The Back Pages

viewpoint

Reconciling the head and the heart

'I UNDERSTAND all that, but he's such a dear little chap' — the typical reaction of an intelligent father who has read the evidence on the safety and efficacy of the combined MMR vaccine, but then looks at his baby and finds his courage has deserted him. How can this impasse between the head and the heart, intellect and emotion be resolved?

Like all dilemmas, the issue boils down to the weighing up of two things that can't be measured in the same units. No amount of logical argument, data and expert opinion will touch the heart, any more than tears, pleading and emotive headlines will change Department of Health (DoH) policy or convince researchers that 'there must be something in it because there's no smoke without fire'.

Information goes to the head for intellectual consideration. Information there must be and information about the MMR vaccine there is aplenty, including leaflets, websites, packs for parents and telephone helplines. But information is not enough. I have watched parents in postnatal groups absorbing the video made by Health Promotion England and I have concluded that a video is a talking leaflet. At the end, the questions the parents ask me have just been answered on the tape. Their heads have all the information they need to understand that the MMR vaccine is safe, but they are not really asking for more information. They want something extra that goes to their hearts to give them the confidence to believe in what they have just heard. Where does confidence come from?

Confidence comes when both the head and heart are in accord. Providing fodder for the head is relatively simple, but how can the heart be won over? I believe that this is achieved when we talk to someone we trust, either because we know them or can identify with them. People who are ill-informed, who hesitate or fudge their words, do not inspire confidence, even if we know them well. People we don't know, or who we can't identify with, although they may be knowledgeable, give facts but not feelings. To transmit confidence, both elements — information (for the head) and trust (for the heart) — must be present.

Herein lies the success of the tabloids. The National Squealer is an old friend: a daily chum who lies on the doormat with catchy headlines and sensational pictures. The parents can identify with the people depicted in its pages. The 'information' is given with strident confidence. While it is gratifying to know that journalists as a profession recognise how ill-served the public was with regard to the MMR controversy[1] the damage has been done.

What do we know about talking to parents? We know that they get most of their information about vaccines from the primary healthcare team.[2] We know that they trust healthcare professionals. In a recent Mori poll, over 90% of people said that their doctor is trustworthy; far fewer believe what the politicians or journalists have to say.[3] Two-thirds of those who initially refuse the MMR change their minds later, so it is worth persisting.[4] And the question they always ask: did you have your own children immunised? We must be ready to answer this question and to promote immunisation actively. Half-hearted answers do not generate confidence.

Confidence is contagious. How do members of the primary healthcare team catch it? The same principle applies. Information may come from the pages of a medical journal, but confidence comes when that same information is delivered by a trustworthy source. This may be the local immunisation co-ordinator who, in turn, caught it from colleagues at the DoH.

So, I believe confidence in vaccines is generated when we hear someone we trust speaking knowledgeably about them. In primary care, we have all seen the struggle that is going on in the minds of some parents. These consultations can be difficult. However, provided we know our facts, we should be in no doubt that the relationship we have with our patients will contribute to their trust in us and so make it easier for them to be confident in the vaccine.

Marilyn Lansley

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contents

WONCA Europe, Slovenia, June 2003

THERE is hardly a more boring thing to read than reports on conferences. They often consist of a brief and general description of a scientific programme and the accompanying social events with an obligatory sentence that the conference was a success. They sometimes include a picture of a smiling group of people you have never met against some door of some conference centre that is said to be located in yet another tourist destination of Europe.

If I were to describe the WONCA Europe conference in Ljubljana in that way, I would have to say that it was aimed at the future of the discipline, that the programme was organised around three themes: future health problems, future tools and future role of the general practitioner. That the programme was run in 14 parallel sessions. That the number of all registered participants was over 1,600, and that they came from 59 countries, of which the only missing European ones were Bulgaria, Belarus, Andorra, Luxemburg, San Marino, Liechtenstein, Monaco and Vatican City. That it was the biggest gathering of different European countries so far. That we have had an opening and closing ceremony and interesting social events. And, of course, that it was successful.

With such a description I would not be able to capture the true spirit of this meeting. Conferences are also about people discussing their experiences, sharing common ideals and information. They are about friendship and communication, where practitioners talk to each other and share their problems, solutions and anxieties. They can be a way to find support and sometimes comfort and friends.

The conference began with the anxiety of the organisers about whether the relentlessly pouring rain would stop in time to allow the official opening at the castle to take place in the open air. And miraculously, soon after the country's president had finished his speech and the choirs had stopped singing in the main auditorium, just an hour and a half before the party was due to start, the skies cleared and we were able to enjoy the reception by the mayoress of Ljubljana, the drums and the fireworks.

The conference ended when the exhausted, but satisfied organising committee bowed before the audience for the last time and received warm and deserved applause.

In between these two events there were many memorable experiences. I will long remember Iona Heath's magnificent keynote speech as well as the presentation by Bosnian general practitioners about their struggle to develop family medicine, which was an especially touching experience. All those present at the event will without doubt have taken home good memories of workshops and presentations. EURACT, EGPRN and EQUIP had their own open meetings, describing their work and goals to a wider audience. WONCA Europe had its own open meeting. There were many interesting posters and presentations and a terrific amount to choose from.

When everything was over, there had clearly been widespread satisfaction with the conference. And there are many different reasons for that. The participants, while accustomed to visiting well-known tourist destinations, discovered in Slovenia a venue with a difference, one with an almost exotic flavour. Many people were surprised at how beautiful the country is. Some even decided to prolong their stay in Ljubljana or Bled. The warmth of the people helped the visitors feel at home and enjoy themselves. The technical part of the programme ran smoothly with the number of technical difficulties kept to an absolute minimum. The weather was fine, there were no strikes, no last minute cancellations, no political tensions or other disasters that can threaten the success of a conference.

An important indication of the success of the conference is the impact it has had on family medicine in the country. The conference received a lot of positive media coverage in mainstream journals and national newspapers, something family medicine in Slovenia is not used to. As a result, politicians have been reminded that Slovenia has a good number of family physicians who need adequate support.

The event was a strong motivational force for Slovenia's family medicine community. In a country of two million inhabitants, the number of general practitioners is just 850, while the number of participants at the conference was almost double this figure.

The challenge of organising a conference in Ljubljana met with widespread enthusiasm. Volunteers appeared out of nowhere to organise social events, help in scoring abstracts, help in resolving last-minute minor catastrophes — such as the Royal College material being stuck in customs. A quarter of all the general practitioners in the country attended the event.

Therefore, in many ways, the Ljubljana conference was not just another conference. I for one will certainly remember it for a very long time to come.

Igor Švab

flora medica theophratus bombastus

From the journals, June 2003

***New Eng J Med* Vol 348**
2285 In type 1 diabetes it is worth striving for tight control, since this can reverse microalbuminuria; it also slows the progression of vascular disease as measured by carotid intima-media thickness (p.2294).
2355 Until recently, we thought that neurones never divided, but we now know that following ischaemic damage, lots of new neurones are formed and migrate to the area of damage. Unfortunately, very few of them survive.
2379 Pre-term delivery can be prevented in many high-risk pregnancies by giving progesterone from 16–20 weeks onwards.
2407 Definitive evidence of the superiority of ambulatory blood pressure measurement has been slow to arrive, but here it is, in a big Belgian study with hard end-points.
2508 Lots of leisure activity in retirement slows dementia.
2517 Before blood tests for endomysial and gliadin antibodies arrived, coeliac disease was hard to diagnose. Now a study of Finnish children pushes the prevalence up to one in a hundred — more than ten times higher than we used to think.
2599 Greeks who 'Westernise' their diet die faster — keep to the Mediterranean stuff if you want to stay around.

***Lancet* Vol 361**
1945 What actually causes diverticular disease? Degeneration of innervation to smooth muscle in the colon, perhaps.
2000 Statins for everyone with diabetes — courtesy of the Heart Protection Study.
2017 But forget about 'anti-oxidant' vitamins — if you want to reduce cardiovascular risk, you're better looking at B vitamins (see letter, p.2087).
2032 Don't let general surgeons refuse to operate on your fat patients — show them this study which shows that weight makes little difference to outcomes.
2114 Adding a little magnesium to the nebuliser fluid makes salbutamol work better in severe asthma.
2189 Pneumococcal vaccine to prevent recurrent otitis media? An unsuccessful trial.

***J A M A* Vol 289**
2819 The appealing idea that non-steroidal anti-inflammatory drugs might slow the progression of Alzheimer's disease is dealt a blow in a study of naproxen and rofecoxib.
2827 Paroxetine is shown to suppress menopausal flushing — just as we are getting wary of this drug.
2963 Can mice cause carpal tunnel syndrome? Only by biting you on the wrist — the computer mouse is innocent.
3145 In an issue devoted to depression, a British systematic review of educational and organisational interventions to improve the management of depression in primary care.
3243 More evidence to confirm that hormone replacement therapy increases breast cancer from four years' use onwards, and makes it more aggressive and difficult to detect on mammography.
3254 This applies whether the progestogen is intermittent or continuous.

Other Journals
***Ann Intern Med* 163:1440** describes the most effective intervention for reducing all-cause mortality in diabetes — walking for at least two hours a week. ***Ann Intern Med* 138:992** is called 'Zen and the Art of Physician Autonomy Maintenance' — an entertaining essay which argues that we must give up autonomy in order to regain it.
***Gut* 52 Suppl iv:34** looks forward to a time when difficult and uncomfortable gut investigations will be replaced by MRI. Moving upwards into ***Thorax* 58:489**, we find a study suggesting that house-dust mite avoidance might be a good idea for atopic children after all.

We may soon be into the era of folic acid fortification of bread, which will help to lower homocysteine. But a US study in ***Stroke* 43:e15** shows that low B6 is still a risk factor for stroke and transient ischaemic attack, irrespective of homocysteine.

Did you know that blood can speak (in Latin)? ***Vox Sanguinis***, in its **84th volume:274**, deals with the question of whether blood transfusions in the UK can spread hepatitis B or C or HIV. The risk is unmeasurably small.

As you look forward to those holiday weeks when your adolescents will be at home all day, you can consult the ***Journal of Research on Adolescence* 12:373** for insights into how your ideas about their 'nurturance rights' may differ from their own. Or you can try telling them to tidy their room.

Plant of the Month: *Cladastris sinensis*
This is just about the most unobtainable of trees, though it is hardy in the UK, sets abundant seed and can be grown from cuttings. If you are lucky enough to find one, you will be rewarded by sprays of scented white flower in late summer — something worth looking for.

Postcard **What is a father?**

It is not so strange that I love you with my whole heart, for being a father is not a tie which can be ignored. Nature in her wisdom has attached the parent to the child and bound them together with a Herculean knot ...
(Sir Thomas More, 1517)[1]

IMPLICIT in the term 'father' is a relationship with a child. The orientation of this relationship in western kinship is readily indicated in the difference between the verbs 'to mother' and 'to father'. Whereas the former carries notions of care and nurture, the latter suggests a transaction of a more direct kind involving ideas of legitimacy rooted in crude biology. In this short essay I offer some observations on how this crucial nexus has been transformed, particularly as a result of recent strides in reproductive and genetic technologies.

So, what is a father ... ?

Not what he used to be?
A century ago to ask the question 'what is a father?' would have been absurd, given the strictures that hedged, contained and disciplined the vast majority of men at that time. The roles and expectations that went with being a father were largely unambiguous. Yet, although the image of the father was strong, paradoxically, he was often absent, removed from the home for long periods in the pursuit of waged labour; a distant figure with whom direct and affectionate contact was far from routine. In the second half of the 20th century, however, the distant despotism of the pater familias was progressively undermined as the economic, legal and gender relationships that had previously underpinned family life began to fracture. For some, the 1960s made the uncoupling of sex from marriage a possibility. Sex outside marriage was no longer tinged with shame and opprobrium largely because contraception had become more widely available. Liberalisation of the divorce laws in the 1970s ushered in a further uncoupling, with parenthood and marriage slowly but inexorably spliced apart.[2] Indeed, implicit in the increase in the number of 'single' or 'lone' parent families engendered by this change are other stories about the extent to which fathers increasingly withdrew from parental involvement. The final uncoupling began in the 1980s with the development of techniques, such as In-vitro Fertilisation [IVF], Intra-cytoplasmic Sperm Injection [ICSI] and Intra-Uterine Injection [IUI], which made it possible to achieve reproduction without sex. Men's role in reproduction might come down to little more than the donation of sperm. Placed in the context of women's rising participation in the workforce, the decline of 'male industries' and men's loss of pre-eminence in a range of professions, changes in the domestic sphere have given many men an uncomfortable sense of marginality. The social and, indeed, physical reproduction of the family is now possible without the continuity of role and person which fatherhood once implied. Far from being bound to the child by a 'Herculean knot', the father may often be hanging on by his fingernails — socially, economically and emotionally obsolete.[3]

So, what is a father ... ?

A genetic marker that happens to match?
As the social and cultural frameworks upon which relationships are hung have become more flexible, precarious and transient, there has been a corresponding desire for certainty in kin relations. Once upon a time, the fact of lifelong, monogamous, heterosexual marriage rendered paternity beyond question. Questions of legitimacy and connection were not troubled by the mere facts of who gave what genetic material to whom. However, it is now possible accurately to determine biological paternity, or, in common parlance, who the 'real' father is. Commercially available paternity testing now offers the possibility of making metaphorical 'blood' a literal truth in the form of shared DNA. Beneath the family of social and conventional appearances may lie a biogenetic family which is of rather different configuration — subject of the deepest secrets, of nagging suspicions or, perhaps, of blissful ignorance. But knowing the identity of the man whose biogenetic material was transferred at the moment of conception can be dangerous. The biogenetic family has no history of care, emotion or the morality of obligation, and making sense of the fact of biological paternity, which once known cannot be unknown, can create profound disjunctions in identity and biography. One-night stands and misplaced paternity are nothing new, but what is different today is the alignment of science and the state (in the guise of the Child Support Agency) when it comes to the use of biogenetic connection in the reading of familial obligation.

So, what is a father … ?

A medical record to which I do not have access?
There are now some 30,000 Britons conceived by donor sperm and there is a

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steady and irreversible push towards openness and away from secrecy when trying to read one's family history. Couples, heterosexual or lesbian, may wish to construct their families without reference to the donors who have made conception possible. The reason is understandable given that, at one level, the connection is trivial; it arises from an ejaculate containing millions of spermatozoa which typically has been produced by a masturbating young man, happy to peruse soft porn, claim expenses and have tea and biscuits on the way out. But, at another level, the connection is a profound source of identity and, at worst, it can be the cause of fantasy and obsession; the root of an abiding sense of incompleteness. The asymmetry of meaning for those so connected is stunning. Attempts to confront this asymmetry have resulted in a shift in the balance of power away from parental rights in favour of children's rights; current debates initiated by the Department for Health and Human Fertilisation and Embryology Authority (HFEA) about the continued anonymity of donors raise questions about whether donor offspring should have any information about their genitors and if so what — age, blood group, looks, occupation, a 'pen portrait'? This is not surprising in an era when the human condition is becoming increasingly understood in terms of genetics and to be denied knowledge of one's heredity is, in effect, to be denied access to half of one's medical records.

So, what is a father ... ?

A pen that spilled ink?

In trying to find a way through the thicket of ethical, legal and social dilemmas generated by the new reproductive technologies, the Human Fertilisation and Embryology Act (1990) made a rather fascinating recommendation in relation to AID and paternity. It stated that the man who signs the consent form agreeing to fertility treatment using donor sperm would be recognised as the legal father of the child. This move placed the significance of the inky fluids of social paternity above the seminal fluids of biological paternity. But, at the point where the biology of connection meets the culture of relationships, attempts to solve some dilemmas are apt to create new ones.

In February 2000, a case came to the Court of Appeal in which a man was claiming access to a one-year-old child. The man, who was infertile, had no biological connection to the child but was basing his claim to contact on the fact that he was the man who had signed the consent form when he and his partner had sought fertility treatment. His claim to be a father was pursued despite the fact that he and his partner had separated before she underwent the IVF treatment which resulted in the birth of the child and after she had found another partner. The second man, although her 'partner' and the 'social' father to the child, was not a signatory to the fertility treatment she underwent. In court, all parties agreed that the first man was without doubt the child's 'legal' father, but it was felt in the best interests of the child that, for the time being, he be denied contact.[4] It would appear that the child in this case potentially had three fathers; one legal, one social and one biological.

So what is a father ... ?

A ghost?

In 1996, Diane Blood applied to the HFEA for leave to use her dead husband's sperm to start a family. Permission was refused on the grounds that appropriate written consent had not been obtained from her husband, who was in a terminal coma, when the sperm was obtained. There followed a protracted and complex legal dispute which culminated in a victory of sorts for Diane Blood — permission was granted for the use of the sperm but the treatment could not be carried out in the UK.[5] To much acclaim, a son was born to Diane Blood in 1998. In 2002, a second son was born having been conceived by means of ICSI using her, by now dead for seven years, husband's sperm.

The Blood case is probably the most celebrated instance of posthumous conception but the ranks of fathers who produce from beyond the grave are growing. It is common in the United States for relatives to request that sperm samples be extracted from young men who meet untimely deaths, for example, in road traffic accidents. Similarly, servicemen in both Gulf Wars cryo-preserved samples of their sperm in case they didn't come back. Indeed, the genetic traces of dead men now lie dormant in serried vials all over the world, and we begin to glimpse a novel architecture of family life in which a new space is opened up — a ghostly absence sustained by genetic memorialism.

So what is a father ... ?

There is no such thing?

The recent panic brought on by the prospect of human cloning has focused primarily on the possibility of creating exact reproductions of human beings. In some Huxleyan dystopia, the uniqueness and individuality of the human person becomes lost forever. A much less-voiced concern relates to the fact that cloning makes possible a form of asexual reproduction. The most celebrated clone, Dolly the sheep, was created using cells from the mammary glands of an adult ewe (hence the name Dolly, after Dolly Parton). Extrapolating the process to human reproduction, it is possible that in the future men need have no part in human reproduction.

So what is a father ... ?

Beyond Procreation?

In this essay I have briefly sketched a trajectory in which the idea of the father, projected by socio-economic change and later hitched to the notion of genetic essentialism, has moved further and further out of the orbit of family life. It may be tempting to link such developments to some of the physical, psychological and emotional health problems that men currently experience. In general, these may be attributed to the much vaunted crisis of masculinity — a deep despondency having fallen or, as some would see it, been thoughtlessly pushed into an existential void, effectively cut off from the caring and nurturing relationships which socialise their brutal instincts. The crisis is identified with boys' under-achievement at school and progresses into poor self-esteem, depression, violence, criminality and various forms self-destructive behaviour. A grim scenario indeed.

All these are problems are real and troubling enough, but there is a positive dimension to recent changes. Many men have been able to develop significant and meaningful ways to be adults in children's lives. These possibilities are often novel and occur precisely because of the ways in which the notion of paternity has been so spectacularly splintered. Indeed, it may be that biology is altogether too precarious a thread on which to hang the significance of being a father. Children are best served by the quality of the relationships that they have on a day-to-day basis and we would do well to celebrate the ways that men might have a positive presence in children's lives rather than bemoan the varieties of biological absence.

In short, being a father is a process and not an event that we should recognise and reinforce rather than simply watching as More's 'Herculean knot' unravels before our eyes.

Bob Simpson

Summary

I examine four different kinds of learning conversation: reflective practice, clinical supervision, work consultancy and performance appraisal. I propose that there is a close and reciprocal relationship between these kinds of conversation, and that they represent different aspects of a unified field, or continuum. I argue that appraisal should be seen as part of this learning continuum rather than as form of monitoring.

Introduction

THIS article proposes that reflective practice, clinical supervision, work consultancy and performance appraisal can be seen as different kinds of learning conversation that are closely akin to each other and recursively linked. Put simply:

- **reflective practice** is a conversation with oneself about how to manage a case
- **clinical supervision** is a conversation with a colleague about how to manage a case
- **work consultancy** is a conversation about how to manage one's work setting
- **performance appraisal** is a conversation about how to manage one's learning needs and the wider context of one's career.

The article also puts forward the argument that these four kinds of conversation can all be seen as essential aspects of professional development, requiring the same attitudes and skills, and seeking the same outcome, namely 'fitness for purpose'. It promotes a view of appraisal that is firmly linked to development and learning rather than external monitoring.

Reflective practice

The great American educator Donald Schon has drawn attention to the way that reflective practice is a spiral learning process that continues throughout professional life.[1] It draws on existing knowledge and theory, but also generates knowledge and theory about the job and about how to practise it. Schon talks particularly about working in what he calls the 'swampy lowlands' of everyday practice, where the high-level abstractions one has learned during formal training are played out almost unrecognisably in the messy, uncategorisable, emotionally charged narratives of lived experience. He argues that the capacity to practise reflectively is an essential acquisition for mature professionals, and represents the essence of professional as opposed to purely functional or automatic behaviour.

One important aspect of reflective practice in the health professions is that it involves being in encounters with patients as an active participant, but also simultaneously being an analytical and self-critical observer of one's practice.[2] It means taking part in the consultation as a practitioner, but at the same time 'going up on the ceiling' to look down at the patient, at one's own interaction with the patient, and at the wider contexts that influence that interaction. It is therefore a way of being emotionally and intellectually engaged with the patient, but simultaneously maintaining enough detachment to be a dispassionate internal commentator on what is going on at many different levels.

Many GPs will instinctively recognise the nature of reflective practice but may sense that it is under threat nowadays as perhaps never before. In Britain, we work in an NHS culture sometimes dominated by managers who seem to confuse the high-level abstractions with the swampy lowlands.[3, 4] They may even believe that their map is the same as our territory. It can be hard to maintain a reflective stance that tries to mediate between their reality as managers, ours as clinicians, and the reality that the patient brings.

If we are going to mediate successfully between these kinds of reality, we may need to learn how to apply not 'evidence-based medicine', and certainly not what Greenhalgh has described as 'evidence-burdened medicine'[5] but rather a kind of 'evidence-informed medicine'. This means using scientific evidence by processing it through the reflective professional mind. It involves core emotional skills such as empathy, curiosity and self-criticism, but it is also

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essay

connected with core technical skills such as the ability to form hypotheses in the consultation — both biomedical and psychosocial — and to test these through appropriate questions.[6] Above all, reflective practice represents the ability to facilitate unique solutions to each new problem through dialogue, rather than imposing standardised ones through the misuse of professional authority, or enacting official imperatives without regard to individual needs.

Clinical supervision

In some professions, particularly counselling and social work, the word supervision is used very often, sometimes very casually, and always in a non-judgmental way. What members of such professions have in mind is usually some kind of regular, structured one-to-one conversation or team meeting. However, they may also just mean an informal chat about a case, to clear their heads and get some new ideas.[7, 8, 9] Supervision essentially describes an attitude of mind rather than a specific activity.

One way of understanding clinical supervision, whatever form it takes, is to see it as an *externalised version of reflective practice*, sharing the same stance and the same skills. Just as reflective practice is a kind of inner conversation about one's casework, clinical supervision is an enacted conversation with another person. The two kinds of conversation are inseparably linked. Unless you are having a sufficiently thoughtful inner dialogue, it may never occur to you to discuss your cases with anyone else. Equally, unless you are having adequately thoughtful conversations with your colleagues, your own inner dialogue as you practise may become bland, persecutory or even silent,[10] and your working style may become repetitive and automatic.

There is another aspect to clinical supervision as well. To receive or to give clinical supervision, is an acknowledgement that we cannot as individuals think or feel outside the frame of who and what we are. If you have a discussion of a case with someone who brings a different perspective — of gender, ethnicity or profession, or even of a different personality and life experience — you start to hear, notice and understand different things. This may put you in a position to propose different questions and imagine new ways forward for yourself and the patient concerned. A colleague who can challenge glibness in a friendly way, or can gently perturb you by exposing any unexamined assumptions in your thought processes, is also teaching you how to do the same with patients.[11]

Within primary care, people often cannot hear the word supervision without feeling it is some sort of policing. Many GPs say they would rather use an alternative term: case discussion, clinical case analysis, and so on. In spite of this, there are many good reasons to promote both the word and the concept of supervision in primary care, in the positive sense that is now understood in so many other fields.

Firstly, it connects us with the richness of thinking that has gone on about supervision in those fields, especially in nursing.[12, 13, 14] Perhaps more important, it also enables people to identify the enormous variety of conversations in primary care that do have a very strong element of clinical supervision in them. These include, for example, informal chats over coffee or in breaks, GP partnership or primary care team meetings, or even meetings convened to discuss complaints and how to deal with them. Although these activities are rarely noted or researched, they probably provide essential support and learning for most GPs. (There are many formal activities for the profession that can also be regarded as forms of clinical supervision, like self-directed learning,[15, 16] mentoring,[17] PUNs and DENs,[18] Balint groups[19] and training courses of all kinds where time is spent discussing clinical cases.)

While noting that a lot does go on by way of supervision in primary care – even though it may not be labelled as such — it is also important not to idealise this. There is a contrast, for example, between the enormous amount of case discussion that goes on in a GP registrar year — in one-to-one tutorials and in the local vocational training group — and the dramatic cessation of such discussions upon final registration as a GP and entry into practice. There are teams and practices where nothing resembling clinical supervision takes place at all. Case discussion may share less in common with clinical supervision than with fishing stories (*'I saw a horrendous case this morning.' 'I bet it wasn't as horrendous as the case I saw'* and so on.) These conversations rarely leave people feeling looked after, and rarely produce learning. There is therefore a case to be made for promoting opportunities for clinical supervision where it does not exist, and

Commentary 1

Semantics bedevil what policy cock-ups leave behind. John Launer bravely attempts to pin down some definitions, and does so effectively. However, he does so by creating two new terms — work consultancy and performance appraisal — increasing the scope for confusion. In particular, 'performance appraisal', by which he means developmental appraisal, risks confusion with performance management.

This nit-picking serves to illustrate the larger truth: unless we agree on a limited formulary of terms and use them consistently we are destined to re-live endless misunderstandings.

In terms of the substance of this article, I am carried along with his argument. Certainly, I fully agree that the annual appraisal of general practitioners should be a formative, developmental experience. It should operate as one part of a wider constellation of systems and activities, now collectively called clinical governance, designed to promote quality of care and protect the public from poor performance.

The outcome from satisfactory clinical governance should be local reassurance for health professionals and the public alike, and professional approval of fitness to practice (revalidation to continue to be licensed by the GMC). However, the GMC's proposals place the responsibility for revalidation not on clinical governance as a system but on one part of it — appraisal.

Of all the elements of clinical governance, appraisal is the least suitable for this role. Those of us who were content that the evidence collected for appraisal should also be used, with some embellishment, for revalidation, cannot accept that the satisfactory appraisal is evidence that a doctor is, as far as can be determined, fit to practise. An examination of this threat to 'performance appraisal' (as he calls it) would have made Launer's arguments complete.

Mike Pringle

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This article has been adapted from a presentation given to a joint conference of the London GP Deanery and the Tavistock Clinic, 28 March 2003, on 'Supervision, support and appraisal in primary care'. I want to acknowledge the help of Jonathan Burton, associate dean, and Neil Jackson, director of postgraduate GP education, London Region, in developing the ideas discussed here, and also colleagues at the Tavistock Clinic, especially Sebastian Kraemer, Caroline Lindsey and Rob Senior.

extending opportunities where it does, so that GPs can sustain throughout their careers the level of reflectiveness they rightly expect during their training.[20] Raising the profile of supervision could help to transform clinical work from an individual to a collective responsibility, shared jointly by colleagues as they take care for each other's technical and ethical development.

Work consultancy

I have remarked before on the irony that there is a *British Journal of General Practice* but no British Journal of General Practices.[21] This contributes to the impression that the problems in our work only relate to its content, and that the context is itself quite unproblematical. Anyone who has worked for long in primary care, or provided support and consultancy for partnerships and primary care teams, will know that this is an illusion. Our working networks may be sources of intellectual and emotional nourishment for some of the time, but few GPs go through their careers without times of conflict within their teams, and these conflicts will virtually always have an impact on the clinical work too. Even at the best of times, careful case management can often depend as much on trying to achieve a coherent approach among all the professionals involved in the case — inside and outside the practice — as on trying to identify the right treatment for the patient. Just as it is worth promoting the notion and activity of clinical supervision, it may also be worth identifying work consultancy as something that should be named and routinely available in general practice.

In reality, a great deal of work consultancy happens all the time. It arises naturally in the course of case discussions or clinical supervision, without anyone realising that it is going on. In GP education, for example, it is rare to have an intelligent discussion about any case without at some point having to consider how the professional network is functioning, and whether it is supporting or hindering practitioners in their work. Similarly, formal or informal case discussions among experienced GPs regularly address issues such as professional or interprofessional rivalries, and problems concerning communication, money, politics or power.[22]

Although work consultancy can happen in this way, there are also times when it has to take place as a distinct activity, as a facilitated conversation involving several members of a team. This need may arise because of some kind of workplace crisis or dispute, or because of a significant moment that occurs in the life cycle of the team, such as a retirement or change of premises.[23] Some teams (possibly the more reflective ones) regularly set aside some time for members to think together about their roles and responsibilities, or their pressures and objectives, in the form of extended meetings or even awaydays with a facilitator.

Whether work consultancy takes place in the context of clinical supervision or as a separate activity, it requires the same stance of curious tolerance, the same capacity to challenge without confrontation, and the same skills of hypothesising and questioning, that should inform reflective practice. It may therefore be helpful to regard it as a third kind of professional conversation, an important counterpart to the other two kinds, and perhaps even a prerequisite for anyone working in the complex settings that most GPs do.

Performance appraisal

What has all of this got to do with appraisal? Isn't performance appraisal an entirely different process from other kinds of professional conversation — a far more formal, structured, annual process guided more by external requirements than by internal needs?

There is in fact a strong case to be made that performance appraisal is a fourth kind of conversation that bears, or ought to bear, a strong resemblance to the other kinds discussed so far. In reality, a great deal of reflective practice, clinical supervision and work consultancy shades quite naturally into an informal kind of performance appraisal. Indeed, in many of the everyday conversations that we have about our work, both with ourselves and our colleagues, we are constantly having to think about how to respond to the changing demands of our jobs, and indeed how to adapt to the demands of external authority in the form of guidelines, targets or professional codes of conduct. Conversely, in the context of formal appraisal, doctors are likely to need exactly the same kind of tolerant, client-centred stance they would wish to bring to bear in their clinical work and in their conversations with colleagues. They might also want to exercise the same kind of facilitating skills with appraisees as they do with their patients and team-mates, in order to help them think about their needs and how to meet them.[24]

Following this line of thinking, appraisal could be prevented from becoming an annual ritual of box ticking and turned instead into a model of how professionals can help each other to think about their professional roles, their performance and their learning needs, and could regulate these themselves. If appraisers can be helped to acquire an appropriate stance and

skills, they can model for their appraisees exactly the kind of behaviour that may be most effective at all the other levels of work activity. If appraisers can give clear signals to their appraisees (and indeed to their PCTs) that they regard appraisal not as an end in itself but as a part of a pattern of evolving growth for the profession, they will be well placed to promote a whole range of training that might run alongside appraisal, and be offered as resources to appraisees.

The main advantage of reframing appraisal in this way is that it firmly places it in the domain of professional development rather than the domain of monitoring. This, of course, is precisely where it was originally intended to be — certainly as far as British doctors are concerned. According to the original guidance from Department of Health, there was no question that appraisal should be seen entirely as a personal, developmental process, and that where questions arise of under-performance or negligent or unethical practice, the appraisal process should cease forthwith.[25]

At the present time, there is much work to be done in persuading primary care organisations, the government, and most of all our own regulatory body in Britain to return to such a view. The decision of the General Medical Council to link performance appraisal with revalidation may undermine the developmental nature of the process, without achieving its other aims of detecting underperformance or increasing public accountability.[26, 27] This conflict of purpose may in the end only be resolved by developing an entirely separate (and possibly external) form of policing, related to measurable outcomes or explicit inspections, and thereby protecting appraisal for formative purposes alone. Many GPs who want to preserve the developmental aspect of appraisal might not object to this.

In the mean time, the best way to protect what is most valuable about appraisal may be to conduct it as a particular kind of conversation, closely akin to so many other productive conversations in primary care. It is the kind of conversation where the appraiser chooses to act not so much as a representative of authority, but as someone who facilitates thinking about how clinicians want to manage authority. The advent of appraisal, paradoxically, may still represent an opportunity to promote better learning conversations between colleagues than the ones that have often taken place in the past.

Conclusion

The four kinds of conversations discussed in this article can all be seen as forms of facilitated learning. One way of reframing them might therefore be as follows:

- **reflective practice** = the learning mind
- **clinical supervision** = the learning relationship
- **work consultancy** = the learning workplace
- **performance appraisal** = the learning profession

One advantage of this reframing is that it immediately suggests how conversations about the emotional or interactional problems that arise in practice might intersect with more concrete learning activities, including the continual technical and biomedical education that primary care work requires.[28]

These four forms of learning can also be understood as ways of promoting and achieving 'fitness for purpose'. In its original, Darwinian sense 'fitness' is not a linear, supremacist notion but something far more interactional, in which everything that survives does so by virtue of its capacity to adapt responsively — in other words, to become *a better fit.*[29]

Taking up this idea, one can see how reflective practice is practice that most adequately 'fits' the needs of the patient, not by virtue of brutalistically applying the latest protocol or guidelines, but by learning to find a fit between what the practitioner knows and what the patient needs.

In like fashion, clinical supervision and work consultancy can be seen as conversations that explore the potential for achieving a 'fit' between what the supervisor or consultant has to offer, and what the client, on behalf of his or her patients, is looking for.

If it is to promote fitness for purpose, performance appraisal will do so not by measuring practitioners up against reductionist targets. It will do so by inviting them into a learning process that encourages, evokes and models fitness for purpose in a truly professional sense: as 'practice that fits'.

John Launer

Commentary 2

A thoughtful, constructive article by Launer. How does it help us?

It helps by illustrating that, not only in the use of 'appraisal' but in the use of other words and phrases, different professions use words to mean different things.

That consultants use 'appraisal' to mean a review of performance is no more perverse than GPs using it in a formative, educational context. For the public at large 'appraisal', in different guises, is used in many work situations — not necessarily in a positive, formative way, but sometimes quite negatively.

Given the composition of a Primary Care Organisation, how many differing understandings of the word 'appraisal' may be represented as they establish their local revalidation process?

When (if) the public learns that appraisal x5 is being used in the revalidation of doctors — will they be reassured? Or when they learn that in addition a local NHS group will examine a doctor's folder every five years — will that give them confidence that there won't be a poorly performing doctor to be found by 2010?

Serving on the RCGP's Good Medical Practice for General Practitioners Working Group and on the Revalidation Working Group, I observed total acceptance that high standards of care in the interests of patients should be promoted; that support should be available to doctors in need of it, and that the sooner their need was identified the better for all concerned. They were working towards honouring the original intentions, stated in 'Revalidating doctors — ensuring standards, securing the future', to protect patients from poorly performing doctors, promote good medical practice, make the register a valid indicator of current fitness to practise, and so increase public confidence in doctors. That was reassuring.

The eventual withdrawal of the GMC to the sidelines, ditching some of the honourable intentions in the name of pragmatism, placed a brake on the feeling that things were heading in the right direction.

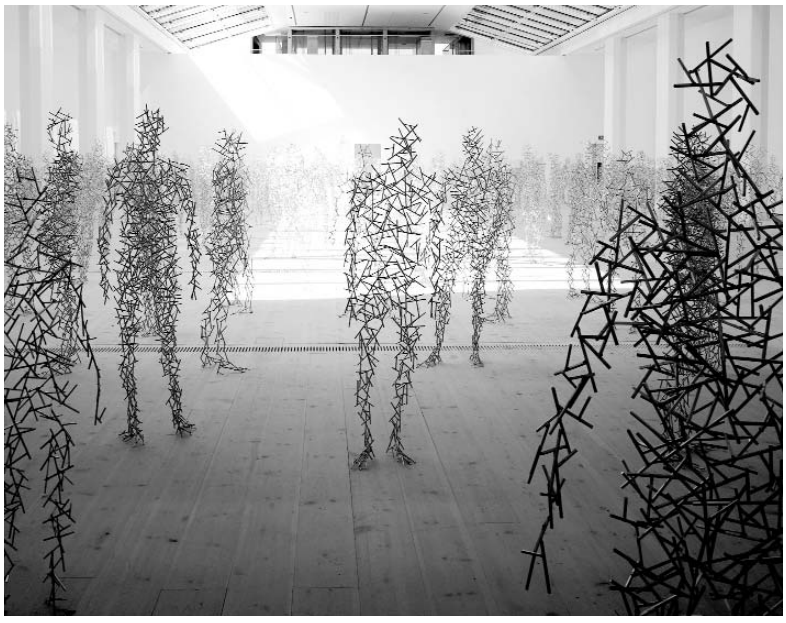
My immediate concern is the need to focus on the primary task: to ensure safe delivery of a robust revalidation process. Surely the message from Launer is to use words not open to interpretation which leave no one in doubt about what the RCGP thinks is the best way of protecting the public and supporting doctors.

Eileen Hutton

Domain Field
Antony Gormley
Baltic, Gateshead till 25 August 2003

WHEN I first visited Baltic, just after it opened in July last year, I was more impressed with what I could see from its windows than with anything on show in the galleries. Baltic is a flour mill turned modern art gallery which dominates the Gateshead quayside. It is best approached over Gateshead's Millennium Bridge which curves elegantly over the Tyne from the Newcastle side and leads you directly to its doors. Visiting level 5 viewing gallery on my first visit we were privileged with a majestic view of the bridge swinging up to admit a ship. This time, however, even if the bridge had been opening my attention would have been held by what was in the level 4 gallery itself.

Antony Gormley, the artist who created the Angel of the North, has been working in the level 4 gallery space since January creating *Domain Field*. This work consists of representations of 286 local people between the ages of two and 85 cast in bright steel bars. The process by which the bodies became these 'domains' of steel has been open to public view from the level 5 gallery since February, truly reflecting the intention of Baltic's director, Sune Nordgren, that the gallery should be an 'art factory'. The local volunteers subjected themselves to being wrapped in cling film, covered in plaster and cut out of the plaster shells once they had set. Volunteers had various reasons for being part of the work but the most frequent was a desire to 'belong' or to be 'part of something', a theme that Gormley himself takes up in the film which accompanies the work and which can be viewed on level 3. He pays tribute to the contribution of the volunteers by saying that the recognition that his art could derive from human forms other than his own was a great liberation for him. After the volunteers were freed the plaster casts were given to welders who worked in the empty space within them ('like climbing inside someone') to create the final representation. The steel figures have now been placed in the gallery to create the *Domain Field*.



Gormley has used the metaphor of 'field' before in his 1993 work, *Field for the British Isles*, made up of around 40,000 terracotta figures crowded into a single room. These figures were not life size and were all orientated with their eyes pointing towards the viewer. This work was striking for its sheer scale and because of the disconcerting gaze of so many little eyes. In *Domain Field*, however, the figures are pointed in all directions and it is possible to wander among them as if you are in a crowd of people. It is not like visiting a waxworks. The figures are more dynamic, despite the fact that they are not lifelike in the conventional sense. The gallery is lit by natural light, playing about the figures, reflecting off the bright steel, onto the pale wood floor of the gallery. It is fascinating to see how the welders have created the bodies from the empty spaces of the moulds. Each body is unique, not just in terms of its shape but also in terms of its density. In some figures the welded rods are widely separated as if to represent a lightness of flesh and, perhaps, of spirit. In others, the rods are densely packed allowing little light between then. This density does not necessarily suggest obesity but rather the relationship of the figure with light and movement.

Entering *Domain Field* I felt excitement that I cannot quite explain. I was among human bodies but sensed their strangeness. Despite knowing that the figures were made of metal and space, there was a feeling of animation which was both disconcerting and appealing.

The exhibition can be viewed from two vantage points, among the figures, and from above. It is worth experiencing both. From above the work expands to include the flesh and blood figures of the viewers moving though it. One criticism — to the right of the *Field* there was a woman in a wheelchair and I wondered why Gormley had chosen to depict all the figures standing on healthy legs.

This work is a must-see for anyone within striking distance of Newcastle-Gateshead this summer. An added advantage is the fabulous and evolving cityscape on both sides of the River Tyne that should now be wearing the crown of City of Culture to be!

Jane Macnaughton

Unless: a novel
Carol Shields
Published by 4th (division of HarperCollins), 2003, ISBN 0-00-714107-6

DESPITE, or perhaps because of, being written at a time of coming to terms with the diagnosis and treatment of breast cancer, Carol Shields, the accomplished Canada- based writer of contemporary fiction has produced her *tour de force* in her enigmatically entitled book *Unless.*

Shields established her reputation with her Pulitzer-prize winning novel *The stone diaries* in 1993. This most recent work, is currently nominated for the Orange prize for fiction.

Unless is an astonishing book, written with exquisite simplicity, yet plumbing the depths of what it is to be human.

The central theme of the book is how a family in crisis makes sense of their loss and sadness. The novel revolves around the protagonist, Reta Winters, a 44-year old writer and mother of three teenage daughters, the eldest of whom, Norah, has withdrawn from life. She has taken up a sentinel post on a corner of a windswept street in Toronto, spending her nights in a hostel for the homeless. Norah's only communication with the rest of humanity is a cardboard sign, slung around her neck, saying 'Goodness'. Her close family are bereft at her 'abdication' from their lives and the story unfolds chronologically over the months following Norah's withdrawal.

Shields uses a narrative style referred to by herself in a previous short story as 'ovarian rather than ejaculatory'. An iterative, circular style which revisits and explores themes and patterns rather than moving forwards in a purposeful and climactic fashion.

A core idea in the book is the exploration of what has actually 'happened' to Norah and in this thesis some room is given to medical interpretations; although the fictional psychiatrist is never so simplistic as to call it 'a depression', nor refer to the social isolationary, prodromal period that can proceed a first presentation of adolescent schizophrenia. Rather, Dr McClure, clearly influenced by Laing's anti-pyschiatry movement, describes the crisis as 'a gift (to herself) of freedom ... the right to be a truant in her own life'. He advocates non-interference, which the family aspire to while still maintaining weekly contact through dropping off food parcels and warm clothes.

Interestingly, Norah's father, Tom Winters, is a family physician, and long-time aficionado of trilobites (a form of pre-historic fossil). In order to cope with the fracture of their domestic life he chooses to believe that his disaffected first-born is suffering from post-traumatic stress disorder and spends endless web hours searching for confirmatory material, abandoning his first passion: 'Well, he is a doctor. The idea of diagnosis and healing comes naturally to him, a rhythmic arc of cause and effect that has its own built-in satisfaction, and how enviable to me, this state of mind is'.

Reta's, and one suspects Shields's, perspective on this is that the socially constructed gender identities women take on can paralyse a woman from fulfilling her potential. There are many explorations of this belief throughout the novel, such as: 'Women are forced into complaining and then needing comfort'.

Part of Reta's quest to reach a greater understanding of the motivation behind her daughter's apparent elective disconnection is revealed to the reader through a beguiling literary technique involving a series of letters. The intended recipients of these letters, editors and publishers in the book trade, are a mystery, as is the puzzle as to whether the letters are ever sent. As such, the overall effect is to add to the sense of questioning and searching which the book promotes, rather like life when we are actively looking for meaning.

They also bear reference to the non-appearance of the great works of literature written by women, such as in cited anthologies, as if they have never played any part in our greater understanding of the human condition.

This is not however an angry feminist diatribe. Far from it, the book exudes a tenderness, seen in the supportive 20-year relationship Reta and Tom share and in the compassion the family endeavour to demonstrate towards Norah and other characters in the book.

This book took my breath away. The supple prose of the writing takes you in its powerful yet tender grip and leaves you reeling with the visceral pain and pleasure of being human, of experiencing loss and yet striving to survive and find meaning in our lives.

Many of us have, at epiphanic moments, experienced similar phenomena while sitting in the doctor's consulting seat, but here Carol Shields, a most gifted writer, offers this experience to a wider audience, and in a beautiful, accessible form.

It is a book that will not fail to move those who allow it to speak to them.

Jane Gordon

Cruel and Tender: the real in the 20th-century photograph
Tate Modern, till 7 September 2003

WALK across the Millennium Bridge, into the Tate Modern's first major exhibition dedicated purely to photography to wonder at the power of the photographic image and ponder over what distinguishes the art of some of the best 20th-century social documentary photography from the ordinary. The difference is at once huge and tissue-thin.

Photographs are part of our every-day experience. Dramatic or sensational pictures are the stuff of daily newspapers, family snaps a ubiquitous ritual. But these are different, special, and compel us to pause and reflect. Big pictures hung in airy spaces pull us into worlds in a way no prints in the hand or on the page can. We see more. The size astounds and the content touches.

Nicholas Nixon's modestly sized portraits of the four Brown sisters posing in the same order every year for 27 years are a moving testament to ageing, to growth and to relationships. To a GP they represent the narrative of a working lifetime of the experience of general practice.

The collection is dominated by American photographers — the stunning painterly masterpieces of William Eggleston, the pathos of Robert Frank's USA road experience, Lee Friedlander's portraits of the new technology workers of the 1980s which capture the distinctive, concentrated look associated with staring into a computer screen. Is this how we look to our patients when we are grappling with Read codes?

But you also have Rineke Dijkstra's striking juxtaposition of portraits of bullfighters and post-partum women, Boris Mikhailov's pictures of homeless Ukrainians, Andreas Gursky's fantastic large-scale colour studies crammed with detail, and lots more. From the UK, Paul Graham's drab pictures of British social security offices complement Martin Parr's garish images of tackiness that you either hate or love.

Photography always fascinates as it offers a version of reality in a vernacular familiar to all. And there are truths here that will resonate with the intense experience of humanity that is the GP's bread and butter.

Two hours of this and you feel you've completed a really busy but extraordinarily varied surgery, and you've done it well. You're elated, exhausted, disturbed, and there is unfinished business as usual. You will not see a collection of photographs better than this for a long time.

Paul Schatzberger

Ljubljana

FEW architects appear on banknotes. Christopher Wren, of course, and Thomas Jefferson, and, until the arrival of the bland Euro, Alvar Aalto. Whatever we make of the symbolism of all this, there is no doubt that it is a particular accolade. And so, when we arrive in Slovenia and obtain our first 500 Tolar note, and we see on it Joze Plecnik and his great masterpiece, the National Library, visiting architects, such as myself, know we are on to a winner. And so it proves.

Ljubljana, the capital of Slovenia, is where Plecnik spent the best part of his working life. He was born here in 1872 and he died here in 1957. This, you may be forgiven for thinking, is probably why you haven't heard of him, and you would be right, but you would be wrong to think that there were no wider European connections in his work. Slovenia was part of the Austro-Hungarian Empire, and Ljubljana was a regional city.

Plecnik went to Vienna to train as an architect, under Otto Wagner, and he did his first work there. After the First World War, his big break was to be invited by President Masaryk to turn Prague Castle into the President's Palace for the new Czech Republic. He formed a close liaison with Masaryk's daughter, but it is unclear just what the nature of their emotional relationship was. In 1927, he returned to Ljubljana, and there he lived alone until he died. But this is not a sad story.

Over the next 30 years, he built an extraordinary amount — the National Library, the central market, the national stadium, the walkways on either side of the river, including the remarkable Three Bridges, all modern buildings built in a modern way with modern materials, but using a very particular classical language. Few architects have ever built so much in a single place, but what he did was much more than a collection of individual buildings, as city planner he helped to shape the town, not in a monumental way, but by making a series of connections, for he was not working with a blank canvas.

There had been a Roman fort here, out on the plain. The outline is still clear, and indeed Plecnik repaired some of the walls, though not without adding one of his characteristic pyramids. The Romans were confidently marking this as an important place on the trading route from the sea (Trieste) to central Europe (Vienna). Local post-Roman regimes were not quite as confident and medieval Ljubljana castle (also repaired by Plecnik) was built off the plain and over to one side on a convenient steep hill, with the Old Town closely huddled below it. The general idea had been to discourage unwelcome visitors from lingering. The late 19th century was more stable, and the town spread out on to the plain again. The railway linking Trieste and Vienna was completed in 1849.

Plecnik was able to stitch together this urban fabric into a harmonious whole. It is the best sort of planning — few people notice it. Plecnik is not without his heavily symbolic side: the street entrance of the National Library leads into a dimly lit, black marble staircase, and then up into the open, well-lit library itself. Here we are clearly meant to reflect on knowledge as being the link between darkness and light, but little of his work is open to such easy interpretation.

His architectural vocabulary is classical, but using such wit and invention that it can sometimes be thought of as working outside the language of neoclassicism. But I think this would be to misunderstand his intent — he was an ardent nationalist, and an ardent Catholic. His was a very particular sort of radicalism. He was, I think, trying to say that who we are is partly a reflection of who we were, but he was not trying to recreate the past. Ljubljana is a modern city, but it is also a city rich with memory.

This is the framework Plecnik left — exciting and still capable of use. Each time I visit, it has more cafés, and yet it has the capacity for plenty more. I urge you to visit. You'll enjoy the coffee and the banknotes (Slovenia has virtually no coins — who needs them? — what a modern idea!)

David Heath

david hannay

The end of general practice

GENERAL Practice has evolved in the United Kingdom with three characteristics. The first is that GPs are gatekeepers for secondary care, which arose because of conflicts at the end of the 19th century between GPs relying on patients' fees and the outpatient clinics of charitable hospitals. The second is that of non-specialisation whereby GPs are generalists; and the third is that of registered lists of patients. This started with panel patients from the 1911 National Insurance Act paid by capitation fees, which was then extended to the whole population with the National Health Service in 1948.[1] International comparisons suggest that such features provide for efficient and effective primary health care, compared to other countries.[2]

Unfortunately recent government initiatives have tended to undermine these characteristics, for instance, by providing alternative access such as NHS Direct. To this has been added the tendency for the techniques of management to become part of market ideology, which led to the 1990 Contract with its emphasis on competition and the internal market. The present government has replaced competition with partnership, but the ideology remains in the management of public services, where the distinction between the public and private sector is narrowed, and professional autonomy and discretion are reduced whether by clinical governance for medicine or national curricula for education.[3]

The New Contract continues this process and further changes these characteristics of British general practice in three ways. Firstly, the link between individual patients and doctors has been broken by making registration with the primary care team rather than the general practitioners. Secondly, the identification of additional services as optional will lead to inequity of primary care across the country, which may have existed before but has now been institutionalised. And finally, quality has been defined in terms of data collection.[4]

Striking about the New Contract is the detail of the quality measurements, and the effort the profession's negotiators have put into designing them — as if attempts to please everybody have resulted in squaring circles of increasing complexity, so that no one can see the wood from the trees. Part of the process is grasping at formulae — so often inappropriate. In the 1990 Contract it was the Jarman Index and in the present contract it is the Carr-Hill formula.

A reason for this situation is partly the pervading management ideology that provides a world view in which the end justifies the means and which is mediated by language. Whether in the private or public sector, there must be competition, contracts, customers, quality assurance and value for money.[3] Another reason is demographic. With equal opportunities, over half of medical students are now women, as are those trained for general practice, and lifestyle, career and part-time working expectations are very different. In rural areas in particular there are few job prospects for spouses or partners, and the importance of dual careers for recruitment and retention needs to be recognised. A third reason is the rise in workload, driven by increasing patient expectations which have become part of party political campaigning.

The emphasis on quality could have been linked to professional accreditation, rather than to the obsessive collection of management data linked to pay. Items of service payments were originally introduced for preventive measures, which were not part of general medical services. However, the prevention of disease and promotion of health were explicitly included in the 1990 Terms and Conditions of Service, although paradoxically the contract, then as now, increased the complexity of such payments.

The New Contract is for primary care clinicians rather than general practice, although those involved don't seem to realise, as the baby of professional integrity is thrown out with the bath water and replaced by the contractual details of a public-private finance initiative. In last year's publication *Good medical practice for general practitioners* doctors are told: 'you must be satisfied that when you are off duty suitable arrangements are made for your patients' medical care'.[5] However, in the world of the New Contract patients are no longer the responsibility of doctors, but rather of the primary care team.

Whether viewed as inevitable or appropriate, the New Contract means the end of general practice as we know it — killed predictably by management ideology, and paradoxically by equal opportunities and the profession's negotiators. Long live primary care.

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New general medical services contract

YOU may recall that Council had an extensive debate on the new General Medical Services Contract at its March meeting. Since March, the ballot was put on hold pending further negotiations between the NHS confederation and the GPC. As you will be aware, the ballot closed on 20 June and resulted in a 'yes' vote to accept the new Contract.

Council took the opportunity to reiterate some of its issues of concern, which were noted and would be picked up by Dr Hamish Meldrum, one of the GPC negotiators.

A main area of work that now needs to be undertaken is to look at the implications of the Contract, with its emphasis on quality. A paper will be prepared for July's Council Executive Committee meeting on the challenges and opportunities for the College. This will be a major opportunity for the College to deliver support for the quality aspects of the Contract.

***Modernising medical careers*: the Departments of Health response to Unfinished Business. The RCGP review of the curriculum for general practice education and training programmes**.

The Chairman of the education network, Professor Steve Field, brought a paper to Council that looked at the recently published response of the four UK Countries Departments of Health to the consultation, Unfinished Business, revising the SHO grade. It was made clear that *Modernising medical careers* did not reflect the concerns expressed by the College in its response to Unfinished Business. In summary, our concerns were:

- It paid little attention to general practice and didn't explore the implications of its proposals for doctors intending to make a career in general practice; the College emphasised the need to radically reorganise the training of GPs.
- The introduction of a two-year foundation programme was welcomed but the College insisted it should not be used to reduce the period for specialist training for general practice. General practice should be treated equally with other specialties.
- The impact of structured training for all training grades on the workload of consultants and general practitioners and the need to expand training capacity was highlighted. The need to attract GPs into academic positions was also raised.
- The need for GP training programmes to be based in primary care while allowing exposure to the secondary care environment was reaffirmed.

To ensure that the College takes the opportunity to set the agenda in light of the SHO grade proposals and the establishment of the Postgraduate Medical Education and Training Board (PMETB), Steve Field put forward proposals to review the GP curriculum and develop competence-based assessment in line with other royal colleges. Two sub-groups will be established, one on education and the other on assessment. Council agreed the framework and timescale for the review. Steve Field emphasised that he wanted to ensure the involvement of all members of Council in this review and was also keen to engage our wider membership to make sure GPs have a significant role in the development of the new curriculum. It is expected that a draft of the new curriculum will be ready by the spring of 2004.

In the first instance, a draft College policy statement regarding equivalence in the length of training with other specialties will be prepared by Steve Field and considered at the July CEC meeting, and then, hopefully, the September Council.

Severe acute respiratory syndrome

A briefing paper will be posted on the College website and be included in the next e-mail bulletin.

RCGP strategy plan

Council was given a progress report on the Strategic Planning process, formerly known as the Income and Activity Review. Council will have the opportunity to consider draft recommendations at the September meeting of Council and be asked to endorse the next stages of the process.

Medicine and management: improving relations between doctors and managers

Council agreed to endorse this document, which was the result of a conference held on 27 March, organised by the NHS Confederation, the Academy of Medical Royal Colleges and the Department of Health. Our Chairman, Professor David Haslam will sign on behalf of the College, endorsing the principles that should govern doctor/manager relationships.

National Collaborating Centre for Primary Care

In 2000, the College became the lead partner on the National Collaborating Centre for Primary Care (NCC-PC). Its remit is to develop evidence-based guidelines for the NHS on behalf of the National Institute for Clinical Excellence (NICE). The lead for the NCC-PC is Dr Mayur Lakhani. It was explained that currently, the development work is contracted out to two University departments. However, one of the universities has informed us that it will not

matters arising

Council and CEC dates for 2003–2004

Council agreed to the proposal to reduce the number of Council for next year to four. This also means that the Council Executive Committee will also be reduced to four meetings per year. Since the decision was made at Council, we have had to amend a couple of the dates slightly, so would you please note that these are the revised dates for 2003–2004.

Council dates for 2003–2004

Saturday 15 November 2003
Friday 13 February 2004
Saturday 19 June 2004
Friday 3 September 2004

Council Executive Committee dates for 2003–2004

Wednesday 21 January 2004 (Joint CEC / Finance Meeting)
Thursday 22 January 2004
Thursday 29 April 2004
Thursday 15 July 2004
Thursday 7 October 2004

We are looking to change the phasing of meeting for 2004–2005 and beyond and will be putting forward proposals to move the timing of the Annual General Meeting, starting with the AGM in 2004. This will allow us to programme Council and CEC dates more effectively in the future.

The **next meeting of Council** is on **Friday 12 September 2003.**

be continuing beyond its current contract, which ends in March 2004. To replace this lost capacity, Council agreed that a College-managed unit be created with the capacity to develop two guidelines, with a possible expansion to four. This work is entirely funded by NICE.

Hard lives: improving the health of people with multiple problems.
Council was asked to endorse a consensus paper which was the result of a conference held in Glasgow on 28 March. This conference was co-hosted by the Health Inequalities Standing Group, the West of Scotland Faculty and the University of Glasgow. The statement sets out the agenda for action at practice level, for primary care organisations, and also at national level. This statement will be available shortly as a College publication.

Statement regarding College policy on disability
The Disability Task Group, led by Dr Charles Sears, put forward a proposed College statement on disability, which was warmly endorsed. The statement reads:

'Conscious of the consequences and implications of disabilities for individuals, families, communities and society at large, the Royal College of General Practitioners seeks to:
- Facilitate the training and the practice of present and future general practitioners through knowledge, skills and attitudes which will help and enable disabled people to live independent lives with dignity
- Encourage a wide spectrum of relevant research, and
- Liaise with government, professional organisations, independent organisations and other bodies, with a view to participating in the development of policy and services for the benefit of disabled people.'

Model devolved Council rules and faculty bye-laws
As part of the changes to the College constitution, resulting in the granting of our Supplemental Charter, one further piece of work is to revise the model bye-laws for faculties and model rules for devolved councils. These were put to Council and approved. I will be circulating the models to all faculties and devolved councils shortly and will be asking that each faculty and country council draw up their proposed bye-laws and rules, for submission to the College. You may recall that it was agreed at January 2003 Council that the approval of actual rules and bye-laws will be delegated to the Honorary Secretary and Chief Executive.

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neville goodman

To bring you up to date…

A LAST thin band of cloud stopped the sun sinking into the sea on midsummer's day, but we watched it that far as the midges nibbled. The waterproof trousers were more donned than not in the first few days. On one walk, the uncertainty of knowing where one's foot, once lifted and caught by the wind, was going to land, forced us off a rocky ridge and down a trackless steep corrie of grass and rock to safety. On another, with the cloud at 500 feet, a stroll across moorland ('The first 200 yards are a bit boggy, but after that the path is firmer', said the guidebook) was alternately a squelch between patches of marram grass and a balancing act from stone to stone, with interim judgements about the solidity of the intervening spaces, on a path that was also a stream.

It was wonderful. If you're warm in your cagoule, and your feet are dry, and there's a hot thermos in the rucksack, and someone else is 500 miles away giving anaesthetics on your operating list, who would be anywhere else? And when, later in the week, the sun came out and we did, finally, complete a traverse — the first half of which we'd done 31 years earlier — we really wouldn't have minded the five-mile roadwalk back to the car. Except that we didn't have to: in those parts, boots and rucksacks ensure successful hitching. Smelly, exhausted, thirsty and happy, we gratefully accepted the offered lift, bundled our kit into the boot of the car, slumped into the back seats and swapped hiking stories with our saviours.

Driving in stages back to England we pondered why Scotland has such a powerful medical tradition. But it's obvious really. It's the place names. They enable a much better description of symptoms, conditions and treatments that English ones. You can sift through an English gazetteer and dredge some up, but in Scotland you're driving past and through them all the time. Everyone knows what you mean when you say you're feeling *slochd*, or you've been a bit *fodderty* since the weekend. This can be much eased by some *arpafeelie* — unless you're *breakachy* in the *drumsmittal*, in which case it's better to go to a registered *inverkeithing* practitioner. If that makes you *dalmally* in the *bottacks*, either give a small dose of *Elsrickle* (sorry for using the proprietary name there) or an *auchtertoo*l will bring some relief. That should ensure your *ecclefechan* is *ecclesmachen* by the morning.

And Scotland has also given us John Reid.

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james willis

All changed, changed possibly

THE sceptics e-mailing the rapid response pages of the *BMJ* may be right — the benefits of the six ingredients in the PolyPill® may not be additive; their wanted effects may antagonise each other in combination, or their ill effects may prove synergistic. Wald and Law[1] may have got their statistics or meta-analyses wrong and overestimated the benefits. Or they may actually have been joking. Or just trying to provoke a debate. On the other hand, Richard Smith may be the one who was right in his Editor's Choice — the 28 June 2003 issue of the BMJ may be the most collectable I have every binned — 'the most important *BMJ* for 50 years'.[2]

One thing is certain — seriously contemplating the possibility of a pill which protects against 89% of coronaries and 80% of strokes, costing only £60 a year, using established drugs in low doses so that preliminary work-up and subsequent medical supervision is unnecessary, which thus bypasses not only the pharmaceutical industry and the medical profession but perhaps even the government itself (if they stand back and let us choose whether or not to take the thing) is a thought experiment of the most fascinating and far-reaching kind.

After a predictable gut reaction of despair and outrage, I am now seeing this thing in a more and more positive light. To start with, to get the benefits of the PolyPill® you don't need to be a patient, any more than you need to be a patient to take a walk, a vitamin pill, or a generous slug of health-giving Merlot. What's more you don't need a doctor, you don't need any checks and you don't need any records. You don't even need to know whether you are especially at risk (God wisely left this out of our equipage at birth and so should we) and you don't need to be given any neurosis-inducing labels. And neither does your insurance company or your employer. And the government has nothing to do with the matter at all.

The idea neatly side-steps the phenomenon of 'coercive healthism' which Petr Skrabanek attacked so definitively in *The Death of Humane Medicine*.[3] You don't need to be dragged into surgery for dubious tests to let your doctor earn a living wage. You don't need to be labelled, admonished, praised, patronised, worried ... or led into orgies of life-threatening celebration. Legions of nurses can be returned to their ancestral calling and be paid to nurse. Your nice, friendly GP can return to the life-enhancing role of being a nice, friendly GP to people who are ill and dying. (This will still happen, note, even if a decade or so later than before.)

All of this, of course, makes huge assumptions — that the low-dose PolyPill® really will reduce cardiovascular events by a large amount, and that it really will prove so safe that routine surveillance is unnecessary.

But let's imagine that both are true.

In that case everything would indeed be changed. And by sponsoring a proper trial to test the concept our government could demonstrate where its healthcare priorities really lie. Because the PolyPill® isn't going to get tested and approved by a pharmaceutical industry that has nothing to gain and much to lose by its success. This is the sort of project in the genuine public interest that this country, through the NHS and the Medical Research Council, used to be good at. You will wait a long time to see this kind of work done in North America

This idea highlights some of the most fundamental issues facing medicine. It is not at all clear whether the government wants people in general to live a decade longer, and it is not at all clear whether people in general want to live that much longer either. It will be interesting to see whether our rulers, eager in the past to appear good doctors, decide to explore making such potentially enormous benefits available to the people who vote for them. Or whether they are going to quietly let the idea (and us) die a death.

References

1. Wald and Law. A strategy to reduce cardiovascular disease by more than 80%. *BMJ* 2003; **326**: 1419-23.
2. *BMJ* 28 June 2003; **326**: Editor's choice The most important *BMJ* for 50 years?
3. Petr Skrabanek. *The Death of Humane Medicine*. The Social Affairs Unit 1994.

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