibits this group could touch, and their normal Maori concert with front seats and requests to remove shoes to feel vibrations. I suddenly realise how hard it must be for a deafblind person to go shopping and have nightmares of police arresting someone for some unintentional misdemeanour. In fact it goes off remarkably well, with only one Tanzanian pair missing their bus home because they were engrossed in shopping.

By the end of the week and hundreds of questions later we are all getting there. I am more comfortable at guiding the blind down steps, and I'm getting used to little groups of people standing right outside toilet doors as they wait for their partner to emerge. A couple of interpreters have become my friends; hotel staff look more relaxed and initiate 'conversations'. Participants say how friendly New Zealand is. Two young New Zealanders with major disabilities, here with dedicated parents, start to walk taller and more independently as they make friends with strangers who know how to communicate with them. Here at least they are not so different.

One conference session focuses on whether the new World Federation of Deafblind should be run only by the deafblind. A tricky issue. Yes, consumers need a strong voice in these organisations, but what will best ensure that the needs of all deafblind are represented? Can the deafblind foresee and meet all the needs of other deafblind? I am exhausted, humbled and amazed and couldn't even begin to answer that one. I only wish I had been able to see the stand-up comedy show, which I'm told was a great success.

Hazel Hodgkin

Viewpoint 2

Why don't people have their eyes examined?

EVERYONE knows that they should go to the dentist twice a year: it is a routine that starts from the time a child's first teeth appear. Unfortunately, the routine for an eye examination is much less clear and a significant proportion of those who should be visiting the optometrist do not do so. Cost has always been seen as a major deterrent, and it no doubt is, but since take-up rates — even among those for whom the GOS examination is free — are still lower than they ought to be, this cannot be the whole answer.

A significant factor is the misunderstanding of the nature of the examination itself. In particular, it is not widely understood that it has a major role in protecting the health and wellbeing of the public. Far from being seen as an important opportunity for health screening and for the early detection of sight-threatening conditions, such as cataract, glaucoma, diabetes, and the like, most lay people consider an eye examination to be no more than a mechanical check resulting in the dispensing of spectacles or contact lenses. The widespread availability of non-prescription spectacles further undermines the awareness of the real nature of the examination by suggesting that self-prescription is often all that is necessary.

It seems odd that I cannot buy a packet of paracetamol without being given the third degree by the pharmacist, but I can walk into a shop on the high street and buy a pair of non-prescription spectacles without anyone asking me why I need them or pointing out that the symptoms that I am seeking to alleviate with the spectacles could in fact be those of a serious disease.

And it isn't simply the general public that is poorly informed about the importance of the eye examination. One wonders how many general practitioners talk to their patients about having their eyes properly examined by an optometrist.

But optometrists themselves clearly have a responsibility, not only to be effective advocates for their own profession, but also to ensure that all patients are fully aware of what the eye examination involves and why. To many patients, expecting no more than the traditional sight chart, modern techniques and equipment are unfamiliar and perhaps even disconcerting.

Optometrists would also do well to realise that patients can find the examination physically uncomfortable. Some, particularly women, report that the experience can be intimidating or even threatening. Optometrists need to be aware of this and take all measures possible to avoid any distress on the part of their patients. The optometrists' continuing education and training programme (CET) is placing more emphasis on the importance of 'communication skills' in putting patients at ease and giving them the information and consideration that they have a right to expect.

Excellent work has been done recently by the Royal National Institute for the Blind in raising the general public's awareness of the eye examination but there is more to be done if the situation is to improve as radically as it needs to. Sadly, it is often those in greatest need and at highest risk who are least likely to come forward for an eye examination. Not only are there major issues of social justice to be considered, from the Department of Health's point of view it would surely make sense to promote this effective, easily available and cheap (too cheap, the optometrists would say) form of health screening rather than waiting for symptoms to develop and treating conditions in hospitals once they are more advanced.

The present situation is serving no-one's best interests and all those concerned have a responsibility to help to improve it.

Melvyn Roffe

Architectural determinism

Does design change behaviour?

ARCHITECTURAL determinism is the term applied to the concept that building environments directly affect behaviour and attitudes. Does it really explain how people behave? Can the built environment really overwhelm other relationships within complex social structures? Here, we review the arguments and evidence used in support of architectural determinism.

The concept that design matters, that it can make a real difference to people's lives, is a fundamental tenet for most design activity.

Designers often aspire to do more than simply create buildings and places that are new, functional and attractive — they promise that a new environment will change behaviours and attitudes. New office buildings are often claimed to deliver a more productive work space in which people work more efficiently, and a more communicative environment in which they are likely to meet one another more often. Because of these attributes, such places are said to aid staff recruitment and retention, providing a comfortable and attractive environment that appeals to the best and brightest. Similarly, new courts of justice are designed to be 'transparent', 'non-threatening' and 'customer-friendly', to reveal the judicial system to all and thereby help to form a more just society. Plans for health centres and hospitals are sometimes described as welcoming, open, breaking down the barriers between doctor and patient, democratising the health experience. By doing so they are claimed to aid health and lifestyle outcomes. As an example, it is claimed that design for Alzheimer's disease patients can 'facilitate mental functioning, minimise some areas of confusion, and allow individuals to function more independently'.[1] For people in care homes, 'places that allow residents to vicariously engage in watching on- and off-site activity will stimulate the mind and spirit.'[2]

How good is the evidence that health outcomes can be improved by environmental design? Recent research compared orthopaedic and psychiatric patients in two pairs of hospitals: one newly designed, and the other an older model.[1] Patients on the newer wards gave higher ratings to the notion that the architectural environment had helped them to feel better, to the treatment they received and the staff who delivered it. Length of stay was lower in the new psychiatric unit than the old, though the researchers concluded that the evidence on length of stay was inconclusive. Less analgesic medicine was required on the newer wards, though the authors again expressed caution in interpreting these results. A study of the impact of the visual, environmental and performing arts at Westminster and Chelsea Hospital, showed that patients, staff, and visitors consider that the overall surroundings contribute to changes in mood and easing of stress levels.[2] The second stage of that study is now examining health outcomes, including length of stay, time of wound-healing, postoperative analgesia, pain management, blood pressure, anxiety, and depression. Gardens and outlook are claimed to aid recovery.[3] Other examples are instanced in Scher's review.[4]

Knowledge of the causal links between buildings and behavioural outcomes is limited by the relative scarcity of evaluative research on buildings. Designers may inspire clients and users with visions of benefits at the start of a project, but rarely return to assess whether or not the outcomes have been attained.

There are several reasons for this lack of post-occupancy evaluation. Cost is one factor. After spending a large amount of capital on a building project — and in all likelihood having seen costs increase over initial budgets — clients are unwilling to spend further on the cost of researching the outcome. They are particularly reluctant in case design problems and inadequacies are revealed, which will reflect badly on the project team, and may be impossible to correct at least in the short term when no further funds are available. So the assertions of design benefits are rarely properly tested.

Another reason is the relative 'uniqueness' of institutional buildings, and the concept that lessons learnt in one location for a particular set of consumers may have little relevance to another project elsewhere.

Third is the genuine difficulty of understanding what conclusions to draw from results that may be established. After moving to a newly designed office, people may confess themselves to feel more productive. But what factors were responsible for this? It may be the new building, or the new furniture, or the new location, the new telephone and computer systems, the feeling of involvement in the process or simply the fact that the new location is less cluttered, cleaner, fresher and more up to date than the former setting. Or, it may simply be the fact that a change has been made, that management has valued them enough to invest in alterations. That conclusion harks back to the Hawthorne experiments in the industrial environment of the 1920s, which demonstrated that any design changes were perceived as positive, even a reversion to the old environment
The context must be taken into account —

References
1. Brawley E. *Designing for Alzheimer's Disease*. New York: John Wiley and Sons, 1997; 32.
2. Regnier V. *Assisted living housing for the elderly*. New York: Van Nostrand Reinhold, 1994; 25.
3. Lawson B, Phiri M. Room for improvement. *Health Service Journal,* 20 January 2000; 24-27.
4. Staricoff RL, Duncan J, Wright M, *et al*. A study of the effects of the visual and performing arts in healthcare. *Hospital Development,* June 2001.
5. Cooper Marcus C. *Healing gardens: therapeutic benefits and design recommendations*. New York: John Wiley and Sons, 1999.
6. Scher P. *Patient-focused architecture for health care*. Manchester Metropolitan University, 1996.
7. Alexi Marmot Associates and Department of Epidemiology and Public Health, University College London. *Hazards within homes*. Scottish Executive Development Department, November 2000.
8. Medical Architecture Research Unit. *Evaluation studies*. London: MARU, South Bank University, August 2001.

new buildings are often prompted by growth in successful organisations buoyed up by many positive feelings among management and staff with the confidence to embark on a programme of investment in new space. In the words of the team at MARU, 'the design of a building and the way it is managed are inextricably entwined in measuring its success'.[7] So if the cause cannot be readily attributed to the design, the amount of learning for the future is limited.

Environmental determinism can be seen as a concept that is too simplified to describe the complex relationships between individuals and their physical, social, and psychological world. Human–environment relations are mediated by many contexts. Environmental psychologists increasingly apply sophisticated research methods; for example, prospective longitudinal studies in multiple locations, using multi-level analysis. In the words of Winston Churchill: 'We shape our buildings; thereafter they shape us'.

In the absence of simple causal links between design and outcomes, designers must rely on knowledge of precedent, their ingenuity, and inventiveness in finding solutions. Clients must judge if the proposed solutions seem appropriate, calling on expert research advice to confirm that the proposals will achieve what the clients want, and what designers promise. The complicated PFI and PPP delivery systems for public buildings now used in the UK, where the customers and staff who will use buildings are far distant from the decision makers, demands that the end users are clear about design intentions. The goal for all parties should be the creation of new and better places commissioned by positive people in inspiring organisations who aim for the best for all future building users.

Public building programmes in Australia, New Zealand, and Canada have actively adopted the need for systematic post-occupancy evaluation. Their departments of public works have developed sophisticated tools to measure the success of their building investments. In the UK, in the past two decades, low levels of investment in the public estate were accompanied by a withering of evaluative research. Now is the time for the UK to take action in evaluating what has been achieved with new architectural investment in schools, universities, prisons and buildings for health care. We need to know the effects and constantly seek to improve outcomes. In architecture as in other areas of action, evidence-based design will help achieve better results.

Alexi Marmot

bromley by bow

THE Bromley by Bow Healthy Living Centre was opened in 1998 as a partnership between a primary care team and a community development project. The Centre runs a range of different projects, including health, education and training, welfare and benefits, art, a park, crêche, and café. The principle is that social care, the arts, education, enterprise, training, and the environment are key to a holistic approach to health care.

Eighty per cent of those involved in the Centre are local people and 35% of local households are users of the Centre and are directly involved in the projects. Local people are not just recipients of services, but owners and deliverers of health and social care.

Key architectural themes

• *'You are your environment'*
The building has been built to the highest specification and includes a two-acre garden. The design has won a national award. The bricks are handmade and the whole building uses beautiful wood and natural light. Many of those visiting the Centre say they walked passed initially — "I just didn't think this was a health centre". Visitors are always left with a memory of many different and unusual experiences.

• *'Welcome'*
The entrance and waiting area are specifically designed to provide a welcoming environment. The entrance is through an archway and walled garden, which includes a fishpond and fountain. Last year, this even had a croaking frog. The waiting area includes an art display. It is free from the usual poster visual assault. Health promotion is through human communication.

• *'No signs'*
There are virtually no signs. This means that not only is help sought but offered spontaneously. The philosophy is that somebody wandering around looking lost is noticed, and help is given.

• *'Maximising use of premises'*
During the joint child health and antenatal clinic, the waiting area has a food co-op, toy library, art group, baby massage and a portrait artist doing portraits of all the new babies. We define the area as a 'market place'.

• *'Bump into'*
The building is designed for people to bump into each other as often as possible — the gallery kitchen, the community café or the open reception — all key to good communication.

• *'Integrated and open reception'*
The reception is for every activity in the centre. The receptionist is more 'gate-opener' than 'gate keeper'. There are no barriers and screens across the desk, which often only raise tensions.

• *'Ownership'*
The centre is designed in a way that enables people to use as many spaces as possible. This creates real ownership. There is very little vandalism. Everyone is responsible for clearing up. You might see the chief executive picking up litter.

• *'Architect involved'*
The Architect has worked with the centre for many years.

In one of the most deprived areas of the country we are on the way to providing truly holistic health care in a setting that is uplifting to users and providers. Nine out of ten consultations in the NHS take place in primary care. Future challenges include: developing 'Healthy Living Centres', in all communities which accurately reflect local needs; and ensuring that the acute sector supports primary care through direct and immediate access to technology, such as exercise ECGs and MRIs, and consultants — the norm in many parts of Europe now.

Sam Everington

The architecture of health buildings

Providing care — can architects help?

Is there any such thing as a therapeutic environment?

The idea of the therapeutic environment has been around for some time and has its supporters, not just among architects and designers but also among the medical and nursing professions. During the 18th century, there was some speculation as to whether the hospital environment could contribute to cure and several doctors proposed reforms for the design and management of hospitals. Among the most influential were John Aitken's *Thoughts on hospitals* (1771), Tenon's *Memoirs sur les hopitaux de Paris* (1788), and Sir John Pringle. All three proposed that ventilation helped with patient recovery by minimising the accumulation of foul air, and this led them to propose that wards should be designed with cross ventilation. They also suggested designing smaller wards to be able to segregate patients with different diseases.

The idea of the therapeutic environment was further developed by Florence Nightingale in the late 19th century. She formulated and published, in *Notes on Hospitals* (1885), an idea about a model hospital and the size and arrangement of hospital wards, still fondly known as 'Nightingale' wards. She believed that the environment had both a physical and psychological effect on patients and set out a vision for the space, interior décor and the general furnishings:

•*'The first requirement of a hospital should be that is should do the sick no harm.*'

•*'The effect on sickness of beautiful objects. Of variety of objects, and especially of brilliancy of colours is hardly at all appreciated … People say the effect is on the mind. It is no such thing. The effect is on the body too. Little as we know about the way in which we are affected by form, colour, by light, we do know this, that they have a physical effect. Variety of form and brilliancy of colour in the objects presented to patients is the actual means of recovery.*'

While these theories may have sought to improve the patient experience and clinical practice, they somehow failed to ensure the creation of humane and beautiful environments. Modern health buildings, particularly hospitals, are widely regarded as bleak and bland environments that are intimidating and irritating. While the designs may have addressed functional requirements for modern clinical practice they had somehow failed to deliver designs that are comforting or inspiring. They have become environments driven by giving priority to medical procedures and management efficiency that have overlooked some key ideas about how a place feels and what it is like to experience it.

There are some notable exceptions, particularly among early modern movement buildings, such as Alto's sanatorium at Paimio, Finland, and Ducker's sanatorium near Amsterdam. These buildings translated the then curative treatment for TB of fresh air and sunlight, into elegant designs taking advantage of orientation, daylight, and natural settings. From a similar era, in the 1930s, Lubetkin's health centre in Finsbury, London, is also recognised as a precedent for good design. Soon after the establishment of the National Health Service, a major development plan to rebuild hospitals was undertaken. During the 1960s, a period known as the heroic years, many new ideas and innovative hospitals were built. But, on the whole, health care design has fallen outside mainstream architectural practice, with few buildings recognised for architectural awards and reviews only occasionally appearing in the press.

Recently, however, a resurgence of the notion of the therapeutic environment has taken place. This not only gives greater importance to design but also provides a framework for convincing key decision-makers that design is important — for clinical staff in improving patient outcomes; for managers in terms of a better service; for patients, visitors and staff in appreciating the value to health of good environmental quality.

So, just how can the environment contribute to healing?

Speculation has now shifted from whether the environment affects healing to understanding just how design contributes to healing. Since we are in an era that highly values performance measurement, there is a call for an evidence base to substantiate this largely anecdotal approach based on common sense. Research about the therapeutic nature of the environment has emerged from three main disciplines: physiological proof, psychological studies, and design theory.

The now well-renowned studies by Ulrich, undertaken in the USA since the 1980s, demonstrate that patients recover faster, use fewer analgesics, experience reduced blood pressure and make fewer complaints when they are nursed in a room with a view of nature than one without. A review of similar studies identified the most influential environmental features on health outcome as light, heat shielding, humidity, temperature, music, sound, noise levels, and window views. A study is currently underway at the

Further reading

Books and articles

Canter and Canter (eds). *Designing for therapeutic Environments*. London: John Wiley and sons Ltd, 1979.

Francis S, Glanville R. *Building a 2020 Vision : future health care environments*. London: The Nuffield Trust, 2001.

Francis S, Glanville R, Noble A, Scher P. *50 years of ideas in health care building*. London: The Nuffield Trust, 1999.

Francis S. A golden record, but is planning past caring? In: *Primary Care. 50 years of health building*. Hospital Development. Special Supplement. June/July, 1998.

Richardson H (ed). *English Hospitals 1660-1948*. Swindon: RCHME, 1998.

Rubin and Owens *An investigation to determine whether the built environment affects patient medcial outcomes*. USA: Center for Health Care Design, 1996.

Ulrich R. A theory of supportive design for health care facilities. *Journal of Health Care Design*. USA: Center for health care Design, 1997.

Policy and guidance.

Achieving Excellence Design Evaluation Toolkit (AEDET). NHS Estates, 2001.
www. nhs estates.gov.uk/design for this and other information about design government policy and guidance for health care buildings

Better Public Buildings. CABE report available from DCMS, 2001.

Francis S, Glanville R. *Designing primary healthcare premises: a resource*. (Out of print.) North West Regional Health Authority/ NHS Executive North West, 1996.

Chelsea and Westminster hospital to investigate the impact of visual art on patients undergoing orthopaedic surgery that will measure relevant biological responses.

The second group of studies was carried out mainly by psychologists to show that buildings have observable psychological effects on users. They are concerned with issues of privacy and territoriality and show that, for example, the arrangement of furniture in a room can have a marked effect on how people interact and behave. Calling on social science methodology, more recent studies have set out to explain patient and staff attitudes to specific hospital environments where visual and performing arts are present.

The third group, draws on design theory that is largely assertive and points out the importance of the sensory qualities of light, colour, texture, and the aesthetics of visual form, proportion, and balance. These theories show respect for the feelings of people as well as their practical needs. While they undoubtedly offer useful insights and expert understanding about the environment, they do not deliver conclusive proof. Indeed they may help us to understand what is therapeutic but even that is not the same as a broader definition of design quality.

What is good design?

After years of indifference, there is now a drive to improve the quality of health service buildings. Practical guidance is now available, for both designers and their clients, illustrating successful projects and defining markers for high quality design.

For a building design to be rated as of high quality, the design must be:

- functional, i.e. fit for purpose;
- use technology, engineering and construction to generate fully integrated designs that are smart, robust and durable; and
- therapeutic in relation to the physical and social context, identity and character of the built form, and the external and internal appearance.

But how can design help to deliver a modern care service for primary care?

In a recent study, *Building a 2020 Vision*, we at MARU set out a vision for future health care environments based on emergent policy, research and practice. One of the most significant findings of our study was the potential change resulting from the modernisation of two industries: health and construction.

The shift in emphasis to patient-centred care places equity, access, and inclusion as key principles for future care. We should harness technology to support the patient journey, manage clinical networks, and develop health plans that work across acute and primary care. To deliver modern, more holistic health care, we need more 'joined-up thinking'. Good health requires fair and fuller employment, and better quality housing. Wider regeneration programmes should include the regeneration of health care provision — where and how health care is provided.

For primary care in particular, modernisation will involve the integration of social and health care, bringing often disparate services under one roof or, at least into, closer joint working through digital links. New types of buildings, such as healthy living centres, information kiosks, and community social and advice centres, will accommodate multidisciplinary teams giving advice and consultations on a wider range of issues devised to suit the needs of local people. Getting access to information is expected to expand to encompass internet and telephone services.

Mapping services, to improve the patient experience and reduce waste in the organisation of services, will translate into built form with the concept that space is used as a resource and not a territory. This means not allocating a room for each person but creating suites of rooms for activities that adequately distinguish between dedicated, bookable/timetabled rooms and those used as bases for hot-desking. Teams include people who work in different ways and this can be reflected in the way they use the spaces, both for clinical and administrative purposes. Of course architects and designers will need to listen very carefully to the voices of those who currently actually work in such teams.

Not only will rooms be described according to their particular function, but also by their characteristics. Creating distinctive characteristics for public, social, and private spaces will help this. Public spaces will be welcoming, formal, and help users to negotiate their way around. Visual clues can give identity at crucial junctions and minimise the need for signage — that calling card of the institutional. Social spaces will provide informal meeting places in cafes or waiting areas that are designed to distract patients from anxiety, stimulate the mind and senses while waiting, and generally support conversations and social exchange. Private spaces for consultations and treatments will offer privacy and dignity, so essential to the delivery of health and social care.

Can this be developed and sustained?

Primary care has enjoyed a decade of innovation and design quality. This has flourished partly as a result of a procurement system that fostered a creative exchange between designers and clients, particularly GPs. Many younger and more innovative design practices have been able to bring primary care into mainstream architectural practice.

There is great concern that the proposed batching of projects to meet future funding strategies (such as PFI) will lead to standardisation of design , in the banal and unimpressive style so redolent of the 1970s. The notion of standardising whole buildings is inappropriate, as it leaves no room for developing the design to suit the particular location However, expectations are now higher, and the dialogue between designers and clients should be more informed and productive as a result.

There are also some clear benefits of standardisation that should not be dismissed. The understanding that has been gained about the detailed design of rooms for particular tasks has been developed and tested over time. There are rooms whose functions basically remain the same: requirements for spaces, such as consultation, counselling and treatment rooms, have been well understood and hardly change. These rooms can benefit from principles and space standards formulated from considerable experience over the years and lend themselves to being repeated rather than re-invented each time.

It is even possible to imagine certain rooms, such as toilets, plant rooms, and utilities, being manufactured in factories and delivered to sites. Although this only has economic benefits for larger schemes it is thought that it is expected to deliver better quality of construction and finishes with greater control over time and budget.

There is no question that architecture has to fulfil the basic requirements of any brief — to be functional and technically competent. But design can also add value by making environments that relieve stress for staff and reduce anxiety for patients. There is the further potential for making spaces that inspire, stimulate the mind and senses, and even surprise users and passers-by. Integrating art, design, and architecture for primary care can work to make designs of quality that may benefit patients and staff — and in an optimistic way, perhaps the rest of us too.

Susan Francis

"Nothing is too good for ordinary people"

Finsbury Health Centre — a gleam of hope

Further reading

Allan J, Lubetkin B. *Architecture and the tradition of progress*. RIBA Publications, 1992.

Allan J. Finsbury at 50 — Caring and causality. *The Architectural Review*, June 1988.

Davies C. Prescription for a Health Centre. *AJ Renovation Supplement,* 22 March 1989.

Glancey J. A vision still worth fighting for. *The Independent*, 29 March 1995.

Field M. A pioneer partially restored to its former glory. *The Architect's Journal*. 16 February 1995.

IMAGINE. It's a smoggy London night in 1938. You're depressed and feel awful. You're coughing. Actually you've been coughing for weeks, and it seems to be getting worse. You tried some of these patent remedies in newspaper ads. Hopeless. But it's not the discomfort that's the worst part. It's the fear. It's TB. You've read about it, and it's a killer. Two people you know have died of it. One was exactly the same age you are now. You remember something a friend told you about some newly opened place near the City. Pine Street, that's where it was. Turn off Farringdon Road and just round the corner, there it is — Finsbury Health Centre — gleaming like a lighthouse, its arms open wide in a gesture of unconditional welcome. This can't be a hospital. For a start, it doesn't have that vile smell. But it's too spacious and elegant to be a doctor's surgery either, with those familiar stuffy waiting rooms in the bowels of some hideous Victorian mansion. Feels more like a club. Relax. A nurse is coming. Look at that mural; it's so colourful, so fresh, so … optimistic. What an inspiring slogan! CHEST DISEASES ARE PREVENTABLE AND CURABLE! You feel better already. In fact you feel something you haven't felt for months. Hope.

OK, it might sound corny now, but it wouldn't have been then. Amid all the political confusion and compromise of the 1930s, Finsbury Health Centre stands out as a beacon of clarity and idealism. Like many outstanding buildings, it owes its existence to just a handful of committed people, in this case two in particular. One was an Indian doctor, Chuni Katial; the other a Russian architect, Berthold Lubetkin.

Katial was Chairman of the Public Health Committee of Finsbury Council, one of the radical East London boroughs of the inter-war period, or 'little Moscows' in contemporary political parlance. Lubetkin was the leading partner of Tecton, a progressive firm of modern architects formed in 1932. It was the centenary of the British Medical Association that same year which brought them together. Starved of real commissions, Tecton had set themselves the theoretical project of designing a TB clinic which they exhibited at the BMA. Impressed by their unusual clarity of thought, Katial noted the architects' details and three years later enrolled their services in the

The club-like atmosphere of the entrance foyer, with its casual seating and, initially, no reception desk. (The original murals — not visible in this view — were later covered up.)

Finsbury's gleaming façade in 1938. The gently curving wall was intended, in Lubetkin's words, 'to present a smiling face on what is in fact a machine'.

development of Finsbury Health Centre. Opened in 1938 by Lord Horder, the King's Physician, the resulting building, now listed Grade I, is arguably the most important piece of social architecture of the era.

Together, Katial and Lubetkin established the essentials of what was at the time an unprecedented building type. The rationalisation and co-ordination of this small Borough's hitherto scattered health services into a single local centre with a strong health promotional agenda contained all the ingredients of the sort of building Lubetkin, a fervent socialist from revolutionary Russia, had long dreamed of. Finsbury Health Centre would be Britain's first 'social condenser' — the Soviet coinage for the progressive architecture needed to help advance social change.

Indeed, for such a relatively small building the battery of services still sounds impressive — a women's clinic, a solarium, a dental clinic and laboratory, a foot clinic, a cleansing and disinfection station, a reception flat for displaced households, a 70-seat lecture theatre, consulting suites and paramedics' offices, an open-air terrace, a mortuary, and of course the TB clinic.

The beautiful clarity of Lubetkin's plan is a product of his classical training in Paris, 1925–1931. The centre is laid out on an H-figure, with a central entrance, gently curving foyer block and symmetrically splayed clinical wings. But beneath this modern classicism the engineering solution was radical in its flexibility of partition layout and easy servicing through strategically placed ducts. These inform the architectural expression, to produce one of the first ever curtain walls — a framed composition of windows and insulated silk-fibre panels, the surface of which — in Lubetkin's words — 'shone like a girlfriend's hair'. The central block combines cream ceramic tiling with a luminous wall of glass block, its fine bronze entrance doors set in a marble surround — exemplifying Lubetkin's maxim that 'Nothing is too good for ordinary people'.

You don't need to dabble in theories of architectural determinism to see how a powerful tool for social betterment is forged when a vision of better health care is fused with intelligent building design. It speaks for itself. Sixty years on, however, despite remaining in daily use and despite partial restoration in the mid-1990s, the Health Centre is now in a state of dilapidation. Yet its value as a life-enhancing resource for its local community is surely incontestable. All it needs is the funding and the will. You can't help feeling that somewhere in all this there is a message for our NHS today.

John Allan

comment

Society needs heroes. And it needs aspirations. Society also has responsibilities.

What kind of society is it that cannot afford to put Finsbury Health Centre into a good state of repair; not to 'restore' it, not to turn it into a museum, but just to celebrate its wonderfulness by continuing to use it for health care? I cannot deny that this would be expensive. But why shouldn't we spend money on this?

Why can't nothing be too good for ordinary people again?

David Heath

finsbury

Living with Lubetkin

IT is impossible not to get a thrill from cohabiting with this visionary man. You can feel his legacy every time you walk across the Finsbury Health Centre lobby. There is a grandness about this funny-looking squat building and the grandness is in his vision. It is an expression of Lubetkin's famous mantra, 'Nothing is too good for ordinary people'.

You would have to be an unusually stony-hearted, world-weary GP not to want to cheer that one. But our relationship with Lubetkin, like any relationship, is not just about the heady romance and razzmatazz, it is about the little things. It is these that make it so special — and also so teeth-grindlingly frustrating.

We, by lucky accident, have come to rent a corner of Lubetkin's beacon. We benefit from the rich pleasures of a Grade I listed building but we face DO NOT TOUCH warnings on every brick and screw and window pane; we are not so much tenants as squatters in a sort of museum. Even trivial things seem to be quickly festooned in smothering red tape. The Community Trust who own the building have been so intimidated by English Heritage, they have hardly dared replace a light bulb in the place for years.

The building is crumbling into dereliction around us. Draughty and insecure, it does not even have proper access for people with disabilities. It is too hot in summer and strangely also too hot in winter, spring and autumn. It leaks mercilessly, yet 'Waterproofing is out of the question …', say the Grade I Listing police, '… unless a long-closed Bavarian tile factory is re-commissioned.' The very thought sends the PCG running for cover. However, despite its inherent problems there is so much love for this building that all parties are now working to realise Lubetkin's dream.

Julie Sharman

Betrayal of trust - the collapse of global public health
Laurie Garrett
OUP 2001,
HB, 477pp, £18.99 (0 19850995 2)

In a tiny kitchen with peeling white walls a pale, watery-eyed woman watches nervously as a man drips with sweat, despite the cold night air, as he grinds pieces of poppy into a powder. He is making an Odessan antidote to the filthy disappointment of life. A man in Bombay returns to his earthquake-ruined home after several months, opens the doors to his decrepit grain store, and is overwhelmed by a cloud of fleas.

Epidemics have modest beginnings, and Laurie Garrett describes them eloquently: In her book, *Betrayal of trust*, Garrett writes about the social and economic failures that allow infectious diseases to flourish. At times a work of fast-paced suspense, an avalanche of evidence, or a marvel of investigative journalism, the one genre to which this book does not belong is, unfortunately, fantasy.

The collapse of public health in the former Soviet Union had been unparalleled in the industrialised world during times of peace. The country's intellectuals were decimated by Stalin and Hitler. Of those remaining, 15 000 scientists left, while 40 000 of them concentrated on developing bioweapons. While measles, polio, rubella, and diphtheria claimed thousands of unvaccinated lives, state-of-the-art genetic engineers toiled away in Russia's numerous bioweapons labs to increase the virulence of diseases such as monkey pox and anthrax. What the immoral scientists did in the labs, nature did in the environment with much more potency. Doctors prescribed drugs incorrectly when they had them, patients bought whatever suboptimal doses they could afford, and drug resistance exploded. Uncured, patients plunged into poverty.

In Zaire, whole villages watched, terrified and helpless, as entire families died within days, of mass haemorrhaging. Ebola virus spread because of a lack of medical expertise and equipment. Mobutu, the self-proclaimed 'all-powerful warrior who triumphs over all obstacles', allowed his people to die while amassing a fortune of over $11 billion. Roads rotted, hospitals fell to ruin, and water ran dry while the West, desirous of the Congo's minerals and political siding, haemorrhaged more money to support the kleptocratic regime.

Public health, as Garrett points out, is a negative; if money is well spent, the system functions, and nothing happens. This makes it easy for governments to slash budgets. The decline in public health expenditure in India is just one of many examples of the betrayal of trust between governments and their citizens that result in preventable deaths. When public health fails the cost is all too easy to estimate; while the 1994 plague only killed 60 people, the cost to the country through lost business and tourism was over $2 billion.

Before one begins to imagine that these epidemics of neglect lie far away from here, Garrett reminds us that the United States has also betrayed the trust of its people. In the late 1990s, nosocomial infections killed 100 000 people each year, adding billions to the national health bill. Drug-resistant microbes adapted to their antibiotic-laden environment so well that they became drug-dependent. Stripped of its power, with little control over doctors' prescribing practices, and no power to confine patients and test hospital personnel, public health in the richest of the countries in the West failed to control infectious diseases.

Bioterrorism is the theme of the book's final chapter, and Garrett's warning that stateless terrorists have all the means with which to release anthrax in New York is terrifyingly prescient. It would be easy to dwell on this, but doing so would miss the main point of this monumental book, which is that the public health system is failing everywhere, on all levels, and people are dying in their millions. The United Nations recently announced that the Ukraine's AIDS epidemic is the fastest-growing in Europe and the former Soviet Union; MDR tuberculosis continues to spread unchecked throughout the former Soviet Union; and Ebola is currently claiming lives in Gabon.

Self-interest has always been the driving force behind development; public health in the United States grew because slave ships to New York brought measles, yellow fever, and a host of other infections. Most of the malarial research in the West was done by the United States army during the Vietnam War, and some say that our best hope for a malaria vaccine is global warming. Now that Western concern is for bioterrorism, tens of billions of dollars have become available, and hundreds of billions more for the military. But the Global Fund to tackle the current killers — AIDS, tuberculosis, and malaria — currently stands at barely one-fifth of what is required.

Betrayal of trust is an emergency siren to short-sighted governments which continue to ignore the fact that global poverty and disease is everyone's problem. The biggest betrayal of all is to the four-fifths of the planet who are neither a threat to national security, nor an attractive market, and who remain of almost no interest whatsoever to the forces that govern public health. The Los Angeles health officer who in the 1890s said that diseases 'know no boundary', is still being completely ignored.

Nathan Ford

The Trust
Channel 4 Television
Thursdays from 17 January, for five weeks

MR Milburn, and anyone wanting to step into his shoes, could have done worse than watched *The Trust*. For all the good that clinical governance, revalidation, and all the other attempts to 'modernise' the NHS have been, this is the real world. It is not a world of Mr Milburn's making, though his government must take some responsibility for denying reality for so long, and for pretending that the answer was clinical governance and the rest. *The Trust* is filmed at Queen's Medical Centre, Nottingham and began in the intensive care unit.

The mathematics of calculating how many intensive care beds are needed is easy. It is simple application of the Poisson distribution. To make sure that 95% of the time there is an empty bed available for an emergency admission to a six-bedded unit requires an average bed occupancy of 2.7. The same mathematics means that firemen spend more time not at fires than they do fighting them, otherwise some buildings would just have to be left to burn. Three weekends before, while on major vascular take, we started the weekend with the unit full and two patients on full support in the theatre recovery area. Long periods of the weekend were spent by the anaesthetists looking after patients in the operating theatre because there was nowhere to send them after their operations. The unit at Queen's has 14 beds, but they too were all full. They have 14 beds but only because the nurses have agreed — or have perhaps been coerced — into sometimes looking after more than one patient at a time. I wonder who will get the blame when a restless patient removes their endotracheal tube? Some patients are being left to burn.

The consequences were vividly illustrated, and etched in the faces of the consultant and sister-in-charge. The young wife of a recovering cyclist was told he was to be moved out to a general ward within 20 minutes to get a new admission onto the unit; the consultant admitted this was not ideal. A motorcyclist had undergone ten hours of surgery. To admit him to the unit meant moving an 82-year-old man anaesthetised, intubated and ventilated, 30 miles to another hospital. The consultant apologised to the relatives. The elderly wife wore the pitiful, confused look of the suddenly out of depth. The daughters were resigned rather than confused.

'He worked all his life and always paid his stamp,' said the daughters. To the camera, the consultant spoke of working with one hand behind his back, always having to juggle priorities.

Mr Milburn's latest answer to this unsolved and probably intractable problem was announced in the same week as *The Trust* started, and just as a private hospital was being severely criticised for its standards of maternity care. He would put failing hospitals in the hands of private managers. But the government has been rumbled. As well as patently not having solved the problems they were set up to solve, the government's plans for health are not really plans at all; they are, in Simon Hoggart's words (*The Guardian*, 16 January) evidence of the world's first 'jargonocracy'. Impenetrable phrases are alleged to describe policies and courses of action but 'the jargon does not describe strategy; it *is* strategy'. He is not the only one to have spotted this. In the same issue of the same newspaper, John Carvel described Mr Milburn's speech as 'long on vision and short on detail'.

And this matters a lot. Vacuous and platitudinous policies rain down on the workforce. The workforce implement them as they interpret them, but whether interpretation, and hence implementation, is successful is judged by the policy makers. Thus are the public services destroyed.[1]

The way forward is not easy. The unpalatable nub of the matter is the question no politician dare pose, let alone answer: what do we want the NHS to do for us? And while we are not sorting this out, but trying with inadequate infrastructure to rescue the service from long years of neglect, can we afford to put 82-year-olds on intensive care units at all? This question will raise howls of protest, but I ask the protesters: what would you do with a young motorcyclist if there is no bed anywhere for the 82-year-old?

Neville W Goodman

Reference

1. Loughlin M. On the buzzword approach to policy formation. *J Eval Clin Pract* (in press).

Paul Klee: The Nature of Creation
Hayward Gallery, London

Until 1 April 2002

Open daily 10.00 am to 6.00 pm (late nights Tuesday and Wednesday until 8.00 pm)
Tickets: £8; concs £6

www.haywardgallery.org.uk

I'VE never had much time for the rarified environment of modern art and its followers, chiefly because I feel that the currency of artistic worth and interpretation has latterly been cheapened by a few who are only interested in celebrity status, and who are skilful at manipulating the sometimes ludicrous art world media into bestowing undeserved kudos and riches. If you despair at the Turner Prize, groan at yet another banal and overhyped exhibition, then take heart: Paul Klee still has the power to blow them all away.

Visiting this major exhibition of Klee's work — over 90 of his most important paintings — is a startling reminder of how great this man's influence has been in so many forms of graphic imagery. His work is genuinely enjoyable, and in many pieces his sense of humour shines through. The delightful 'Bird Drama', a pen-and-ink sketch, and a quirky watercolour entitled 'They're Biting', depicting unsuspecting anglers in peril, were surely precursors to the old Eastern European style of art used in countless animated films during the Communist era.

Klee's central artistic concept, of 'taking a line for a walk' is most apparent in his fascination with representing the geometry of nature, such as the 'strange flora' series and the contoured landscapes of 'Mountain formation' and 'Rock-cut temple'. Dazzling experiments in perspective leave you feeling as if you're suspended in mid-air. His frequent use of arrows to draw the gaze is highly effective; they give works such as 'Dance of the Moth' and 'Young Lady's Adventure' a real sense of dynamism. The more you look the more you can visualise the mechanics of even the most surreal depiction; something which I'm sure Klee meant to achieve.

This exhibition succeeds completely in showcasing a much-loved and much-copied talent. Who needs pickled cows, when you can revel in this celebration of colour, form, and nature?

Lorraine Law

'Abenteuer eines Fräuleins' (Young Lady's Adventure), 1922. Pencil on paper mounted on card. Photo © Tate, London 2001.

Paris — Capital of the arts, 1900–1968
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PARIS was the powerhouse of new art. Artists came from all over Europe to join the party. New movements abounded: cubism, avant-garde, abstractionism, surrealism, and the post-war explosion of modern art. The success of this exhibition is to show why. A good exhibition should be much more than walking dazed through rooms of pictures, like so many blown-up postcards in one's brain, and this exhibition measures up. One can see where the ideas were coming from, and how they are the product of our European culture and traumatic history. All the usual suspects are there — Braque, Matisse, Modigliani, Chagall, Duchamp, Dali, Giacometti. And more Picassos than in a Boston billionaire's bathroom.

Each room represents a new twist in the ride. By seeing each new movement in its context the freshness returns. We can see both why Cubism injected new life, and why within two decades it had run its course. More revolutions than Thomas Kuhn on a merry-go-round. For me the delight was being introduced to some new names, and filling in some gaps. Each picture has the complexity and idiosyncrasy of a consultation, and the exhibition displays some very different models, from the raw stumbling of Byrne and Long to the sublime triumph of Roger Neighbour. Seen in this light the whole exhibition represents a good week's work, but casting confidentiality aside let me share a few favourites.

'L'Ecole de Paris' in the 1920s and 1930s produced nudes that are both dazzling and whimsical. The juxtaposition of three pictures struck me. A magnificent 'Reclining nude' by Modigliani displays all the sensuous but formal grandeur of the artist's liturgy. Next is Bonnard's 'Nude with red slippers', touchingly unglamorous — the still, self-absorbed beauty of an ordinary person. And then we have Pascin's 'Temple of Beauty', a picture of grotesque hilarity, perhaps the result of a bad day at a Montmartre bordello. This little trio represented for me the experience of general practice. The spectacle, the commonplace beauty and the ludicrous realities that daily parade through our consulting rooms.

A darkly lit room introduced me to Fautrier and Soutine. Their carcasses of beef and skinned rabbits are reminiscent of Rembrant's 'Flayed Ox', but also have the agonised power of a Bacon. One is chilled by the recognition that the roots of this art are the trenches of the First World War. Such art calls out for an ICD classification.

The 20th century itself is the exhibition's practice area. The art is constructed from turn-of-the-century optimism, from the dreams of Freud, from the open graves of two wars, from the brutal elation of modernism and the riotous times of late 1960s Paris. And just as art is constructed by artists' singular interpretations of the world, so those who wish to put a particular interpretation on the artists construct exhibitions. This is where art is not like morning surgery. How different it would be if our patients presented themselves in ordered groups, complete with exhibition notes to guide us. Perhaps an exhibition is more like an MRCGP consultation video. Only some make the final edit, and we have the luxury of settling on an interpretation that becomes the given reality. Here's to the inventive chaos of real life!

Being a GP I spent half my time looking at the people. Watch people walking through the disorientating forest of plastic strands of Soto's 'Penetrables', or working out the myoclonic cacophony of Tinguely's 'Miramar'. These artists had a lot to say, but they also had a lot of fun. It was a lot of fun to visit.

David Misselbrook

'Paris Through the Window', oil on canvas, by Marc Chagall 1913. Solomon R Guggenheim Museum, New York. Gift, Solomon R Guggenheim, 1937, 37.438 Photo © The Solomon R Guggenheim Foundation, New York/David Heald.

All Passion Spent

Ageism and public health — a view from the south-west Pacific

In the footsteps of Gauguin, Robert Louis Stephenson, Somerset Maugham — this was my opportunity to retire from the NHS and use the pension to subsidise a South Sea adventure in public health. Is there anything useful to offer, a skill to impart or helpful perspective to attain? Can Papua New Guinea possibly learn from the mistakes of the NHS and avoid repeating them?

Medicine is for the young at heart and the reasonably young in life and limb. Grey hairs are not particularly respected, while the threats of reaccreditation, clinical mistake, legal confrontation, and loss of reputation loom larger as we get older. There is simply more to lose and less to gain. If experience is the ability to make the same mistake twice then fear of failure can dominate our decision making. There are many sides to the question, truth is ever relative, and the very wealth of experience can hinder clear decisions.

It is easier to understand why a surgeon may not so easily be able to perform a complex six-hour operation at the age of 60 as at 50. Out-of-bed work is always hell, but worse hell after 50 with poor concentration and performance the next day or longer. What of public health? The hardest thing is to maintain enthusiasm and interest, not to be cynical about the latest political gimmick/idea but optimistically sceptical; not to be downhearted when the dragons slain 20 years ago have all sprung up again. Poverty is still the main enemy to the public health worldwide, need remains as difficult to define and the measure of outcome a mocking Holy Grail. The information is light years ahead of 30 years ago, the computers are cleverer than I am, and lots of public health specialists can probably do my job in Britain, better and cheaper.

There are calls for more and more doctors — but is this a political mantra? What is the evidence that more doctors mean more and better health for the people? Public health has shown that doctors are not necessary for many of the functions once hallowed by the medical presence. Public health specialists are superb technicians with real and extra skills; I do not have those skills to the same degree but I appreciate them and can usefully direct them. A few public health doctors and many public health specialists seems a much more effective manpower solution.

In clinical practice in the same way, there is the need for small numbers of competent generalists and an army of super-specialist technicians to perform a whole range of very skilled procedures, from coronary stents to laparoscopic surgery, from anaesthetics to morbid histology. To train a cardiologist for 10 to 15 years who then spends 80% of his/her time placing stents in diseased coronary arteries seems a poor use of skilled manpower. Worse, as the technology moves on the cardiologist may be too far into a particular cul-de-sac easily to return and re-train for another skill demanded by a new technology. A technician could be taught to place stents or operate the laparoscope in months. Within a year or two his/her technical skills could rival or surpass that of the medical consultant-for that particular procedure. A technician can be 'recycled' with new skills in much less time and at much less cost than a rather disgruntled doctor.

Papua New Guinea is to Australian public health as Africa is to British. It is here that Australian academics came 20 or 30 years ago and collected their data and wrote their papers. The Australian mandate ensured well-staffed and developed services covering the population. Here, geography makes for real difficulties — mountains, volcanoes, dense rain forest, stormy seas, and few roads, often impassable.

Independence and consequent economic decline have made such services unsustainable. In rural Papua New Guinea the buildings are falling down, the staff demoralised, the supplies of drugs and vaccines unreliable and the basics of clean water and reliable lighting often missing. The health of the people is in jeopardy. The health statistics are getting worse; the population is growing at 3% plus per year and will double in 25 years.[1] The mining industry has collapsed while the environmental scars remain. Law and order is a major problem, for any health infrastructure requires internal stability. There is corruption, debt and dependence on donor aid. The life expectancy is around 50, AIDS is looming, while malaria and typhoid, TB and malnutrition, measles, diarrhoea, and pneumonia all take their toll.

The task then is to enthuse tomorrow's doctors for the struggle. How can we make it interesting enough? The aim is simple — that they all understand enough of public health to realise its crucial importance and practical application to make the health of the people the highest good. The task too is helping them to work in well-managed teams, to steal some useful ideas from Britain — risk management, clinical audit, continued professional development, and data collection and analysis; but also to learn from our failures — inappropriate health promotion, endless half-baked 'quality' initiatives, the screening miseries, waiting lists, endless organisational change.

If to continue to make a difference you need to keep learning, then for old ex-patriates the best bit is problem-based learning. Everyone has to try to teach other disciplines than his/her own. Uneasily, what I can remember of anatomy or biochemistry is interesting, what I have forgotten is vital and 70% of it is anyway wrong 30 years on. (Teachers get rather good cribs to help conceal their ignorance.) So everyday there are new things to learn and to try to interpret in another world. Here, resources are desperately limited and part of public health is to challenge unnecessary technology.

Anyone over 50 is old; after that being that much older does not seem to matter.

For there is good news yet to hear,
And fine things to be seen,
Before we go to paradise,
By way of Kensal Green

G K Chesterton
The Rolling English Road

Peter Sims

1. Duke T. Decline in child health in rural Papua New Guinea. *Lancet* 1999 **354:** 1291-1294.

The Wanless report
Securing our Future Health: Taking a Long Term View is a consultation document issued just before Christmas. Council has received a wealth of views and observations which has led to an stimulating Council debate.The RCGP's response will soon be posted on the College Website.

Leadership Programme
The College has funded a Leadership Programme for GPs throughout the UK. The director will be Professor Aly Rashid who will run this together with his team from De Montfort University, Leicester. There will be more news on this as time goes forward.

College Budget 2002-2003
Council approved proposals, which came jointly from the Council Executive Committee and the Finance Committee for the budget and membership subscription fees for 2002–2003. The continuing pressure on College resources has led unfortunately to rises in the subscription fees slightly above inflation, which is regrettable but entirely necessary.

Quality Indicators
Quality indicators can be used to provide helpful information for individuals, practices and organisations in general practice and primary care. However, they need to be interpreted within the wider context of delivery of care and used with the aim of improving quality of care. Council offered a number of interesting comments and it is clear that the issue does give rise to some fears about the inappropriate use of quality indicators. More news in due course.

Modernising the NHS
We had our usual fascinating and important reports from the UK countries. Our Chairman, David Haslam has been invited to serve on the English Modernisation Board in a personal capacity, succeeding Mike Pringle.

Revalidation and Appraisal
Progress on these areas has been slow, although pilots of appraisal are now starting in Wales. We are hopeful of being able to report on more concrete developments in the coming weeks.

European Society of General Practice/Family Medicine: New Definition of General Practice and Core Competences for General Practice
The new definition of general practice, once it is finalised, could have a significant impact on GP training and education across the EU. For the first time, core competencies of general practice are being defined. Our response indicates that the definition has much to commend it and the advent of core competencies is an interesting development. However, designing a definition for use in many countries where general practice/family medicine is structured and delivered in distinctly different ways gives rise to a number of issues. We have put forward some drafting suggestions to the European Society and hope to influence the way it is debated at a conference in March this year.

Education Network
Council was very pleased to see the work which is going forward under the Chairmanship of Dr Steve Field who became Chairman of the Network in September 2001. The Network is taking the College education agenda forward at a particularly critical and exciting time with the proposals for the establishment of the Medical Education Standards Board in the UK (see below) and the expected Senior House Officer Review. The Network has the aim of influencing and driving the education curriculum for GPs and working with other organisations in doing so. We are looking forward to further reports from the Network as its work develops including how relevant courses and other educational events are being run by the College.

Medical Education Standards Board (MESB)
The Department of Health has issued this document for consultation. We will be giving our response to this before the closing date of 4 March. Council had a debate on the key points drawn from the response to the consultation so far — these will be likely to form part of our response.

The MESB will be a UK body that will merge the current functions of the Joint Committee on Postgraduate Training for General Practice and the Specialist Training Authority (STA). It will therefore be the regulator for standards of Postgraduate Medical Education (PGME) across the UK. The Board will control entry to the Specialist Register (of consultants) and create a new General Practitioner register for GPs eligible to practice in the UK. This will be linked to the local list system to allow Health Authorities, and the public to access information about GP performance.

There is no doubt that the advent of the Board gives some opportunities but clearly there are risks for this College. We have a number of concerns — not least that the document fails to address adequately the tensions between education and service; the way in which the Board will be accountable (to the Secretary of State); and the method proposed for identifying its members. There is inadequate mention of Wales in the document, which is a considerable oversight. There is a lack of clarity around the interface between the Board and the GMC. We have worries over the long transition period that could ensue between now and when the Board becomes operational. Accordingly, we are concerned to ensure that the position of the staff of the

Getting involved in your College
There is a vacancy on our **Patients' Liaison Group** for a GP member. If any Faculty wishes to put a name forward, please let me know as soon as possible. (honsec@rcgp.org.uk)

We are advertising in this issue of the *BJGP* for members who are interested in joining a new **Virtual Forum** to put their names forward.

The Virtual Forum will be used by David Haslam periodically to test out ideas, to seek feedback on policy issues, topics, draft papers or issues where we would like additional input. The Forum is experimental and we plan to run this for a period of one year to see how it works — we will be very interested in feedback.

We are also advertising for more members to help respond to the growing number of consultation documents we receive each year.

Fellowship and Awards
The closing date for Fellowships and Awards for the AGM 2002 is 31st March 2002. More details can be obtained from Kate Messent in Corporate Affairs
cmessent@rcgp.org.uk

If you would like further information on any of the items set out above or information on any other matters discussed at our January Council meeting than please do not hesitate to get in touch by email to
honsec@rcgp.org.uk

Next Council Meeting
Saturday 16 March 2002, at Princes Gate.

Joint Committee is clarified swiftly and appropriately. These and other points together with many detailed matters, bought to our attention by our commentators,will form our final response.

College Constitution
We wish to take forward an update of our Constitution, which has a number of deficiencies at present. The aim is to provide a flexible constitution, which is fit for purpose and written in plain English. We want and need to consult with all members on the proposals and will do so by means of an insert in the March issue of the Journal. You will be able to feed back your views through the College's Website, by fax, or by post, and there will be a telephone line available as well. As well as rewriting the Constitution we are seeking views on some proposals. These are:

- Putting an upper limit on the size of Council at 70 members.
- Seeking powers for the College to be able to establish Councils in Northern Ireland and England as well as bodies for areas of UK countries.
- To clarify the arrangements for additional Faculties representatives to be appointed to Council
- Providing powers to enable overseas GPs who are not registered with the GMC to have some form of "affiliation" with the College — with a scheme to be worked out and decided on at a later stage
- Providing powers to enable UK based Health Professionals (i.e. other than GPs) to have some form of "affiliation" — with the College with a scheme to be worked out and decided on at a later stage
- To ensure that retired members who choose not to retain their registration with the GMC can continue to be members of the College
- To take powers to introduce a limited scheme of renumeration for College Officers. If agreed, a detailed scheme will be developed and put before members in due course.

GP reports to Insurance Companies
This report, written by College member Dr Paul Thornton, was brought forward by our Ethics Committee. Developments in law over the years can be in conflict with the requirements placed on GPs by insurance companies to provide patient reports. Issues will be raised at the highest level, seeking an appropriate resolution.

Spring Meeting 2002
The Midland Faculty is hosting the Spring Meeting, on 12 and 13 April 2002 at the International Convention Centre in Birmingham. The programme and formal business will include the appointment of Fellows and presentation of Awards. Jacky Hayden will deliver the Pickles lecture on *Young Ambition's Ladder*.

Maureen Baker
Honorary Secretary

neville goodman

Bldy BD**

WHAT has been the effect of this journal's valiant attempt to stop otherwise reputable broadsheet newspapers publishing utter garbage? Edzard Ernst was not as condemnatory as I was, but he agreed with my analysis of *The Observer*'s Barefoot Doctor. The man writes nonsense; the newspaper publishes it. So has anything happened? Well, yes. Barefoot Doctor has been promoted. His is now the leading health page instead of half of the second health page in *Life*, the Observer Magazine. Meanwhile, that stable's daily, *The Guardian*, has instituted a weekly page of its own. 'According to Chinese medicine…' precedes another item of claptrap every week.

BD has been into drinking urine (20 January). Justification? It's a widely used treatment in India. The best bit is the first midstream specimen of the morning, which is 'thought to' (useful covering words those) contain properties that 'stimulate the kidneys and hence the immune system'.

The urine is an ultrafiltrate of blood, though I don't suppose they knew that in India when they first started drinking urine. We know the chemistry of urine pretty well, and it's mostly breakdown products of biological compounds that we no longer need or that have been broken down and will poison us if we don't get rid of them. The sheer idiocy of thinking that drinking the stuff is good for you beggars belief.

Then there is the logical dislocation in the explanation: stimulate the kidneys and hence the immune system. Excuse me, but why should stimulating the kidneys affect the immune system? But I overlook that the immune system is the universal explanation for new age hooey, smart-sounding pseudo-science. They don't want science, but they want to borrow the authority of its terms. Meanwhile, things that actually do stimulate the immune system — such as vaccines — are regarded as bad, and do they know that too much stimulation causes anaphylaxis? Perhaps that's why you should restrict your morning drinking to the midstream bit.

Drinking urine also made it onto the BBC's *Watchdog* on alternative medicine (4 February), an appalling programme in which trendy empty-headed people spouted one-liners about all manner of nonsense. The overriding message was the now usual one: once upon a time all this was looked down on by the establishment, but now it's just a matter of time before it's part of mainstream medicine. The programme seemed more worried about the lack of regulation of the alternative sector than about its lack of evidence base. 'Treatments' such as crystal therapy don't merit regulation. They warrant exposure, and of a more critical kind that the media currently give them.

Nev.W.Goodman@bris.ac.uk

our contributors

John Allan is Director of Avanti Architects, and author of *Berthold Lubetkin — Architecture and the Tradition of Progress*, RIBA Publications, 1992.

Sam Everington is a GP based in Bow, east London.

Nathan Ford, a virologist working with Medicins Sans Frontieres in London, is conferencing in New York this month looking at R&D in negected diseases — **www.neglecteddiseases.org**

Susan Francis is co-director and research architect at MARU, the Medical Architecture Research Unit at South Bank University, London. She trained as an architect, and has worked in both practice and research. She is currently developing a qualitative evaluation for visual art and architecture in hospitals, and an evaluation of the King's Fund programme to *Enhance the Healing Environment*. She is an executive member of Architects for Health, and the London Arts for Health Forum

Neville Goodman's campaign to buy the Barefoot Doctor a nice new pair of shoes continues at **Nev.W.Goodman@bris.ac.uk**

David Heath is Chief Conservation Architect at English Heritage, though he writes for the *BJGP* in a personal capacity

Hazel Hodgkin is a facilitator and management coach at Breakthrough Strategies Ltd, Auckland, New Zealand

Lorraine Law is the Journal Manager at the *BJGP*

Helen Lucas is a GP in London, cycles to work and enjoys gardening. She'd also like world peace and a properly funded health service — **hlucas@hotmail.com**

Alexi Marmot BArch MArch MCP PhD RAIA is director of AMA Alexi Marmot Associates, premises consultants, London. AMA specialises in working with building users in offices, health and educational projects. Alexi is from Bondi, Australia, and decanted to London via five Californian years at Berkeley as a postgraduate student

David Misselbrook is a GP in Lewisham, London, and author of *Thinking About Patients*, Petroc Press, 2001

Melvyn Roffe BA FRSA is Chairman of the Lay Advisory Panel, College of Optometrists, 42 Craven Street, London WC2N 5NG

Telephoning **Julie Sharman** at Finsbury Health Centre is unusually exciting. One misplaced digit and callers are put through to Enron Corporation Europe. Spooky!

Peter Sims has worked in Britain in public health medicine on and off since 1973. He managed to spend eight years in general practice and as an academic in Zambia in the 1990s.He now works in Papua New Guinea. He is alternatively excited, frustrated, homesick and bemused, all of which is probably better than 'having the tidiest garden in North Devon'.

alan munro

Baosbheinn, Torridon, 875 metres, midwinter

THE planks of the footbridge, glistening with crystals of frost, look at least as full of broken-bone-potential as anything we hope to meet on our walk. Glassy pools beneath it reflect the yellow dawn ahead of us. The midwinter sun, still imprisoned in the sandstone clefts and ridges above, paints the sky with its impatience to be free of the icy land.

The urgently purposeful roar of occasionally passing traffic recedes as we make our way up the shadowed glen, clasped in silence counterpointed by the tinkle of tiny, melting tributaries and the steady swish of turbulent water sliding seaward through rock and fingered ice in the river now far below. Eagerness to crest the ridges ahead, fiery with the new day, lends a frisson of anticipation to the simple pleasure of plodding through the miles at the steady pace of friends whose comfortable rhythms have been refined on many shared trails.

In the lower reaches of the glen the estate has planted native trees in an area fenced to keep out the ubiquitous red deer. There are convenient gates to allow access by walkers and polite notices explaining their re-forestation policy. Soon, with luck, majestic pines with the birds, insects, and sundry beasties which trees bring, will grace this elemental landscape of water, rock and light. All of which is fine, but we remark upon the islands on the big loch in the distance which are densely covered in self-regenerating pine. Wild trees are generally absent because of deer numbers, artificially maintained for the sole benefit and amusement of the landed classes, those whom Muriel Gray memorably christened 'dick heads who shoot things for fun'.

Rock and light. It seems odd, or sad, that anyone should presume to own it, or regard it as at his disposal.

The head of the glen harbours a small loch, cupped in encircling buttresses sculpted by ancient glaciers from layers of sandstone thrust up by the heave of the planet's crust. Its flawless surface mirrors pinnacles and ridges etched against the mid-morning sky. As we laboriously climb, a small party of deer outpaces us with contemptuous ease and disappears from the shadowy scene of our exertions, over the ridge, into the sudden light, and beyond.

Then we too emerge onto the summit ridge and into the blaze of day. To the north, warm yellow light floods across hillsides of brown, green and red, and showers with diamonds countless blue lochans. To the south, the ridges cast into the valleys slanting shadows, as dark as the thoughts of a jealous god, which lie heavily upon unrippled pools of black mercury, each connected to the next by a meandering thread which leads, finally, to the still, pale sea. Ben Nevis, 60 miles away, presides over the serrated horizon. Skye, Harris, and Lewis languish, becalmed on the benign ocean.

Perched on luxuriously soft cushions of bone dry moss, we eat hugely, and round it off with a very tiny dram. We have seen no-one since we left the road four hours ago, nor will we meet any other soul when in the thickening of the light we make our way back. We doze a little, take pictures, and just look. Shadows of the mountains march over the moor, heralds of night. Reluctantly, we start down. In the last glimmer of day, a kestrel hovers momentarily over the path, an impossibly delicate apparition, then darts off upon his own buisiness.

In the wilderness, the cycles of days and seasons intersect with the long rhythms of geology and the preposterous transience of lives, as a cathedral, where we may aspire to a moment of calm, ironic joy in which the perfect indifference of things stills the hectic gush of generations.

The Gairloch Estate proposes to alter forever the valley, or cathedral, into which we gazed from the top of our walk, by bulldozing, pipelining, raising and lowering water levels, constructing weirs, and building a generating station.