The Back Pages

viewpoint

Time to counter 'fever phobia'!

In general practice there are always phone calls and requests for visits to young children with fever. Usually, the parents or carers tell the health professional that they have given paracetamol (acetaminophen), but despite this the child is still feverish. They might even have tried stripping the child off, putting a fan on them or sponging them down. Parents do these things because of standard advice from most doctors and nurses. However, is it humane, in our northern climate, to strip our children naked, sit them in front of a fan, or douse them in tepid water? We don't do these things to adults, so why to our children? Nor is such advice logical — after every attempt to lower the temperature, the body will try to raise the temperature again. This adds to cycles of worry in parents and carers.

This fever phobia is maintained because of misconceptions held by health professionals. There is still a belief that fever can cause serious harm, such as brain damage and death.[1] However, there is a growing body of evidence that fever is a routine feature of self-limiting infectious illnesses[2] and that there may be an evolutionary advantage to fever.[3] Advice to parents from health professionals should reflect this evidence. There may even need to be a public health campaign to educate both professionals and the public at large on the benefits of fever in children.

Additionally, we should revisit the old orthodoxy that infections are always by definition A Bad Thing. Should, for example, the mission statement of the Public Health Laboratory still be 'Protecting the population from infection'? In fact, early childhood infections (and fevers) may have a protective function against autoimmune and allergic diseases.[4]

Then there are questions relating to our enthusiasm for paracetamol. Paracetamol is not a very safe drug, and is associated with morbidity and mortality.[5] Many over-the-counter preparations contain paracetamol and there is a risk of unintentional overdose.[6] Nor is it effective — evidence that paracetamol has a superior antipyretic effect to placebo is inconclusive.[7] The working mechanism of paracetamol is unknown. Paracetamol may also increase mortality in severe infection, prolong infection, reduce antibody response in mild disease,[8] and frequent use may contribute to asthma morbidity and rhinitis in adults.[9] Rather than recommending the use of paracetamol, should we not be restricting access, in the same way as we do with aspirin?

A consistent message from health professionals is needed.[2,10] We should explain that it is good to have a fever. Reassure the caller that temperatures do not go up and up and up till death ensues, but that fevers plateau out. Separating the well from the unwell child remains a key issue. Ensure that dangerous, underlying conditions, such as meningitis, are unlikely. Can the child sit upright with legs stretched out on the bed? Can the child look down at their belly button? Is the fever associated with a rash, particularly a non-blanching rash? Febrile convulsions (the other worry) usually happen before fever is apparent and then only in the first few years of life. Parents can be reassured that convulsions will not cause disability. In children who are too young to communicate, one should feel the hands and the feet. If cool it will be more comfortable for the child to be kept warm. If warm and the child is uncomfortable, people should respond as they would when caring for themselves.

Fevers are part of growing up. More and more evidence is emerging to show that early childhood infections can be beneficial, not only physically but possibly also psychologically.[11] Public health advice should help to make parents and health professionals confident, not frightened, and should be evidence-based.

Wouter Havinga

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"Every profession has its powder keg issues, the elephants that sit in the corner of any discussion, unacknowledged but dominating what can and cannot be said. In primary care there is no topic so complicated and so crammed with unnamed elephants as that of GP remuneration... "

Paul Hodgkin, on the vicissitudes of GP pay, page 259

"Independence is not only good for doctors — it is essential for patients who increasingly need an independent voice in an imploding NHS beset by political correctness, spin and frank lies!"

Brian Keighley, wielding his elephant gun, page ***

contents

viewpoint 2

Another conference report (with a message...)

LAST month I was invited onto a panel at a conference organised by the Naz Project,[1] a voluntary group forwarding the interests of those with HIV infection from Southern Asia and Middle Eastern, North African, Horn of Africa, and Latin American countries.

The conference, entitled 'Safe Haven? Immigration, Asylum and HIV', aimed to address 'critical issues affecting people living with HIV and insecure immigration status or seeking asylum'.[2] The day was spearheaded by George Alagiah (from BBC Television news) and he asked that we look for 'sound dispassionate information' about issues relating to asylum seekers and refugees, and that we should be aware of the 'deep unease' with which such topics are being debated in the current climate. I work in a practice where we have always signed on asylum seekers and refugees — a needy group no less deserving than other vulnerable groups in our area.[3,4]

The conference had an unusual format: in the morning, a couple of narratives in the form of two short performances, one of which was a heartfelt story of an African woman who had arrived in this country with nothing bar her clothes. The other consisted of a young bisexual man talking to a hospital voluntary worker and explaining that if anyone was caught with HIV drugs in Colombia they would be summarily shot — a macabre public health initiative designed to eradicate HIV. This was the reason why he sought asylum in the early 1990s.

Then a panel discussion followed around several issues, such as entitlement to health care, finding friendly GPs, and the special needs of women, children — indeed whole families with HIV infection — both inside and outside of London. In addition, the question of mandatory testing came up several times.

Several points are worth noting. Apparently, the Home Office are sending letters to doctors asking for information regarding a patient's HIV status and, worryingly, their progress in terms of combination therapies. Secondly, since 8 January this year, asylum seekers who do not state their claim on arrival will not be eligible for basic welfare provision, including food and shelter.[5] Lastly, it was reported that many patients — irrespective of their migration status — could not register with a general practitioner. This seemed to be worse in inner cities, but not always.

Please stop and reflect on these issues. If the Home Office send you a letter then you should ensure that you have the consent of the patient; if you don't then you should return the letter to the Home Office, asking them to obtain permission. A leading barrister at the conference noted that this letter implies that doctors are 'obliged to answer such questions'. However, what about patient confidentiality? To be truthful, I'm not even sure we ought to be sending such clinical information to the Home Office anyway; perhaps the defence bodies can advise on this. As you can guess I have not received one yet; however, I am determined not to divulge without informed consent.

On the subject of closed lists, I suggested that in areas where registering with a GP is a problem then the local primary care organisation (PCO) should be notified. This may well mean patients or families being allocated, but at least the local PCO know about the numbers who need GPs. Of course, if other systems are in place, such as Personal Medical Services practices, then local GPs ought to be informed anyway.

One last plea — resist the call for mandatory HIV testing. This is not the way forward, even if I could work out the logistics of such a programme and what happens thereafter (who do they test — men, women and children with foreign-sounding names, or people who just look strange? What happens to the results and who else is informed?).

I realise that some of these issues are highly sensitive; the global trafficking of people is one of the most serious problems to affect all developed countries currently.[6,7] I also know that NHS resources are tight, perhaps becoming tighter as expectations continue to rise along with health care costs.

The simple fact is I can't quite believe that this government is behind such thinking. My one abiding memory from the conference is the lady from North Africa who was in tears, as she recounted her bitterly painful story of arriving in the United Kingdom and being abandoned by her companions. As the fourth richest country in the world, surely we can devise a humane system which is rigorous enough to sift out those who shouldn't be here and those who are in genuine need of asylum and help?

Surinder Singh

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2nd International Shared Decision Making Conference

This event will take place from **2–4 September 2003 at Swansea Clinical School, University of Wales Swansea, Singleton Park, Swansea SA2 8PP**, and has been organised by Dr Glyn Elwyn and Dr Adrian Edwards (University of Wales Swansea); with Dr Angela Coulter (Picker Institute Europe), Dr Theo Schofield (Ethox, University of Oxford), Dr David Pink (Long Term Medical Conditions Alliance), and Dr Aileen Clarke (Society for Social Medicine).

The conference will be opened by the Chief Medical Officer of NHS Wales, Dr Ruth Hall, with keynote speakers including:

Professor Annette O'Connor (Canada Research Chair in Health Care Consumer Decisions Support, and Professor, University of Ottawa), and **Professor Albert G Mulley, Jr** (Chief, General Medicine Division, and Director, Medical Practices Evaluation Center, Massachusetts General Hospital)

To submit abstacts or to make general enquiries, please visit **http://extraweb.swan.ac.uk/sdm_conference/**

Sixth WONCA World Rural Health Conference

This conference will be held in Santiago de Compostela, Spain, from 24–27 September 2003. The main conference theme will be 'Rural Health in a Changing World', with the scientific, professional, and cultural programmes reflecting the link between culture and medicine and the ancient principles of pilgrimage and renewal. The main scientific programme will focus around ten key themes:

1. The changing countryside;
2. The urban rural debate;
3. Peoples and populations at risk.;
4. Common problems in rural practice;
5. Technologies in rural health;
6. Developing a responsive and sustainable rural workforce;
7. Farming, rural industries and occupational health;
8. Public health and the rural practitioner;
9. Research in rural practice; and
10. EURIPA and the rural practitioner in Europe.

For further details on submission of abstracts, visit **http://www.ruralwonca 2003.net/**

flora medica theophrastus bombastus

From the journals, January 2003

***N Engl J Med* Vol 348**
15 Potentially great news for sufferers from multiple sclerosis and Crohn's disease (see page 24): monoclonal antibodies against α-integrin seem to be highly effective in small, short-term studies. Well tolerated too. Natalizumab is a name you may have to remember.
42 The *N Engl J Med* may cultivate an air of sophistication but it often contains good reviews of bread-and-butter clinical problems: this one covers falls in the elderly. Unfortunately most interventions don't help.
109 Ethanol is the most effective drug we know for preventing myocardial infarction, but it does have adverse effects; and this study shows that it needs to be taken 5–7 days a week.
195 A landmark study of imaging in childhood urinary tract infection (UTI). Most of it may be unnecessary, but always send off an mid-stream sample of urine if a child has had a previous UTI. Worth keeping a copy of this paper and the editorial (page 251).
236 If there is doubt about suspected appendicitis, computer tomography (CT) can help sort it.
287 Too much retinol can make your bones brittle, so go easy on the vitamin A.
383 The Danish STENO-2 study was a sort of smaller, shorter UK Prospective Diabetes Study, and its message is the same: if you have type 2 diabetes, your blood pressure and cholesterol need reducing as much as possible.
433 PMT, PMS or PDD? This useful review calls it premenstrual dysphoric disorder, and suggests that selective serotonin reuptake inhibitors (SSRIs) can be effective taken during the second half of the cycle only.

***Lancet* Vol 361**
13 The best treatment for acute myocardial infarction is primary angioplasty, as shown by this definitive systematic review.
51 The common cold gets a seminar. But if you want relief, try zinc nasal gel (*QJM* **96:** 35–43).
107 Confused about the indications for carotid endarterectomy? Here's a well-presented analysis of all the trials, showing benefit in symptomatic patients with stenosis of 50%–99%.
151 Atopic dermatitis gets an excellent update here: look out for staphylococcal infection on the weepy bits and fungal growth on the flaky bits.
195 Does screening for retinopathy in type 2 diabetes really need to be annual? Probably not if the retina looks normal.
288 Single mothers in Sweden get much better support than in the UK, but their children still have higher rates of sickness, injury and death.

***JAMA* Vol 289**
56 Sildenafil works well for erectile dysfunction associated with SSRI antidepressants.
65 Another possible use for angiotensin receptor blockers: the prevention of migraine.
179 Population data from the United States showing that influenza is associated with three times the mortality of respiratory syncytial virus, except in the first year of life.
187 An important reference paper charting years of life lost due to obesity in the USA. For Dutch data, see *Ann Intern Med* **138:** 24-32.
313 Will it ever be worth screening for lung cancer using helical CT? Just possibly, if you're a chain-smoking millionaire: otherwise the cost-benefit ratio is dismal.
323 Whereas brisk walking is free and helps obese ladies lose weight.
324 Career satisfaction among US doctors is related less to income than to professional autonomy, patient satisfaction, and the ability to deliver high quality care.

Other Journals
***Arch Intern Med* 163: 59-64** concludes that SSRIs do cause gastrointestinal bleeding, especially in combination with non-steroidal anti-inflammatory drugs or aspirin. Using the highly specific cardiac troponins, a study (pages 165–168) shows that influenza rarely causes viral myocarditis. Paracetamol proved useless in a study of knee osteoarthritis, whereas diclofenac helped (pages 169–178).
***Ann Intern Med* 138: 10-16** confirms that elevated pulse pressure predicts heart failure better than systolic or diastolic blood pressure. If the thrombophilias confuse you, there is a simplified guide on pages 128–134.
***QJM* 96: 45-52** looks at trends in myocardial infarction: it may be on the wane, but seasonal patterns are unchanged.
A big Oxford study of cognitive function in the elderly (OPTIMA) reports an association between high homocysteine and memory loss (***J Am Geriatrics Soc* 50: 2014–2018**).
Smoking reduces arterial elasticity and raises pulse pressure even in young people (***Hypertension* 41: 183–187**).
'Doctor, do you think I should have Shreddies or All-Bran for my breakfast?' You won't be lost for an answer if you are a regular reader of the *Asia-Pacific Journal of Clinical Nutrition* **11: 274–284** (Dietary fibre content and nutrient claims relative to the bulking efficacy of breakfast cereals.).

Plant of the Month: *Helleborus thibetanus*
A little hellebore of recent introduction: its nodding pink flowers make most of the oriental hybrids look blowsy.

An oral history of general practice 10: Diagnostics and therapeutics

Audio extracts from the interviews can be listened to as sound files on the ScHARR website:

http://www.shef.ac.uk/~scharr/hpm/GS/

In a study published in 1988, Bosanquet and Leese found that younger general practitioners were much more likely to invest in, and pursue innovations in, their practices than were their more experienced counterparts. These authors described older doctors as more 'traditional' in their attitudes, with a firmer commitment to home visiting. Bosanquet and Leese's study is both exceptional and somewhat limited by its health economics perspective.[1] The question remains open as to how GPs, younger or older, locally or nationally, individually or in groups, have responded to the challenge of biomedical and technological change as it impinges upon their specialty. Has general practice kept pace with biomedical science? The history of this aspect of general practice remains to be written.

Both retired and older working doctors in the Paisley project[2] argue that one of the most important changes in their clinical practice has involved gaining access, from the mid-1960s onwards, to a range of hospital-based aids to diagnosis. First and most important was radiology, followed by laboratory facilities for haematological, and other similar, testing. These same doctors also recall that a number of practices in the town had made provision for laboratories in their premises, although not all were convinced of their usefulness and few would claim that tests carried out within practices were as reliable as those conducted in the hospitals. Open access to laboratory and technological aids to diagnosis was particularly significant in Paisley, given that GPs in the town were in the process of resisting attempts to move their practices into two large centres.

While a growing range of hospital-based diagnostic procedures became available to GPs in the 1960s and 1970s, open access was not established as a principle, and the deployment of some diagnostic technology continues to remain in the gift of secondary care. There is also a great deal of frustration among Paisley's doctors that some investigations are thwarted by the lack of resources and the resultant long waiting times. Examples mentioned were psychiatric assessments and barium investigations of the gut.

Furthermore, the skills required in dealing with uncertainty in diagnosis and treatment continue to be valued by GPs, some of whom voice concerns that intrusive diagnostic investigations may cause more harm than can be justified. There are doctors who continue to believe that part of the role of primary care is to defend patients from the excesses of hospital medicine.

Those practitioners currently in mid-career, or beyond, have experienced a therapeutic revolution.[3] While being interviewed, they would often recollect the innovations in surgery and pharmacology that had occurred in the course of their careers. Most commonly listed were elective heart surgery, improved pharmacological control of blood pressure and asthma, the revolution in the understanding and treatment of peptic ulceration, and the impact of non-steroidal anti-inflammatory drugs. Above all else, however, it is the move from curing to long-term caring in primary care that the practitioners discuss and, in particular, the difficulties that this has entailed in the context of earlier hospital discharges, tighter budgetary control, and rising patient expectations.

The oral evidence also suggests that mental illness continues to pose particular challenges in general practice. Even after the introduction of more effective psychotropic agents, from the 1960s onwards, many GPs found the treatment of the mentally ill difficult. Our Paisley study suggests that, whereas female practitioners were often more willing to advocate a holistic view that embraced the management of psychiatric conditions, their male colleagues were much more likely to state a strong preference for treating physical illness. Indeed, hostility towards psychiatry, both during education and in practice, was evident among male GPs of all ages. There were of course notable exceptions to this and the oral evidence also suggests that particular group practices from the 1980s onwards developed a more positive approach to mental health, including a willingness to engage with drug dependence, self-harm, and similar issues.

Similarly, some partnerships were historically much more likely to be interested in purchasing diagnostic equipment. Conversely, other partnerships exhibited a tradition of concern that a greater emphasis on technology might devalue the patient-centred art of medicine. There may, indeed, be some evidence that GPs with positive attitudes towards caring for mentally ill patients displayed less enthusiasm in adopting new technology, while those who were most keen on technical innovation were not as comfortable in treating mental illness.

One of the most significant changes in the way GPs understand disease has been in the development of a greater emphasis on preventive medicine and, more recently, on health promotion.[4] For some of Paisley's doctors, however, early enthusiasm for population-based initiatives has given way to cynicism and anxiety that some screening programmes may be ineffective or intrusive.

As in Bosanquet and Leese's study, Paisley's younger GPs expressed a greater interest in new developments. Older practitioners can, however, often recall that they displayed a greater commitment to change at earlier points in their careers — to the improvement of record keeping systems, for instance.[5] Doctors who were in mid-career and beyond also argued, however, that their conservatism was born of bitter experience. They cited the difficulties of managing patients dependent on sedatives, coupled with the impacts of drug scares, most notably thalidomide.

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6. GPP 30.
7. GPP 15.
8. GPP 30.
9. GPP 07.
10. GPP 21.
11. GPP 18. GPP 02 makes a similar point.
12. GPP 10.
13. GPP 09.
14. GPP 05.
15. GPP 21.
16. GPP 04.
17. GPP 22.
18. GPP 09.
19. GPP 28.
20. GPP 02.

The oral evidence

Older doctors identified similar changes in the recent history of clinical care in general practice.

Stewart McC: *'When I started in practice* [in the late 1960s] *it was x-rays for example. You could send a patient up with an x-ray card on a Wednesday afternoon and get a chest x-ray … or whatever bone or joint x-rayed … Wednesday afternoon was the only time that was open to GPs. Now of course … we have much easier access to the hospital in general, you know.'*[6]

Donald W: *'We didn't have open access to x-rays in the 60s. We didn't have open access for bloods … If I needed somebody's chest x-rayed I sent them to the chest clinic. If I thought somebody needed their bloods done then I had to send them up to the medical clinics … The other thing was people's illnesses weren't really documented in their records … Mrs So-and-So is hypothyroid, because my partner's got her on thyroid tablets … Now the clinical diagnosis has been made by my partner some time before … but if you want this documented then get the various tests done … by referring them. And a lot of that went on'.*[7]

Stewart McC: '*Therapeutics have* [also] *changed a lot … There are lots of conditions that have been around for a long time that we really could do very little for and now there are ways of dealing with them. One very simple example of that is if you look at peptic ulcer disease … People don't do gastric surgery nowadays, you know, they don't do vagotomies or pyloroplasties. I don't know when the last one was done but you know it was a long, long time ago and then even better proton pump prohibitors you know and now somebody's discovered* Helicobacter.

'… The other thing, which in terms of therapeutics has been helpful, is the development of sustained release … Most people remember to take a drug once a day.'[8]

Changes in drugs therapeutics presented a particular challenge for Robert E and his partners when they took over a neighbouring doctor's list on his retirement.

Robert E: *'…The old barbiturates were disappearing* [and] *… the number of patients that he had started on barbiturates as sedatives before the war and were still taking them! … The number of patients he had who were taking one or two tablets … at bedtime. Thirty years you're talking about … I remember enthusiastically trying to wean them off to begin with and then I gave up. In view of the fact that they obviously weren't needing increased amounts, I just gave in and gave them scripts …*

'… I never really wanted to be the first to do anything. Eh, I didnae want to be the last to give anything up … With regard to things like treatment for lowering blood pressure … I think I was quite enthusiastic at trying everything that was new, when I started off, and became more circumspect in later life.'[9]

Some changes have been less visible to practitioners, including the growing acceptance of psychology and psychiatry in some practices.

John H: *'I don't have any hostility towards psychiatry. In fact we do a lot of psychiatry in here. We're high prescribers of antidepressants …'*[10]

Linda F: *'I mean my own feeling would be that no-one should be able to go into general practice without having done six months in psychiatry. That's my own personal bugbear.'*[11]

This is despite the continuing opposition of some male doctors of all ages.

Charles McC: *'The one that really got up my nose was psychology. I mean I think it happened to the whole class.'*[12]

David D: '*I just completely hated psychiatry and that was a serious low point in my career'* [laughs].[13]

Brian R: *'But psychiatry and I didn't get on, because I like to have things regimented and ordered and psychiatry is not like that. In fact I got a pass/fail oral in my psychiatry, which was a bit of a shock to me.'*[14]

There were also practitioners who expressed an enthusiasm for technological development. John H, for example, recalled a senior partner in a practice in which he himself was once a partner:

John H: *'His idea was to have almost a kind of one-stop place there where you would have an ultrasound machine and you would be able to do everything for the patient on the premises. And I think that's fine, I think that would be a good way, but only if that's the way things go … But I think we're more generalist here. I think it's more relaxed here as well.'*[15]

Such enthusiasm was particularly evident among younger GPs.

Graham D: *'Well I think things like it would be nice to get a new ECG machine, ehem Histofreeze, we use Histofreeze just now, but we'd like to use liquid nitrogen minor surgery. In fact I've got my list sitting up on the wall there. Doppler ultrasound for pulses, liquid nitrogen, angle-poised lamp, fluorescein lamp, step for the couch, autoclave, vaccine fridge, things that you have principally. So that was it, we're not having a swimming pool out the back for our benefit. I don't think my senior partner would wear that at all.'*[16]

Others were less sure.

Colin R: *'And I was doing a lady's tummy one day and the baby spoke to me. I don't know who got the biggest fright, the mother or me. In thinking about it, presumably we picked up a taxi who happened to be on the radio at the time I switched on. But it was* [sighs] *there was really honestly voices came out this damn thing.*

'I mean I switched on the Doppler, which is just a wee ultrasound thing, and there was voices came out of it. So the only thing we could think of was it was a taxi or a police car or somebody on the radio had just at the right time. We picked up this — as I say the mother nearly fair came off the blinking couch.'[17]

David D: *'I'm referring people with a diagnosis now more often than for investigation. I think that is something that's changed … I think I'm probably referring people with a much clearer idea of what I'm expecting a consultant to do… There's always a danger that you can get too caught up in investigations just for investigations' sake. And if you make expensive investigations too available then I think that there is a risk of that. I could be guilty of that but I can think of other people that would be a lot more guilty of it.'*[18]

There are other changes to contend with.

Fiona T: *'No I don't think, health promotions sort of eh, was a, was an issue when I started* [in the early 1980s] [laughs]. *So that's a big new area and it's something that we're currently looking at.'*[19]

Christopher J: *'I remember health screening, even when the contract came out in 1990 you know, everybody had to have a three-yearly health check and some people believed it was a good idea and did these things, there was no evidence for it at all, eventually it just got dumped, but we just didn't do it at all.*

'… It's all part of this health police stuff and health promotion and doctors controlling your life as to how you should behave. We'll all be wearing little black uniforms, little HP insignia and peaked caps and we'll be going down the street taking people's cholesterol in the street and if it's over 6.5 put them in jail or fining them for having high cholesterol or whatever.'[20]

Graham Smith
Malcolm Nicolson

polemic

GP pay — naming the elephants

For the past 40 years, the way GPs are paid has ruined the development of teamwork in primary care. Every profession has its powder keg issues, the 'elephants' that sit in the corner of any discussion, unacknowledged but dominating what can and cannot be said. And in primary care there is no topic so complicated and so crammed with un-named elephants as that of GP remuneration. As the high noon of the new contract draws near, let's haul a few of these elephants into the daylight in the hope that we can generate a way of paying GPs that is fair and equitable for GPs and for the rest of the team as well.

The elephant that rankles most with our colleagues is the way GPs generate personal income from the work of others. Health visitors and nurses give almost all childhood immunisations, and midwives do 98% of all maternity care in the practice. However, the NHS pays twice over — once for their salaries and once in items of service to the GP. To our sister professions this looks and feels like exploitation and — more than anything else — perpetuates all the myths about GPs being money-grabbing and hard to work with.

Then there is the question of what is a 'full-time' GP. The old contract allows GPs to define the term 'full-time' within extremely broad limits. Many GPs who call themselves full time actually work only 3.5 days in the practice — which to Joe Public sounds like nice work if you can get it. This particular elephant is just waiting for the *Daily Mail* treatment ' "Full-time" GP who failed to visit dying patient only works 3 days a week!'

Next comes self-employed status — an elephant that is of particular interest to the Inland Revenue. If we are no longer going to hold individual contracts but practice-based ones, if our major business investments (computers) are bought for us, if increasingly our staff choose to be employed by an organisation other than the partnership, if our professional work is ever more closely specified — then in what sense are we still self-employed?

Finally, the biggest elephant of them all — what is it exactly that GPs do that is worth £60 000 to £70 000 per year? We've given away so much — obstetric care, out-of-hours care, triaging of minor illness, counselling, a lot of palliative care, increasing amounts of chronic disease management, and now prescribing (to nurses) — that we should not be surprised if people ask what it is we do. No matter that we still actually do much of this work ourselves. In principle and with remarkable generosity we have conceded the right and ability of others to do what previously only we did. Now we are all certain that patients, other staff, and we ourselves, know there is great and essential value in what we, and only we, can do. But it is getting both more urgent and more challenging to say exactly what that value is.

For the General Practitioner Committee and many in the profession all these elephants can be argued away. The NHS does not 'pay twice'; GPs are contracted to provide a service, not as salaried contractors, and the independence of GPs is an essential bulwark against yet more governmental control. These points have merit to the *cognoscenti* but from the outside it still just looks like rich GPs exploiting colleagues.

The new GP contract is a real opportunity to sort some of this mess out, to get a system of payment that no longer leaves us ever so faintly queasy and our nursing colleagues seething and cynical. It also represents a great unknown, for right at its heart lies the phrase 'practice-based contract'. Most of us think this means 'partnership-based contract' and assume that at most it will mean that some practice nurses and managers get to be partners. But 'practice-based' opens the door to a range of new legal vehicles; for example, companies limited by guarantee, where decisions on who get to be the directors are voted on by shareholders. These shareholders could be staff. Or patients who have chosen to pay a nominal fee. Or practices run by the Primary Care Trust. Or the local acute Trust. None of this can be imposed on us and getting such vehicles to run smoothly will take a deal of fine-tuning. But a practice-based contract enables modern primary care to experiment with legal vehicles fit for the 21st century. After all, who in their right minds wants to have joint and several liability for any aspect of modern health care?

But practice-based contracts also create a potential shedful of new elephants. How will remuneration be worked out as a practice? If partnerships of GPs control the show then they carve up the cake and nothing much changes. But a 'diversity of provision' (the phrase used by our friend Alan Milburn, the Secretary of State for Health) means that other forms of primary care provider are likely to emerge sooner rather than later. The market will then drive provision of primary care into a variety of new forms. And, under a practice-based contract, what is to stop a nurse asking why — since she sees minor illness, looks after chronic diseases, prescribes and refers — she is paid so much less than the GPs?

Ensuring that GP pay is free of elephants means defining the core set of GP skills without which primary care would fall apart. These include:

- diagnosis;
- handling uncertainty — those situations when the guidelines give out and you have to be able to handle anything the waiting room can throw against you;
- dealing with complex situations — people with complex co-morbidities and multiple therapies;
- supporting patients in complex situations

Disclaimer
The opinions expressed here are entirely the author's own and in no way reflect the views of any organisation with which he is associated or for whom he has worked.

where they are choosing between many different options;
- co-creating meaning with the patient — the old shamanistic functions of medicine; and
- leadership.

These are high-level, sophisticated skills, characterised both by their importance and their level of uncertainty and they certainly justify high levels of pay. Nurses, who bring different skills, rightly avoid this terrain where uncertainty and ambiguity rule. But much bread and butter work falls outside these criteria and arguably should not be seen by GPs.

Given that these are the skills we want to reward, we need a variety of remuneration routes, including self-employed partner, salaried by practice or PCT, and profit-sharing director of limited company. But whatever the route it should conform to a basic set of principles:

- Overall, GP pay should keep in touch with consultants' starting pay.
- Pay incentives should explicitly reinforce and support multi-disciplinary working.
- Extra responsibilities over and above the standard should be paid for in transparent ways that are clearly linked to new responsibilities.
- When the practice as a whole generates new income by, for example, progressing a level on the General Medical Services (GMS) quality framework, then this income should be used in ways that are transparent and fair for the whole team.

Some practices will choose to stay with the tried and trusted partnership. Some will experiment with companies limited by guarantee — a legal vehicle that allows for a whole variety of internal arrangements that can be specified by the Articles of the company and chosen by the partners or directors. Others might choose to be salaried in the flexible manner of consultant colleagues — with increments and agreements recognising extra responsibilities. Some GPs may give up the unequal battle of trying to be businessman, property developer, and employer, as well as full-time clinician, and opt for being taken over by a private provider or one run by the PCT.

Primary care is becoming ever more complex and hence demanding and stressful. Effective teamwork across disciplines and organisations is no longer an optional add-on but is essential to modern health care. To thrive we need to build great teams and to inspire them to make the very best of their multidisciplinary talents. We can no longer afford to have a pay structure that consistently leaves our colleagues disenchanted with what they perceive to be our endless capacity for venality.

Paul Hodgkin

Commentary

Risking the description of 'dinosaur', I believe Paul Hodgkin describes elephants that either do not exist or, if they do, are based upon major misconceptions by newer generations of doctors who fundamentally misunderstand the nature of general practitioner remuneration.

One of his larger elephants is the misconception that doctors are paid twice over for work that is actually performed by nurses, health visitors, and midwives. Is it now not self-evident that doctors can no longer deliver primary care all by themselves and that delegation to others with particular professional skills is now mandatory? What remains is the organisation, supervision and enablement of that care — what the current administration is pleased to term 'modernisation'. Doctors' remuneration is based, not on the economic cost of the service provided, merely on that proportion of Intended Net Average Remuneration the Review Body deems appropriate. Does Hodgkin really believe that £116 is the economic cost of providing nine months' antenatal care?

Hodgkin believes that another elephant emerges in the form of part-time working. Where has he been? Doctors are rightly developing 'portfolio careers', taking on other ancillary interests, including administration, audit, and clinical governance. What is certain is that temporarily absent doctors are not on the golf course while their 'angels of mercy' colleagues beaver away back at the surgery!

His next elephant rejoices in the name of self-employed status and we are asked to believe that this is no longer appropriate, notwithstanding the thousands we have invested over the years in premises and infrastructure. A firm of solicitors can have a partnership contract to provide legal services to an organisation without compromising the individual partners' independent contractor status. Independence is not only good for doctors, it is essential for patients who increasingly need an independent voice in an imploding NHS beset by political correctness, spin and frank lies!

Where is this ideal practice on which these arguments are predicated? A practice where general practitioners have no worries over static income in the face of rising workload, while being supported by trusted nursing colleagues working to a team agenda who take personal professional responsibility for every single action? Where is this ideal GMS or PMS practice with an administrative structure that allows clinicians to see patients with no worries over how to fund a crumbling service or to maintain income?

Hodgkin's biggest elephant is the disparity between the incomes of general practitioners and other primary care team members. I hold no brief for the paltry rewards of nurses or others, but surely our natural comparators are our specialist colleagues (who know more and more about less and less). We have fallen way behind consultants' remuneration and pension benefits and, as most sensible doctors know, general practice is still the hardest discipline to do well.

The potential 'shedful of elephants' brought about by a new contract are well argued, and Hodgkin's description of proposed core general practitioner skills is sound. Yes, other team members need more pay, but if general practitioners as the driving force of primary care remain undervalued and under-rewarded then the future of the NHS is bleak indeed.

As a medical screener for the GMC I know all about the greedy behaviour of a very few doctors in NHS general practice. Equally, however, after 25 years of representing my colleagues' interests I also have insight into the dedicated professionalism of the vast majority. Hodgkin's prime error is to look at reward from the bottom up, a view that demeans our training, commitment, and personal investment in our practices. Turn this approach on its head and we might approach a surprising consensus.

Brian Keighley

Natasha's Dance — a cultural history of Russia
Orlando Figes
Allen Lane, 2002
HB, 729pp, £25, 0 71399517 3

THE title of Orlando Figes' brilliant panorama of Russian culture, in eight thematic chapters from Pushkin to Stravinsky, derives from a tense scene in Tolstoy's *War and Peace* (1869). Natasha Rostov, filigree product of the European (largely French) education favoured by the Russian aristocracy, finds herself with her brother in the home of a distant relative who has embraced the 'narod' and taken a serf wife, as many Russian intellectuals were to do after the emancipation of the serfs in 1861. Once the homely meal is finished, 'Uncle' strikes up a melody on his guitar, and although Natasha has never learned to dance in the Russian way, this slim, graceful, French-speaking countess finds herself, to her relief and general applause, doing 'the right thing'. She dances with perfect atavistic poise.

Written in the long shadow of the French invasion of 1812, Tolstoy's recounting of Natasha's dance is a perfect illustration of his aim to construct a patriotic epic illustrating the fundamental unity of the Russian people. Napoleon's advance on Moscow, which had been deliberately razed on the orders of General Kutuzov to deprive the Grande Armée of provisions (a devastating typhus epidemic followed), introduced a new sense of 'the nation' based upon the virtues of the common man. Conventional society had corrupted the nobility, many of whom could hardly speak more than a few words of Russian. Salvation, if it were to come, could only come from below. This, as Figes shows, was the point at which, rather than become a nation-state in the European mode, the Tsarist state emerged as God's chosen agent for a new historical dispensation.

No other country has ever become quite so absorbed by defining what it is, or troubled by the idea that reality might not measure up to the ideal. What was at stake, after all, was salvation, and not just Russia's: Dostoevsky expected the 'Russian soul' to redeem the west. Other thinkers, such as Petr Chaadaev, had been declared insane and housebound on the Tsar's express orders, for the temerity of suggesting, in 1836, that Russia was essentially a void. Gogol, for his part, became a martyr to what he claimed was the 'beautiful Russia of his heart': the trouble with his great novel *Dead Souls* (as far as Gogol was concerned) was that the characters kept butting in to remind him, with some gusto, that Russia was anything but what he thought it was. 'God, how sad our Russia is!' said Pushkin, when he read the manuscript; but Gogol's Russia is quite as phantasmal as the dead souls 'bought up' during its progress. Tolstoy was also tormented by the idea of Truth (*istina*), one of the few words in the Russian language that fails to rhyme. Perhaps only Chekhov, whose grandfather had been a serf and who had a bit of medical experience to fall back on (Gogol, for instance, had very few practical dealings with Russia), was not undone in some way by the power of myth and illusion. He knew, as several of his stories suggest, that the idealisation of the Russian peasant was largely a townie projection. An icon is good for praying, as the critic Belinsky once pointed out, 'and you can cover the pots with it as well.'

The tension between different kinds of Russia goes back much further in time. Peter the Great's decision to build a new capital on swampy coastal land was a negation of medieval Moscow, and all its Byzantine splendour. St Petersburg symbolises Russia's eighteenth-century aspiration 'to reconstruct the Russian as a European'. It was an act of brazen cultural engineering. Built at great human cost, its grid plan, zoned districts and embankments created a strange kind of vertigo in those who contemplated it. If Peter built it, Pushkin created its image; and it is one that has haunted generations of writers (see Gogol's story *The Overcoat*).

But the tension was more than just a tale of two cities. Which way was Russia facing: east or west? The 18th-century westernising movement was called into question by the Slavophiles, who believed in what the soil taught. They, in turn, were outraged by the pioneering work of the historian Stasov in the 1860s, which suggested that Asia had widely influenced all aspects of Russian culture. Horses, in the wake of the devastating 13th-century Tartar invasions that overran early Russia (Rus'), became symbols of the apocalypse in Russian art: Blok's 'Scythian' poems of the 1910s fairly drum with their hoofbeats. Semi-pagan legends mingled with early Christian ideas and gave rise to tenacious beliefs: the city of Kitezh was thought to be hidden beneath the lake of Svetloyar and could be glimpsed only by true believers. (This legend informed the last major opera by Rimsky-Korsakov, the most famous of the five 'national school' composers known as the Mighty Handful.) There is a clear line of descent, too, from the Orthodox belief in Moscow as the Third Rome (after the fall of Constantinople to the Turks in 1453) to the Moscow of the Third International.

The idea of Russia as a nation flared briefly in February 1917, while Europe was at

Tracey Emin
Stedelijk Museum of Modern Art
Amsterdam
www.stedelijk.nl

A tent embroidered with the names of everyone the artist has ever slept with (1963–1994), a video of the artist dancing, entitled 'why I never became a dancer', a letter containing her thoughts following an abortion — exhibits in a ten-year retrospective of Tracey Emin's work in the Stedelijk Museum of Modern Art, Amsterdam.

What is modern art? One woman's great painting is another's collection of sub-adolescent daubs. Spelling is not one of Tracey's strengths. But are 'envey' and 'featus' genuine mistakes or are there layers beneath the layers I don't understand? Her scrawled letters (to herself?) are compulsive reading, but would they be better suited to a book than a wall?

A newspaper cutting from the 1980s contains the story of the grim death of a man in a car crash. He was Tracey's uncle and surrounding the column are artefacts from his life including a crumpled cigarette packet that he was holding when he was decapitated. The viewer is drawn into the emotional scrapbook of Tracey's life. Here is an extracted tooth; there is a bottle of mefenamic acid for period pains. What would I choose in similar circumstances to illuminate my own life?

Art raises questions. This exhibition challenged me to define art and its emotional repercussions far more than paintings in the Rijksmuseum. I enjoy the new, the modern. Maybe it is transient and only relevant for its time. But then so am I…

Jill Thistlethwaite

slaughter, and almost immediately went underground again, like the city of Kitezh. The autocratic imperial tradition had reimposed itself, along with a utopian faith in a new internationalist culture based on the Soviet model: *Proletkult*. Many artists (Meyerhold and Eisenstein) endorsed industrialisation in the 1920s, and endeavoured to make men glad cogs in the gigantic industrial Machine. What was seen as the nightmare of the production line in the west was hailed in Russia as liberation. Twenty years later the 'Kremlin mountaineer' (the term given to Stalin in a poem by Mandelstam) began to emulate Ivan the Terrible and brought to an end any lingering belief in the new man. Sentimental 'people's art' now went hand in hand with state-organised terror, though genuine culture continued to flourish in conditions that sometimes beggar the mind: Shostakovich's Seventh Symphony was performed in a bombed-out Leningrad (the new name for St Petersburg) in 1942. Anna Akhmatova was persecuted for years, but persisted in desperate conditions to write some of the defining poems of that entire era. Poetry was freedom when prose was so clearly the state's business.

Now, sixty years after the battle of Stalingrad, the turning point in the Second World War, Russia might seem to be a 'normal' nation. Its last great prophet-writer, Solzhenitsyn, was recently forced to cancel his weekly television address to the nation for lack of interest.

But I'm not so sure. Messianic beliefs in the end of history, penned by the philosopher Vladimir Soloviev circa 1880, inspired not only the poet Blok but the philosopher Kojève who, in exile in Paris in the 1930s, taught an entire generation of French thinkers and diplomats: their hobby-horse was the European community. Premier Putin has coaxed old Slavophile ideas back to life to inspire young people. And last week, on German radio, I heard a report on the city now known as Volgograd: so dismal is everyday life in contemporary Russia that some of the locals want to change the name of their city back to that of its glory days: Stalingrad.

I could only find two small errors in this masterpiece of a book: the façade of the Winter Palace is green not blue, and Prokofiev's violin sonata that opens sounding 'like the wind in a graveyard' is in F minor, not D major.

Iain Bamforth

roger neighbour - behind the lines

On the wearing of hats

My great-great-great aunt, Miss Laetitia Neighbour, was for many years secretary to the Medical Grand Committee for Sorting Everything Out. Recently I learned that she also authored a popular column in the *London Gazetteer* advising readers on finer points of social etiquette. Her piece 'On gentlemanly conduct in the bedchamber', for example, won her the profound, though private, gratitude of many a duchess and milady.

Laetitia's diary records her mounting irritation at the predilection of Members of the Grand Committee for keeping their hats on during session. Thus prompted, she penned the advice transcribed below:

To those of the Medical Fraternity who would Wear their Hats so Low upon their Brow as to be Blinded to the Presence of Others

Choose one style of hat and remain faithful to it. Allow it to accommodate to the contours of your cranium, replacing it, when it becomes shabby, only with another of similar design (though more fashionable). People will applaud you for your constancy and trustworthiness. In colour and style the hat should complement your daily habit; if over-flamboyant or ill-matched it may distract attention from what you may say, and hint at vainglory.

Choose a well-fitting hat. Nothing is more ridiculous than a hat so large as to obscure the wearer's countenance, nor one so small that its wearer must forever be clutching it lest it fall off. It is commonly believed that, if too large a hat is habitually worn, the head will expand to fill it. This is too uncertain a phenomenon to be relied upon, and when it occurs will startle and antagonise onlookers. Remember too that an over-large hat may cause difficulty in a strong wind. Do not jam it down all the harder onto the head, as it will catch the breeze like a sail, making navigation hazardous. Yet, the regular wearing of a hat too small for an enlarged head may engender a compensatory conceit, attended by unwarranted hostility to others less lofty, on whose lesser brows it might have sat easy.

Wear only one hat at once. And be thoughtful as to whether a hat need be worn at all. Out of doors, amongst strangers, a multiplicity of hats may pass almost unnoticed; but not so within doors. If attending a meeting where by common consent hats are not to be worn, leave your own outside, where it may nonetheless be admired on entering or leaving. Omitting to do so will provoke wearisome descriptions of hats your companions could have worn, to the detriment of the business of the day.

In meetings where hats are customarily worn, should your hat be so large as to obscure the vision of others it is courteous to remove it. It is ill-advised to take more than one hat into a meeting, and especially to change hats while it is in progress, however surreptitiously. An attempt to do so will assuredly be noticed and will call down ridicule upon you. Should you possess a large collection of hats, you should resist the temptation to sport them in dizzy rotation. To onlookers, this suggests indecision and a lack of self-assurance, and causes pain in the neck.

When wearing a new hat for the first time, you should modestly draw attention to it, and graciously allow others to inspect, feel or otherwise appreciate the novelty, in order to gain confidence in its presence. If, on the other hand, you possess no hat at all, you should not attempt a home-made one; the sight of such a surrogate will inflame the passions of all those with custom-made, or even ready-made, headgear.

A dilemma may arise if another person, of the same company, should come wearing a hat identical to your own. In this case it is wisest for you two to take seats alongside each other; it is better to acknowledge the fact with a laugh than to sit on opposite aspects and affect ignorance of the duplication. Your companions will soon lose heart in their attempts to provoke division between you.

As a hat-wearer of mounting experience, you will eventually encounter jealousy, even mockery from others less impressively accoutred. You should not attempt to mollify their envy by, for example, offering to lend them one of your own hats. Rather, you should inform them where a hat of comparable splendour is to be got for themselves, while hinting at how exclusive is your own, and how costly.

Take heed that to wear your favourite hat on some occasions — in bed, or in an ale-house, or travelling abroad — indicates instability, and leads ultimately to kapelophilia, a morbid addiction to the wearing of hats. Finally, and at risk of indelicacy, some hats are prone to the defecatory attentions of over-flying birds. The reasons remain a matter of bewilderment for the bespattered hat-wearer, though not always to the amused witnesses.

Meeting with Prime Minister
David Haslam reported on a meeting he had had earlier in the week with the Prime Minister, together with several other medical leaders. Council discussed this meeting and was concerned to ensure there was unity across the profession, noting that the General Practitioners' Committee had not been involved in the meeting. The subsequent discussion highlighted the need to engage with PCTs at various levels, both strategically and locally.

Shipman Inquiry
The RCGP has participated in seminars discussing death certification. We have been able to make important points not made by other contributors. Our evidence to the death certification seminars is already on the Shipman website, which publishes all submissions on the day they are discussed. (**http://www.the-shipman-inquiry.org.uk/home.asp** — hearings from days 121 and 125).

Council approved our draft submission on the subject of controlled drugs. This is an area where the College has not done extensive work over the past few years and it seems likely, therefore, that it will be a particular focus for new regulation by the Inquiry. Finally, Council had for information the submission we made to the Inquiry on monitoring and disciplinary systems and complaints.

Budget 2003–2004 and annual subscriptions
Dr Tony Mathie brought his final College budget as Honorary Treasurer to Council for approval. As you know, Dr Mathie will be succeeded by Dr Colin Hunter from November 2003 as Honorary Treasurer.

In order to meet the budget requirements this year, the full subscription rate is increasing by 3.6% to £348 and the overseas rate by 2.9% to £142. All other subscription rates remain unchanged. This year's budget is very much an interim arrangement pending the outcome of the income and activity review, which is now underway and which is timetabled to be completed in time to inform the 2004–2005 budget. One of the features this year has been the preparation of business plans by faculties, which have now been received and will be considered for funding. Council was happy to approve the proposals both for the budget and the level of subscriptions.

Tony Mathie also gave an update on the outturn of the WONCA Europe 2002 conference, where there was a significant shortfall. A provision had been made in the budget to repay £82 500 to RCGP Conferences Ltd annually for four years to meet this shortfall.

Income and activity review
David Haslam brought to us the outline timetable for this review, which is intended to be completed in time to inform the formulation of the 2004–2005 budget in the autumn of 2003.

College examination syllabus
The Examination Board brought forward an examination syllabus that is a first step in reviewing the whole structure of the examination. Council was pleased to approve the syllabus, which will form part of an external process of a review of all Royal Medical College curricula, syllabuses, and examinations through the Academy of Medical Royal Colleges.

One issue that arose from the discussion was the frequent requests received for an explanation from the College of how it treats vocational training and examination of the management of rare diseases by GPs. This is to be developed into a College position statement.

Joint memorandum between the Academy of Medical Royal Colleges and the Department of Health
David Haslam brought to Council for information a Joint Memorandum that had been agreed between the Academy and the Department of Health, the principle objective of which was to improve the availability of high quality care of patients by increasing the number of trained doctors and providing modernised high quality training programmes. All members of the Academy have signed up to the statement.

GPs with special interests (GPSIs)
There were a number of papers on this subject that have been brought forward by Dr Clare Gerada, who is the leader of the project to develop frameworks in ten clinical areas for GPs with special interests. These reports were put into broader context following concerns raised by members of the Midland Faculty that, in supporting this project, the College might be seen to be undermining generalism. You will be aware that we have produced a number of reports on the subject, which can be found on our website at **www.rcgp.org.uk/rcgp/education/professionaldev.asp** but it is acknowledged that there might still be some confusion and doubts in parts of the profession.

Council debated the subject and there was a general conclusion that, while this was an area that had dangers, provided the College was in the lead it was less likely that this would erode generalism. The alternative was likely to see a number of the specialist discipline Colleges develop programmes for GPSIs, which they would expect general practitioners to undertake and which could be very secondary care-orientated.

We also discussed a number of the draft frameworks and the draft guidance for primary care organisations. Some helpful

Revalidation
David Haslam reported on meetings that he had just prior to Christmas, when it became clear that the General Medical Council's approach to revalidation had been modified significantly. A GMC briefing on the arrangements for the licence to practise and revalidation indicated that doctors working within managed systems, such as the NHS, and who were subject to annual appraisal, could expect that their appraisals (provided that they were linked to the headings of Good Medical Practice and properly done), would normally provide suitable and sufficient evidence for revalidation. This would mean that those doctors should not, as a rule, need to collect any information for revalidation over and above that which they would need anyway for their appraisals.

The main issues as far as the College was concerned were that the appraisals, which were intended to be formative, educational and supportive, would now have a summative element and doctors were unlikely to talk openly about their areas of weakness and where they needed to improve. Furthermore, there was no lay involvement in the process, and, finally, the GMC was no longer attempting to deal with doctors who were not in managed structures, which could cause divisions, particularly in general practice.

Council was very concerned that all the work the College had done, particularly that led by Professor Mike Pringle on *Good Medical Practice for GPs* and *Criteria, Standards and Evidence for Revalidation*, might be wasted and that the public reaction to this diluted form of revalidation could be negative. Sir Graham Catto, President of the GMC, has been invited to the next meeting of the RCGP Revalidation and Appraisal Working Group. The Chairman said he would continue to take forward the arguments and concerns about revalidation at all possible levels.

comments were made and the frameworks will now go forward. Once these have been approved by the Department of Health, the frameworks will appear on the College website and Department's website.

Presidential portraits
Council discussed the increasing cost of providing portraits of retiring Presidents. Although this only arose once every three years, the tradition has been for the President's faculty to meet this cost. There are varying practices in other Medical Royal Colleges and, as a result, Council was invited to consider whether the Presidential portrait should be continued and if so in what form. Council was very clear that a pictorial record of Presidents should be maintained. It was further agreed that it should be up to each President to choose the form that the pictorial record should take (such as a portrait or a photograph) and that the College should provide a sum of £1000 per year at current values (to be kept under review) and any balance required might be brought together by the President or through the faculty or other means.

RCGP Clinical Unit
At the suggestion of David Haslam, the idea of the College introducing a Clinical Unit to support clinical activity was discussed. A feasibility study had been commissioned from the Department of Primary Care in Oxford University to assess how this proposal might best be taken forward. Two options for supporting practice and primary care organisations to deliver better clinical care had been proposed. At this stage, Council was invited to consider whether the proposal should be taken further forward and if so to invite CEC to develop the ideas. Council was supportive of the option of 'clinical implementation modules' aimed at helping practices deliver better clinical care with the target being the GP practice. With this steer, Council agreed that CEC should be invited to look at the primary objective of the Unit, how it should fit with other parts of the College and how it should be funded.

Spring General Meeting 2003
The Severn Faculty has prepared an exciting programme for the Spring Meeting from 4–6 April at the Wills Building, Bristol University. On the morning of Sunday 6 April there will be the formal Spring General Meeting, which, in addition to the usual Awards and Fellowship Ceremony will include the annual William Pickles lecture to be delivered by Professor Barbara Starfield.

Next meeting of Council
Friday, 14 March 2003.

Maureen Baker

neville goodman

God, am I depressed!

Mr Milburn has gone for broke. Thwarted, as he sees it, in getting consultants to do more work, he has issued a document, entitled *Improving rewards for NHS consultants*, which describes an NHS in which everything that we do will be measured, and in which improving measurements increases pay. The rejected consultants' contract was a trade-off of more money for more management control. Rather than re-negotiate, Mr Milburn has decided to use the money on another grand plan. He still thinks we're not doing enough work, so he wants to give us incentives. He thinks that pay is the best incentive, and so he intends performance-related pay.

There is no other way of interpreting these documents. He intends that all specialties devise, or have devised for them, standards of practice, whether of outcome or productivity. He wants objective measures of performance. The phrase is in bold type. The clinical excellence awards, which will replace merit awards, will be open and equitable. He thinks the standards can be published in March this year. It will require masses of bits of paper as we try to decide how many hip replacements equals how many adolescents seen in a psychiatry outpatients equals how many medical students taught for an hour on the ward. It is medicine by piece-rate. It will cause resentment and mayhem.

It is some time since I read such a depressing document, from someone who has chosen to learn nothing about medicine or about consultants. The media made much of consultants' right to take sabbaticals. That is indeed an excellent idea. In a letter to all consultants and registrars, Mr Milburn describes the scheme:

'Initially, by 2005/2006 we want to enable about 800 consultants per year to enjoy sabbaticals from their work of between two and three months. As NHS capacity expands [sic] the number of consultants benefiting from sabbaticals will also grow.'

I cannot think of a better way of dividing and demoralising the workforce. Even more targets, even more explicitly drawn up. The incentive pay — there is an illustrative table that awards NHS Trusts £3000 and Primary Care Trusts £1500 per percentage point improvement in A&E waiting times — can be paid either to individuals or to teams. But even the performance of teams is affected by factors outside their control. Sorry chum, the medics can't discharge their patients, so the surgeons can't get their cold cases in, so the anaesthetists won't be paid this week.

The document has been released for discussion. We must stop saying, 'If we don't do it, they'll do it for us'; we have to tell Mr Milburn this is where we get off. We've got better things to do, such as treating our patients.

Nev.W.Goodman@bris.ac.uk

our contributors

Iain Bamforth's literary companion to medicine, *The Ironic Doctor*, will be published by Verso in November

Theophrastus Bombastus is soon to tour Scotland seeking better ways of managing heart failure

Neville Goodman is an Apple man, if that wasn't already obvious, and finds PCs positively mephitic

Wouter Havinga has developed a few hobby horses over the years and the benefits of fever is one of them. Since 1995 he's worked half-time in general practice in St Luke's Medical Centre in Stroud and the rest of the time with the Gloucestershire Countywide Substance Misuse Service

Paul Hodgkin begins a new series of Postcards in the *BJGP* this summer

Brian Keighley is a GP in Balfron, a village in the lee of the Campsie Hills, north of Glasgow. He serves, often by election, on every important committee in our land

Malcolm Nicolson lectures at the Department of Economic and Social History, University of Glasgow. Research interests include the history of twentieth-century biomedical science and the history of diagnostic practice

Surinder Singh is a lecturer in primary health care at the Department of Primary Care and Population Sciences, University College London. He is on the Editorial Board of the *BJGP*

Graham Smith is an oral historian now based in the Department of Primary Care in Sheffield

Jill Thistlethwaite has a strange enthusiasm for the work of Tracey Emin, currently the subject of a major retrospective at the Stedelijk Museum of Modern Art in Amsterdam. Titian it ain't, to be anagramatic

All of our contributors can be contacted at the *BJGP* office via e-mail at journal@rcgp.org.uk

jill thistlethwaite

Home visiting

A FEW weeks ago two third-year medical students interviewed me for the undergraduate magazine, fetchingly entitled *Rectum*. (Fortunately, this august publication is no longer the sexist and politically incorrect organ it once was, a reflection, perhaps, of the current female student majority.) This sort of interrogation prompts reflection and, as I am responsible for the personal and professional development module of the curriculum, I wanted to stress the importance of communication skills and empathy in my clinical work. I recalled that it was not until I became involved in the nurturing of GP registrars, and then medical students, that I felt I was becoming a 'good' doctor.

The arrogance that doctors sometimes display is the flip side of empathy. I am sure that most general practitioners remember feeling annoyed at 'trivial' consultations and even angry at 'trivial' visits. In mitigation, these feelings are often precipitated by a heavy caseload and lack of sleep. In the middle of the night, facing the thirtieth house call of the day and a full surgery in fewer than five hours, Dr Perfect would have difficulty understanding the worries of the single mother with a crying but symptom-free baby or the wife of the pensioner with minimal shortness of breath.

I spoke to the medical students about the importance of developing empathy and why I wished I had been exposed to such ideas when I was in training. The next day, synchronicity in action, I realised that conflicts of empathy are also a doctor's burden. My sister rang. She was worried about our father, who had been diagnosed with bronchitis by his GP two days previously. He was worse, more breathless and with chest discomfort. He had rung the on-call service over five hours previously and again an hour ago and had been told a doctor would call.

My sister wondered if I could do anything. I rang my father, who sounded breathless but was able to carry on a conversation. He has at least one chest infection a year and a history of a thoracoplasty (the pre-antibiotic do-or-die cure for tuberculosis in the 1950s).

I have not been 'on-call' since I became an academic six years ago. At that time my practice rota meant I worked one night a week, covering 18 000 patients. I do not remember any patient waiting more than two hours to be seen after a visit request. I rang the deputising service, pulled rank and spoke to a supervisor. I was told that there were five doctors covering the whole of the large metropolitan area in which my father lives. 'His' doctor had eleven calls waiting. I refrained from saying 'something must be done'.

I could empathise with the overworked doctor rushing from one house to another, albeit with a driver, with a list of 'urgent' visits. I could empathise with my sister, the impotent relative living some distance away, worried about possible pneumonia in an elderly man living alone. I was reluctant to intervene diagnostically or therapeutically over the phone. It was easy to criticise such a seemingly inefficient service, but then I was only too happy to give up my twenty-four hour commitment.

My father was eventually seen nearly eight hours after his initial request and his antibiotics changed. Probably he could have waited to be seen until the next day, if you look at things purely from a clinical viewpoint. But that would be to discount the necessity of reassuring both the patient and his distant relatives.

As I told the students, once you start your medical training you will never again be solely a worried relative, a sick patient or an innocent bystander. You will be viewed as an insider by both patients and health professionals, yet be expected to empathise on both sides of the doctor–patient boundary. You may be pressurised to take sides while wishing to remain neutral. Medicine: it is a hard life being a doctor…