All letters are subject to editing and may be shortened. Letters should be sent to the *BJGP* office by e-mail in the first instance, addressed to **journal@rcgp.org.uk** (please include your postal address). Alternatively, they may be sent by post (please use double spacing and, if possible, include a MS Word or plain text version on an IBM PC-formatted disk). We regret that we cannot notify authors regarding publication.

Status of the *Occasional Papers*

In the 2001 James Mackenzie Lecture by Professor David Mant, published in the July issue,[1] it is stated that *Occasional Paper 25* was 'The RCGP's response to the Black Report' and comments are made.

This *Occasional Paper* was not a formal response from the College; on the contrary, it was an individual manuscript written by the late Dr Donald Crombie[2] and arose from his McConaghey Memorial Lecture of 1983. Dr Crombie and Professor Mant both had freedom of speech in their eponymous lectures but as individuals, not as organisational representatives.

This *Occasional Paper* included the statement '*Occasional Papers* are discussion documents and opinions expressed in them are those of the authors and should not be taken to represent the policy of the Royal College of General Practitioners unless this is specifically stated'.

SIR DENIS PEREIRA GRAY
Honorary editor, RCGP *Occasional Papers*, 1976-2000.

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The future of *Hoolet*: Scottish magazine of the RCGP

I note with sadness the lukewarm backing for *Hoolet* magazine from Scottish Council of RCGP. For many years the Scottish GPs have had the benefit of a lively additional magazine as part of their College membership. It is a great magazine fulfilling a need not met by other publications, and has a relevance far beyond Scotland.

I see *Hoolet* as a magazine for ideas in general practice. It is well written and spirited. Opinions are owned by individual authors, and I sense a lot of power emanates from this forceful subjectivity. There is but little truth in many statements that begin, 'There is.' And I yawn when I see 'this suggests that it might be the case... that further research is needed.'

When views are owned and clearly expressed they are more understandable and the reader has to think about how to respond to them. Getting the reader to think and respond is the art of good writing and the beginning of learning. Think of authors like James Willis and Julian Tudor Hart in full flow.

Hoolet is a great forum for launching new writers and floating new, and not necessarily fully developed, ideas. It is not going to have the exactitude of a report of a clinical trial. However, not everything that really matters in medicine (or life) can be reduced to such an 'either/or' RCT scenario. Many important aspects of medicine are at best observable, and often happen below the level of conscious awareness. It is here that a journal that can shine light into these hidden corners and suggest new ways of seeing things can come into its own.

Hoolet helps take us away from the tyranny of objectivity. Many of the concepts we discuss intensely are anything but objective, tangible or definite. We need a forum to discuss such concepts because they matter deeply, although they may not be material!

I think *Hoolet* needs to fly its Scottish nest and become a UK-wide magazine, probably as a supplement to the *BJGP*. If used well it could become a national magazine of new thinking, new writing talent, and point the way forward to progress in general practice, anticipating the arrival of formal proofs of ideas by several years.

Does the College have the courage to take *Hoolet* forward? I hope it will have the courage to accept the opportunity offered by *Hoolet*.

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Telephone consultations

McKinstry and Walker[1] question the time saving suggested in our recent paper on telephone triage.[2] We can confirm that there were no partnership changes in the participating practice for the duration of the study. While the overall provision of appointments remained unchanged, one-third of all appointments were strictly embargoed for use by the GPs following triage. Receptionists were not permitted to book these appointments without reference to a GP. This removed the need for patients to negotiate with receptionists about the need for an urgent appointment and placed this responsibility with the GP. This aspect made the study very popular with receptionists who are noted to report finding appointments a major source of stress in their work.[3] Phone calls were made by GPs during scheduled breaks in their routine surgery. All appointments in the surgery were set at ten minutes and most phone calls were significantly shorter. GPs who did not invite patients to attend for an examination could in theory finish surgeries before colleagues who were more inclined to offer a face-to-face appointment. The telephone triage service was not advertised and there were regular meetings with receptionists to ensure that the service was not being abused by patients who were repeatedly using the service to access GPs on a same-day basis when they could

more appropriately have booked a routine appointment. We did not perceive any significant increase in the number of phone calls during the study period. Nevertheless, we acknowledge the need for further research in this field including efforts to benchmark the quality of telephone triage and the need to investigate if some patient groups are disadvantaged by the practice of offering telephone consultations.

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Headache

O'Flynn and Ridsdale's discussion paper identifies an important gap between the impact of headache and the resources directed to research in the area.[1] They argue that it may be wiser to target clinical effort on patients with severe problems.

We report a study that aimed to establish the impact of headache on primary health care staff against the background of a recognition of the importance of occupational health to the primary care sector.[2]

Two hundred and seventeen questionnaires were sent to medical and non-medical staff of four Exeter practices asking them 'Do you have headache that affects the quality of your life?' One hundred and seventy (78%) questionnaires were returned. Assuming that non-responders did not have a problem, 69 (32%) suffered from headache that affected the quality of their life, 21 (30%) of the positive responders had seen a doctor for their problem, ten (14%) had more than six headaches a month and four (6%) had headaches on more than 15 days of each month.

The headache group had a Headache Impact Test[3] score of 54 (±8.2) in an instrument where a score of 56 or above shows a substantial impact on quality of life. The MIDAS score,[4] a sum of the number of days in a three-month period on which productivity at home or work or social or leisure activity was affected due to headache, was 5.7 days per person. Extrapolating the MIDAS scores to a period of one year, 40 days of work were missed and 304 days of productivity were reduced by half or more annually across the four practices.

In summary, we have identified a high unmet need, with significant impact on quality of life and reduction in productivity, in headache sufferers. We would suggest that many of the population have 'severe headache' and do not present to primary care services. We must ensure that these patients are not discouraged from discussing their problem with their doctor by a policy aimed at targeting the few with severe problems.

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X rays for back pain

The editorial[1] concerning the two papers published in the August issue of the *BJGP*[2,3] is academic, as is appropriate, considering its origin. In practice, face to face with the patient, the ideal guidelines recommended by the various bodies are harder to achieve.

Professor Little states that 'the paper by Hollingworth *et al* confirms a very low yield from X-ray (approximately 2% of significant pathology)'. This figure may seem small but, to these 2%, the results are significant. However, when the paper itself is examined, in 48% of patients there are findings, which may or may not have a bearing on the patients' symptoms. Even the normal ones are useful from the point of view of diagnosis.

Professor Little also states that 'it is difficult to justify a modest improvement in psychological wellbeing'. This suggests the psychological wellbeing of the patient to be of little importance. It underrates the power of human emotion.

He is also concerned about unnecessarily 'medicalising' back pain. The patient has already 'medicalised' the condition by attending the doctor. If the doctor does not listen to the patient, then there is the danger of the patient being trivialised.

Professor Gordon Waddell states that 'serious spinal pathology accounts for less than 1% of all back pain'.[3] This leaves 99% for the GP to diagnose and handle. Over 40 years of practice, I found the concept of facet joint pain as against disc pain to be useful.[4,5]

The patient has back pain compounded by his worries about what is causing the pain. One patient with arthritic back pain said to me that it must be cancer because it is so sore. People equate cancer with pain and pain with cancer. And to wait six weeks with such a doubt would be callous.

When in practice I would give a patient a good deal of time, listening, examining and outlining a regime on back care. In Australia, if I did not do an X-ray, the patient would go to the chiropractor and have one taken. In Britain, with six or ten-minute consultations, it would be quicker to cut corners and have an X-ray done.

In addition to the patient's worries are the doctor's worries that he might miss something, especially in the present climate of increasing litigation. Thus, to the patient's psychological wellbeing can be added the doctor's psychological wellbeing. By implication, a 'common or garden' GP is not as intelligent as a university professor and is more prone to self-doubt.

Balancing the patient's fears of seri-

ous illness and the doctor's fears of being sued, against the vague risk of a possible increase in the chance of cancer, taking an X-ray is the likely outcome.

A way of cutting down on the number of X-rays would be to make them unavailable to the patient by means of cost and/or distance. In a small village in a developing country, where the nearest X-ray unit was 50 miles away, few X-rays were done, which was a problem in a region where TB was prevalent.

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Postnatal depression and SIDS

Sanderson, *et al*[1] have demonstrated an association between postnatal depression and sudden infant death (SIDS). Their discussion speculates on causation, suggesting that either maternal depression leads to SIDS or that babies at risk of SIDS cause maternal depression. Remarkably, in a study that excluded participants who had not shared a physiological environment within the preceding 12 months, the possibility of a common cause for both conditions was not considered. Perhaps both conditions could be improved were we to develop a better understanding of their relationship to the antecedent antenatal environment.

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The map is not the territory

I am grateful for the splendid and insightful articles in the August issue of the *BJGP*[1-3] that explore the mental territory of general practice. All concern various aspects of how GPs might perceive themselves and their role in the context of today's health service.

I would like to add another dimension from the work of Alfred Korzybski on general semantics.[4] Semantics explores the meanings of words. In his theory of general semantics Korzybski explored the relationship between a word and the actual reality it related to. He concluded that a word was a representation of a thing, not the thing itself. The analogy he used was of a map that is a representation of the territory but not the territory itself. The usefulness of the map depends on how accurately it corresponds to the territory being traversed.

In our day-to-day life we build mental maps of the territories we are crossing. We build up representations of what 'a manager' or a 'typical GP' will be like and should be like. The reality is often surprisingly different from our preconceptions, and success on traversing the territory depends on being able to rapidly and flexibly resurvey our maps to adapt to new perceptions.

I sense that all the participants in the drama of the NHS are probably using outdated mental maps of each other and this can result in mutual incomprehension. To achieve progress, with the necessary personal and group adjustments we are going to have to make, we need to learn to align our mental maps with those of the other players in the drama. Likewise, they will have to learn to adjust their maps to ours.

When the maps match we will have incorporated the perceptions of all the relevant players into a much more powerful and unified group-map and culture. Achieving this would be a great step forward for GPs, managers and patients.

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Editor's note

It is not open to an English editor to comment on the actions of Scottish Council. But I thought the agenda outlined by Peter Davies was precisely that being addressed by the Back Pages. Or have I missed something?

Community-oriented primary care

I enjoyed the article by Iliffe *et al*[1] and the accompanying editorial by Alasdair Honeyman.[2] The publication of a methodologically less conventional study is refreshing and does the *BJGP* credit. We experienced considerable difficulty finding an outlet for an earlier evaluation of application of community-oriented primary care (COPC) in 11 British general practices.[3]

We also found that selected general practices could develop and implement innovative primary care services addressing locally identified needs. Furthermore, even including costs of training and support, our primitive economic analysis suggested that benefits outweighed costs. However, we also found that public involvement at all stages of the COPC cycle was limited.

In addition to the barriers that Iliffe *et al* listed, the availability of a managerial champion in the local health authority (with access to finance, information and public health support) was a major determinant of success. Practices engaged in COPC benefited from opportunities to liaise with one another.

Fundholders, able to channel resources of their own into their chosen project, advanced further, and the COPC model may have particular resonance for more autonomous personal medical services practices. While no single element of the COPC cycle is entirely unfamiliar in the context of British primary care, the approach has

continuing relevance for primary care trusts. It provides frameworks for in-service training that can strengthen public health skills in general practice.

Honeyman's editorial points astutely at some of the limitations to this and any other 'new' model of care. Was it HL Mencken who said that for every difficult problem there is a simple solution — and it's wrong? The latest fads, such as breakthrough collaboratives, offer attractive panaceas for managers in search of swift solutions. They invariably fail to live up to unreasonable expectations. Complexity theory helps us understand why, and should make us wary of 'projectitis'. Communities of practice are part of a more sophisticated model of organisational development. One part of their intuitive appeal lies in their acknowledgement that different professionals within the organisation cannot avoid spending high quality time with one another. Honeyman's proposals have implications for all those struggling to give shape and coherence to the latest embodiment of the primary care-led NHS. As yet, these collectives of practices controlling 75% of NHS resources have yet to engage those who are ostensibly leading them.

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Editor's note

My memory of the quotation goes something like: 'to every complicated question there is an answer that is simple, straightforward... and wrong.' Repeated searches in books and on the web have failed to locate its source. Can any reader enlighten me and Steve Gillam?

Patient-doctor relationship: Duet or duel? A physicians' perspective

The promotion of a balanced doctor–patient partnership is still in its infancy in Latin countries and, while more advanced, remains at an unsatisfactory level in Anglo-Saxon countries.[1] Many obstacles hinder development of a mature, consensual partnership.[2] We believe a key role is played by lack of awareness of mutual problems and real motivations.[3]

Little is known about what doctors actually think about patients' behaviour, and this tends to circulate almost entirely underground. On this premise, we explored the opinions that Italian public primary care physicians have about patients, in order to help clarify some of the unpleasant situations encountered in the doctor–patient dyad. A pilot analysis is presented.

A focus group formed by Padua GPs was conducted.[4] A list of three key discussion topics was drawn up and used to direct focus group discussion. The topics were: the ideal patient; the real patient; and suggestions for solving problems.

Ideal patients emerged as the ones who trust and respect their doctor, who was chosen in full consciousness. They went to their doctor and listened to their ideas, aware that they might have received incorrect information from other sources. Inappropriate behaviours were believed to reside in: lack of knowledge about the role of GPs; widespread misinformation (such as regarding the need to motivate refusal to refer patients for inappropriate procedures); unwillingness to comprehend institutional settings; and sometimes to accept a doctor's judgment regarding a diagnosis or urgency level.

Suggestions for improvement were chiefly based on the promotion of health education and information/clarification campaigns, the teaching of communication skills to doctors, and creating opportunities for patients to more carefully select their GP.

Despite its limitations, our qualitative exploration (which will need a larger study design) reveals a series of apparently conspicuous drawbacks in routine medical practice, probably not easy to manage. This poses problems of: excessively high user expectations and the tendency to take every pathological event to extremes, and blame the health service for lack of solutions;[5] the difficulties present-day physicians face, on the one hand, in abandoning their paternalistic role, while avoiding unreasonable requests, and — on the other hand — in keeping it, with all the ensuing legal pressures and perception of the system's complexities; sociological phenomena, such as the desire to have 'everything at the click of a finger', typical of younger generations.

We do not consider removal and denial to be the best strategy. Openly comparing opinions would be challenging, but would make a contribution to the propitious achievement of partnership.

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Correction

In the September issue of the *BJGP*, the paper by Siriwardena *et al* (*Br J Gen Pract* 2002; **52:** 735-740) had Table 3 accidentally omitted from the text. A correct version of the paper will be available on the *BJGP* website (www.rcgp.org.uk). We apologise to the authors for the omission, and to readers for any confusion this may have caused.