The Back Pages

viewpoint

On screening for colorectal cancer

'All screening programmes do harm' declares Muir Gray, arrestingly, in the opening sentence of his chapter on screening in the latest edition of the Oxford Textbook of Medicine.[1]

But not screening for colorectal cancer, perhaps. June in Slovenia and at WONCA Europe, enthusiasts considered screening populations for colorectal cancer. Colorectal cancer is nasty, relatively common, and early detection and treatment saves lives. Delegates quoted the unequivocal conclusions of the US Preventive Services Task Force (USPSTF) — 'Colorectal cancer screening is effective in reducing mortality rates from colorectal cancer and can decrease the incidence of disease through removal of adenomatous polyps.'[2] Mid-July in Scotland and the atmosphere is similarly hawkish as colorectal surgeons gather in Edinburgh and affiliated golf courses — 'Our recommendation to the Department of Health is that FOBt screening should be part of new national strategies targeting colorectal cancer.'[3]

A *fait accompli*? Should you 50-somethings out there brace for screening colonoscopies every 5 years (or 3 years, or annually)?

Time for thought. First the minor quibbles. No one has worked out yet exactly what screening test should be used. Should it be FOBt or sigmoidoscopy or colonoscopy, or any combination of the three? What is the ideal screening interval? Is the unpleasantness (or danger) of screening techniques being underestimated? Colonoscopy (in expert hands, at centres of excellence) carries a perforation rate of 1%. For the 99% of colonoscoped who aren't perforated, 40% report that 'it wasn't as painful as expected', which is of little reassurance to the 60% who found that it was. In the USPSTF studies, FOBts are described as carrying 'no harmful consequences', which will be news to primary care physicians who find that the false positive rates are routinely high. Anyone who likes their sirloin on the rare side can expect a colorectal surgeon loitering with intent, and as for those of you with piles and fissures ...?

So far, so facetious. But there are more convincing reasons why whole-population screening for colorectal cancer should be resisted for the moment.

Muir Gray again — minimum criteria for the introduction of population-based screening tests:
* The **condition** — All the cost-effective primary prevention interventions should have been implemented as far as practicable
* The **test** — simple, safe, precise, validated, acceptable to the screening population
* The **treatment** — management and patient outcome should be optimised in all healthcare providers prior to participation in a screening programme
* The **screening programme** — *evidence from high quality RCTs in reducing morbidity and mortality; that the complete screening programme is clinically, socially, ethically acceptable to health professionals and the public; benefits outweigh physical and psychological harm; plus managing, monitoring, staffing, quality-assurance, economic issues of screening programmes all addressed prior to the implementation.* (My italics).

Measured against these criteria colorectal cancer screening entirely fails to measure up. First, US and European populations are different — Americans are fatter and eat more carcinogens, and extrapolating US data to Europe is a dubious exercise.[4] Second, opportunity costs of colorectal cancer screening are considerable — when colorectal surgeons are screening for cancer they're not doing other things, like, for example, investigating sinister GI symptoms. (And, talking of opportunities, let's also ensure that the voices of screening test manufacturers, and also specialists, are heard, but without undue amplification.) Third, and most importantly, is the inadequate quality of the evidence in favour of introducing screening. Smallish RCTs and shallow meta-analyses would not be good enough for introducing new COX-2 inhibitors, or atypical antipsychotics, or HRT. Would they?

Screening programmes — intrusive, potentially harmful, and always irreversible — for predominantly healthy people, can only be introduced on the firmest of pretexts. Until evidence for colorectal cancer screening measures up we should just stick to eating our greens.

Alec Logan

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Acknowledgement

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'In the Philippines ... the Japanese have established retirement villages for themselves, fully staffed by local people who have been taught to speak Japanese, are versed in tea ceremonies and Japanese cultural values. The lifestyle is Japanese, but the costs are third world — Kyoto-on-Sea is a reality ...'

Shah Ebrahim, on the demographic timebomb, page 744

'The RCGP has its motto — '*cum scientia caritas*'. And it has its heraldic crest — an arrangement of assorted fauna, pressed flowers and bric-a-brac. What it has hitherto lacked is a signature dish ...'

Roger Neighbour suggests parsnips, page 749

contents

In Safer Hands — exploring the anatomy of risk in primary care

A 1–day conference for GPs, practice managers and nurses, and other health professionals working in primary care.

Managing and monitoring risk, getting the balance right, communicating with patients about risk or patient safety incidents — these are just a few of the myriad patient safety challenges facing primary care.

Focusing on creative, practical measures and solutions to key issues, this conference addresses patient safety within the unique context of primary care. With a healthy mix of plenary and elective workshop sessions, the day's programme includes — among other topics — the use of IT to improve patient safety, new approaches to managing and administering high-risk medication, and creating an open and fair culture.

This event — organised by the National Patient Safety Agency (NPSA) in conjunction with the Royal College of General Practitioners — aims to increase delegates' understanding of risk in primary care and to provide practical examples of good practice that can be applied to their own working environments.

An interactive exhibit of *In Safer Hands* — the RCGP publication supported by the NPSA, exclusively aimed at the primary care audience — will give delegates the opportunity to help shape and identify key issues for future editions. The conference will also feature an exhibition of organisations with an interest in patient safety.

For a booking form, please go to: http://www.rcgp.org.uk/rcgp/quality_unit/index.asp

Jamie Kaffash

Association for Medical Humanities inaugural conference 21–22 July 2003

Collingwood College, University of Durham

Medicine and the humanities in practice: What can be achieved, and how?

TO its activists and enthusiasts, 'the medical humanities' appears to be one of those ideas whose time has come; to interested onlookers it seems to denote something fashionable but vague. The Association for Medical Humanities is now in its second year, and having spent much of the first year planning its inaugural conference, by July of this year it was high time we held it.

From the outset the intention was to aim beyond simply swapping reports of how this or that special study module is taught in this or that medical school. If the medical humanities embodies anything academically substantial or distinctive, anything capable of enabling greater understanding of the medical encounter and the human conditions of health, illness, disability, and health care, then this needs to be articulated and discussed.

This then was the rationale for this first academic Conference of the Association, and its six substantive themes accordingly had a rather academic, rather than journalistic, sound to them. They explored such questions as the distinguishing characteristics of the humanities in medicine, how their impact can be measured in the contexts of medical practice, education or research, what constitutes genuine interdisciplinarity, whether medicine itself offers to the humanities anything in the way of 'cultural resources', or the resources which humanities perspectives might play in understanding and managing chronic illness.

These are serious and difficult questions; they required serious attention from formal contributors and from ordinary participants alike — and they got it. From the organisers' viewpoint, the most gratifying aspects of the conference lay in the intellectual seriousness, and the uniformly positive and friendly dispositions, of the conference delegates, drawn as they were from an encouraging variety of backgrounds predominantly within clinical medicine, and from a variety of nations. As well as participants from Sweden, Croatia and Switzerland, there was a strong showing from the United States (where the medical humanities has a longer history) with senior and eminent figures, such as Howard Brody, Kathryn Montgomery and Faith McLellan, playing prominent roles.

In his keynote speech, Professor Brody recounted and 'anatomised' a genuinely interdisciplinary collaboration in the multiple authorship of a book on the life and work of John Snow, the Victorian pioneer of epidemiology, anaesthesia and obstetrics. The key points concerned how certain aspects of understanding Snow's work could emerge only when authors from different disciplinary backgrounds could engage in a discussion through a vocabulary all could learn to share, and from which individual discussants could contribute an insight drawn from their own disciplinary

What will survive of us is love.
(Philip Larkin)

AND so I repaired to Durham, a favoured and favourite city, for the headily-awaited inaugural conference of the Association for Medical Humanities. The coincident sun and rain mirrored my joyous expectation and fraught foreboding as I entered a near-empty Collingwood College to register and mark time. Hellos and introductions — always a lovely start to a conference.

Sir Kenneth Calman's opening address was as gentle as it was innovative, honest, and self-baring, sharing the last 6 months of his 'commonplace book' with us. The delight was his delight at his recent memories, and the permission it seemed to give to grasp the moment, to revel in perhaps a fleeting glimpse of paradise, unlikely to be repeated in that context, so no need to strive to achieve again, but forever in the memory. Thank you for that, Sir Kenneth.

He was matched, phrase for phrase, at the other plenary, Howard Brody's masterful exposition of John Snow's life, merging his epidemiological papers and the famous Broad Street pump with his anaesthetic career, demonstrating a man born ahead of his time. To hear Brody wax over Snow's writings as a man who spoke as though born over 100 years later, was both moving and wonderful.

There was, in fact, a third plenary, originally listed as a workshop, 'A Brush with Humanity', beautiful viewing of beautiful and not so beautiful, unnamed paintings, known and unknown. With a personal statement on each as a demonstration of a learning tool for healthcare students. This brought art to my level, allowing the validity of my own interpretations, a permission I can move to poetry too. An excellent presentation by Andrea Sarginson.

The meat was the six parallel sessions; can't go to them all, which shall I choose? From the reductionist pose of the jobbing GP to the seminal reasoning of the philosophising academic, from curriculum description to an exposé of time, the political controversy of *Bodyworlds* to connections between literary

perspective, but not distinguishable prior to such interdisciplinary discussion. Here indeed was one model for how medical humanities enquiries could proceed.

Earlier, Professor Sir Kenneth Calman, Vice-Chancellor of the host University of Durham, opened up for the participants his 'commonplace book' of the last 6 months, in which he compiled insights and experiences which might not find their way unaided into academic textbooks, yet which illuminated the small change of experience of healthcare practice and of medical education — precisely the kinds of illumination that humanities perspectives can frequently offer.

It is invidious to list only a selection of contributions but, having made that admission, other notable contributions included seminar presentations on the limitations of linear models in health and health care (Kieran Sweeney, Marija Kovandzic), the importance of varying perspectives of time (Cecil Helman), information, aesthetics and identity in clinical judgement (Alan Bleakley, Rob Marshall) and varying roles for literary or dramatic insights in the clinical encounter (John Quin, Rolf Ahlzen, Steven Wainwright).

For the Association for Medical Humanities, this conference was the event at which it would be expected to 'come of age'.

It did.

Martyn Evans

and patient narratives. Descriptions of graduate and undergraduate teaching merged with erudite philosophical discussions and literary examples, filling the all-too-short time so that at the final session, a sharing of burning ideas to take forward so well orchestrated by Gillie Bolton, it seemed that yesterday was a week away.

This particular observer gained much, as one often does, in meeting so many more people all intent on 'rendering visible the deeper meanings of our lives', old friends, new friends, names known and not, American, British, Scandinavian, Yugoslavian, with the cement of Martyn Evan's self-effacing humour. And students engaging in this new world with gusto. I have new terms, the 'tolerance of ambiguity' will stay with me, and new concepts, of time as a spiral and not as a line with its relentless imperative of forward motion, ever forward.

As the memories will fade, I am buoyed by Philip Larkin's words, clearly written just for us.

David Gelipter

flora medica theophratus bombastus

From the journals, July 2003

***New Eng J Med* Vol 349**
139 A diagnostic breakthrough in multiple sclerosis: antimyelinating antibodies. A simple blood test which predicts progression following a single demyelinating episode.
146 Cancer increases the risk of thromboembolism, for which the best treatment is here shown to be low molecular weight heparin rather than warfarin.
215 Prostate cancer proved alarmingly common in this US trial of 'low-risk' men given finasteride or placebo. The finasteride group had fewer positive biopsies but nastier cancers.
225 Going to bed with house dust mites seems a bad idea if you have asthma or allergic rhinitis. However, keeping them out of bed with impermeable bed-covers makes no difference to either condition.
327 After the menopause, bone becomes progressively demineralised, but a slight consolation is that it becomes a bit thicker too, due to periosteal deposition.
335 Diagnostic studies depend on the existence of a gold standard, which in the case of prostate cancer is multiple transrectal biopsy. This is not only unpleasant but prone to its own inaccuracies (sampling, histopathology): moreover it is only done in men already suspected of having the condition because of rectal examination or high prostate specific antigen (PSA). This paper attempts to correct for verification bias by re-analysing screening studies of PSA, but to me confirms that these initials really stand for Perfectly Stupid Attributes.
359 They asked nurses in Oregon to report experiences of patients who refused food and fluids to hasten death. Most had a 'good death' within 2 weeks.

***Lancet* Vol 362**
7 If you are managing your heart failure patients properly, you should be trying to give them small but increasing doses of a beta-blocker. The COMET trial shows that carvedilol is better than metoprolol in advanced heart failure.
147 But of course most of your heart failure patients are elderly with a lot of co-morbidity, especially respiratory disease: this review is a very useful summary of demographics and concomitant disorders.
185 A big cohort study showing that the huge long-term experiment of oral contraception has turned out to be entirely harmless in terms of overall mortality.
316 Yet more about heart failure: there is a lot of confusing literature about B-type natriuretic peptide (BNP), and it is reviewed comprehensively here. It is really very simple: BNP is just the heart saying 'ouch'.

***JAMA* Vol 290**
41 Screening for bowel cancer using sigmoidoscopy not only misses all lesions beyond the scope but also a few between examinations. The editorial on page 106 discusses 'how often and how good' — the bottom line, so to speak.
207 Red clover extracts work as well as placebo — an impressive 36% relief — in this US study of menopausal hot flashes. They say flash, we say flush, let's call the whole thing off.
336 Children who go on to display autistic spectrum disorder tend to be born with smaller heads, which then go through two periods of accelerated growth.
502 You don't have to take a statin to achieve large reductions in cholesterol — a very low fat vegetarian diet can achieve the same.

Other Journals:
A cheap, harmless drug which slows down the progression of osteoarthritis and relieves symptoms too? Glucosamine works: ***Arch Intern Med* 161: 1514** meta-analyses the literature and **1587** shows that it does not affect diabetic control. Does a 'test-and-treat' strategy work for dyspepsia? A Dutch study confirms that serology for *Helicobacter pylori* is as a safe and effective as endoscopy in guiding treatment (**1606).**
***Ann Intern Med* 139: 19** shows that we don't know the optimal time to continue anticoagulation after pulmonary embolism. On page **97**, a huge observational study shows that statins do not improve bone density or fracture risk in postmenopausal women.
***Thorax* 58: 580** is a systematic review showing that short-term bronchodilators help in chronic obstructive pulmonary disease; page **629** holds out the promise that ACE inhibitors may help some of these patients too.
***Occup Environ Med* 60: 468** shows blood pressure going up in female healthcare assistants when they are treated unfairly. Remember that you can protect your receptionists' cardiovascular health by being nicer on Monday morning.

Plant of the Month: *Ficus carica* 'Black Ischia'
Victorians could buy British-grown figs, but if you want to eat one nowadays, you have to grow it yourself. Don't settle for 'Brown Turkey' if you can find this delicious variety.

Postcards 3 ... The demographic time bomb

Who does the dirty washing?

SUPPOSE an army of invading aliens announces to the world that from now on Earthlings will take in the aliens' laundry and have it ready for the end of the week. Fail and we will be annihilated. The leaders of the world confer and within minutes the entire efforts of the planet are put to the business of washing, drying, ironing, repairing zips, and sewing on buttons. People's conversations revolve around the new work; there is some curiosity about the three-legged trousers and the absence of any collars. At the end of the week the aliens demand their laundry. 'You can take the shirts but the rest won't be ready till next Friday. We've had a rush on,' the chief negotiator patiently explains. Woody Allen tells it better, but in essence the current approach of the NHS to our changing demography is the same: we just don't seem to have enough people to do the dirty washing. So what should we do?

If any healthcare system is to provide high quality services it must recruit, train and retain its staff. No amount of technology can substitute for the people who do the caring or provide the human interface between patient and machine. Health care for elderly people is particularly devoid of technological fixes and it is also becoming harder to keep nurses, occupational therapists (OTs), and physiotherapists in post. Keith Andrews and John Brocklehurst noted this 'crisis' two decades ago in a *BMJ* editorial.[1] They identified the need to recruit more school leavers into the NHS, but this never occurred. Why? The policy makers decided that current patterns of provision had to change so the NHS got out of providing comprehensive health care for older people and we shifted their care into the private sector — where OTs and physiotherapists are not part of the scenery.

Malthus's treatise on demographic trends provided the first warning of the consequences of unchecked population growth outstripping the material resources necessary for survival.[2] His predictions have also failed to come true — so far. Instead a complex pattern of regulation of population size kicked in — in almost all societies economic growth seems to go in tandem with declining fertility. A by-product of this demographic contraception has been population ageing. Happily the predicted expansion of morbidity and disability that was expected to swamp our ability to cope has also not materialised. As a species, we have become fitter, so that at age 80 years we are more capable than octogenarians of previous generations. An equilibrium has been achieved where lower levels of disability balance the increased numbers of elderly people.

Even if disability levels are improving, we all have to die sometime. Healthcare systems, aided by doctors who cannot accept death as a good outcome for some, are enormously bad at providing care for dying people. The diagnosis of dying is not so difficult, but implementing cost-effective palliative care seldom occurs for the majority of older people. Instead resources are squandered on futile intensive and invasive care in the last weeks of life. It is not the costs of an ageing population that are the problem, it is the cost of dying that require control.

The story of the aliens' laundry also has another point to it — we will have to be imaginative in our conceptions of what our old age future will be like. I'm writing this in Spain sitting in the sun with approximately half a million British pensioners now resident here for at least 6 months of the year. Spain has taken in our dirty washing in return for economic growth. Whole villages have become English and new developments cater solely for the needs of expatriates. But for British pensioners, retirement in Spain looks like a good option with more than adequate numbers of people willing to provide care of a high standard when it is needed.

Indeed, in an earlier life as a professor of geriatric medicine at Barts and the London Hospital Medical College, I was asked by the director of a health authority what my views would be on the transfer of 40 frail, elderly, demented patients with no next of kin currently resident on the back wards of the local hospital, to a purpose built Spanish hospital that was going to carry out coronary revascularisations for expatriates. To make the plan an economic reality, a reservoir of patients were needed to keep occupancy rates at a stable level and cash would be realised by releasing their NHS beds. I explained that it might be a little difficult to move such patients — they would be confused, agitated, and incontinent. He replied that it would probably not look much different from any UK flight to the Costa del Sol! The plan never materialised.

The same story, although rather better planned, is occurring in the Philippines where the Japanese have established retirement villages for themselves, fully staffed by local people who have been taught to speak Japanese, are versed in tea ceremonies and Japanese cultural values. The lifestyle is Japanese, but the costs are third world — Kyoto-on-Sea is a reality. In

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India, the beaches of Goa are awash with intrepid British pensioners eating a more authentic chicken tikka massala. Will they colonise this cheaper, but culturally Anglophone part of the world? And where next — Bangladesh is even poorer and its major resource is human. These solutions to our care needs in old age have an attraction — they provide economic growth where it is badly needed, they do not uproot and destabilise poor countries in the same way that economic migration has done in the past. Is this our future?

The majority are unlikely to want to rest their bones in some foreign place. What will the NHS provide for them? The pervasive pessimism surrounding the NHS is based on the myth of infinite need and the resulting belief that rationing is inevitable. But much NHS activity is discretionary and of marginal benefit to patients. Better management of the resources used, and a refocusing of activity on those areas of health care where ability to benefit is established would undoubtedly make a huge difference.[3]

The government must be alarmed to see the prize for so much new investment in the NHS is growing discontent and less output. A service that provides 11 million episodes of hospital care a year and 2 million primary care consultations a week is not broken. Instead of exploring and fixing the roots of clinical and managerial failure in the NHS, the government seems to have decided that the whole thing has to go. The NHS modernisation programme will result in the fragmentation of one of the world's largest employers into a myriad public and private sector purveyors of health care. A close reading of the policy on Foundation Trusts demonstrates how the NHS will be comprehensively dismantled through the creation of autonomous businesses, capable of doing pretty much what they want, provided that they do a little health care, with an extremely light hand from the regulator, and open access to the expertise of United States and multinational healthcare corporations well versed in how to extract profit from suffering.[4]

A further unexplored consequence will be the pensions of those employed by the NHS — what will happen to the contributions already made? Re-employing NHS staff in private and new public agencies will remove the responsibility for their pensions from government.

For patients, the lines of where intermediate care and social means-tested care begin and end are currently being drawn. Foundation Trusts will provide older people with another barrier between themselves and access to intermediate care. No Foundation Trust will want 'unprofitable' patients that make them no surplus for re-investment, so it seems likely that only the rapid turn around, large volume 'replacement' businesses such as joints and cataracts will survive for elderly people.

In the same way that population demographics have defied Malthusian pessimism through finding a new equilibrium point, it seems likely we will have an NHS that no longer attempts to do everything. A new balance will be struck, shifting more of the onus on the individual and less on the state. Instead of attempting to recruit every school leaver into health care, old people, sisters and brothers, will be doing it for themselves. Self-care and mutual support will become a much bigger part of health and social care for older people. What we must now ensure is that these changes to the social contract are widely debated, hidden costs and consequences are made clear, and we are not simply presented with a 'solution' of doubtful provenance by a temporary secretary of state for health.

Shah Ebrahim

Demography is destiny

Fertility rates are in rapid decline across most of the developed world. A stable population requires 2.1 births per woman.

In the UK the rate is around 1.6 and across most of Western Europe it is less than this. In parts of northern Italy the replacement rate is currently a microscopic 0.8. If current birth rates were to continue (and in the absence of epidemics or mass immigration) Italy's current population of 57 million will decline to around 25 million by 2050. To maintain roughly its current age structure, Spain needs to accept 1 million new immigrants every year between now and 2023.

These declines in fertility are quite unprecedented. At the same time people are living longer. By 2030 most people in their 60s will have at least one living parent and a significant number will also have a grandparent. In consequence we will have elongated 'bean pole' families: The majority of European children in 2050 will have no siblings, no cousins and no uncles or aunts. They will however have 3–4 grandparents and 1–3 great-grandparents.

Parallel to this we have great numbers of economically inactive people. In the UK some 3 million people currently receive incapacity benefit, around 1 million are unemployed and there are around 10 million people aged 50–75 years (a figure set to grow to around 18 million by 2031). Many of these people would love to be able to contribute more.

Clearly there could be a solution here where people 'do it for themselves and self-care and mutual support form a much bigger part of health and social care for older people'. Primary care will be key to realising such a beneficent future. We may be a long way from it, but I'm not looking forward to my old age much if we fail.

Drucker P. The next society. A survey of the near future. *Economist* 2001; **3 November.**

Caring for the dying at home: companions on the journey
Keri Thomas
Radcliffe Medical Press, 2003
PB, 320pp, £27.95, 1 85775 946 X

WE are all travellers, and on the unmapped journey that is life we all have a common destination. Images of the 'journey' towards death crop up frequently in literature, poetry, music and art, both secular and religious. Keri Thomas was keen to call her book simply *Companions on the journey* but was advised by the publishers that it would end up in the travel section of the bookshops. It is not fashionable or appealing to talk about death, even, or perhaps particularly, in medical circles. The enduring concept of death as the ultimate failure of medical care can lead to a reluctance to acknowledge and prepare for the approach of the end of life, to the immense detriment of both patients and carers. Palliative care was unheard of before the pioneering work of Dame Cicely Saunders brought the needs of the dying into the domain of professional care, and began to make it a medical specialty in its own right. Even now the work of the hospice movement is regarded as 'fringe' by many, and is only part funded by the NHS, perpetuating the image of the work as charitable rather than specialist. Most patients dying of cancer, if consulted, express a desire to die at home, whereas currently over 75% are admitted to a hospital or a hospice to die. Hospices provide a wonderful safe, supportive and comforting environment for the patient, but moving from home may be felt as a failure by the patient and carers, and tragically, last minute admissions are often due to inadequate symptom control at home, fear of the unknown, or lack of professional support for overburdened and exhausted carers.

Keri Thomas' vision and goal is to enable all patients dying of terminal illness (not just cancer) to receive the quality of care in their chosen environment that is currently available only to a few. *Caring for the dying at home* is a book that sets out very clearly to achieve just that — to raise standards everywhere to the level of the very best — and demonstrates with clarity and wisdom just how this can be attained by simple changes and improvements in planning and communication.

A GP with a Diploma and MSc in Palliative Care and many years of experience in hospices and in the community, Keri now has the role of National Clinical Lead for Palliative Care of the Cancer Services Collaborative and is Macmillan GP Advisor and Lead of the Gold Standards Framework Macmillan Support Programme.[1] As such, Keri is uniquely placed to bring the concept of palliative care in the home to a wider audience; the GPs and district nurses and other members of the primary care teams who are intimately involved in caring for patients on the last phase of their journey towards death.

The book is structured in three sections, the first exploring the needs of the dying patient, drawing on experience and reliable evidence from large numbers of sources and extensively cross-referenced. It is illustrated with stories and narrative experiences of individual carers, patients and professionals. The disarmingly simple but evocative cover illustration, *Healing touch* is by Michele Angelo Petroni, from a series of paintings and words entitled *The emotional cancer journey*, and further thoughtful illustrations and quotes are included within the text.[2] The second section sets out how we can apply existing evidence, experience, and wisdom to improve the practical delivery of palliative care at home for our own patients. This section also includes a useful contribution by Dr Susan Salt on key clinical features of palliative care. The third section is effectively the 'handbook' for the Gold Standards Framework in Primary Care, and provides an invaluable tool for professionals wanting to bring about enduring improvements in the way palliative care is delivered at home. The simple measures of introducing structures and routine communication between team members can help in anticipating and averting problems before they arise, and make crises less likely. Keri reminds us that the practice of medicine involves the head, the hands, and the heart, and demonstrates how when any one of these elements is missing, the care will be less than ideal.

The book demonstrates with passion and conviction the need for professionals to recognise, acknowledge, address, and treat all the needs of the dying patient, not just the physical symptoms, but the fears and the spiritual needs which come sharply into focus in the face of mortality, but which many people have huge difficulty in articulating. As professionals we often find it uncomfortable talking about spiritual matters with our patients, indeed, one of the main reasons why many people would go a long way to avoid just such a discussion is because it touches so intimately on our own needs and vulnerability. It is instilled in us, as medical practitioners, generally to avoid that degree of exposure or 'involvement'. In fact when it happens, in a secure and trusting environment, in the context of a whole package of care, being such a 'companion' can be one of the most rewarding experiences that the practice of medicine has to offer. Acknowledging the hurdles and pitfalls on such a journey, Keri sets out clearly and systematically how we can achieve it within the existing constraints of time and pressure

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in general practice, by implementing a co-ordinated approach to communication, planning, and record keeping, while never losing sight of the very personal bodily and spiritual needs of the dying patient.

This book is of particular interest in the light of the new GP contract, in which 'general management of patients who are terminally ill' is one of the few elements deemed to be an essential service. In the Quality and Outcomes (Q&O) Framework the only points allocated for cancer apply simply to record keeping — 6 points for 'having a cancer register' and 6 points for recording a review 6 months after diagnosis. During the consultation phase in the preparation of the contract a bid was submitted to include palliative care at home in the Q&O Framework, but was rejected by the negotiating team on the grounds that there was 'not a shred of evidence' to support its inclusion. This begs the question as to where this evidence was actually sought, since it is abundantly available, and eloquently presented in this book. Unfortunately much of what is good about general practice, and about palliative care is both intangible and unquantifiable. This is not much help when the paymasters want to count and measure everything.

It does mean, however, that we owe it to our patients to provide, as routine, the best possible quality of terminal care at home, and this book is indeed the 'gold standard' reference for all primary care clinicians.

It is a tribute to GPs' caring instincts (as well as to Keri's enthusiasm and dedication) that the Gold Standards Framework is now being embraced countrywide, independent of government imposed targets. The keeping of patients at home in the last stages of life brings benefits to all concerned; patients, relatives, carers, and professionals. It seems most appropriate to close with Keri's own words, from a delightful chapter of the book comprising 'Sources of help and words of wisdom':

'Loving medicine' is a term we may be shy to use with our white-coated scientific mindset but it is a driving force for many in this area of work. As you mull over the words in this book and begin to use it as a practical manual, my hope is that something resonates with you, deepens your wisdom, and that you are encouraged, enabled and inspired to continue in this noble and privileged work as a companion on the journey'.

Wendy-Jane Walton

Paul Nash
Tate Liverpool
23rd July – 19th October 2003

The venue for this exhibition is the magnificent Liverpool Albert Dock built in 1846. Over 150 years later the buildings now successfully combine the original classically based form with modern innovation. The same could be said of the work of Paul Nash.

It is a brave art critic who also exhibits, and an even braver artist who enters the commercial art world — Nash did all three. This exhibition reflects the breadth and depth of his talent through the paintings, photographs and engravings, as well as some of the papers on view.

On entering the exhibition rooms one is immediately struck by the muted tones of his early work that also experiment with form and media. Moving through the exhibition the work changes. It reveals an artist, who was a participant observer of life with all its pain and pleasure, struggling to communicate what he saw and felt. Quotes from his literary work introduce each room and demonstrate thoughtfulness and imagination regarding the place of art in life.

Looking at his work is a little like observing a painful illness that has elements of stark brutality, yet is also suffused with vitality and hope. He recorded the dreadful World War 1 experiences of the troops and although his personal life took a battering, was not stultified by his experiences. The vibrancy of colour and form in his interwar period reveal an artist who retained his dreams and visions. It is said Cezanne and Blake influenced his work, however ideas Ruskin generated find a resonance in Nash's work, in spite of the fact that Ruskin did not approve of giving human characteristics to nature as Nash did.

Abstract paintings only work for most people if they are based in competent draughtsmanship. Here we see the progression from accurate realistic representation, to paintings and engravings that express reflections and personal feelings. Like it or hate it, the more abstract and surrealistic work on display is not always easy to understand, but it is still accessible as one can trace the journey into the abstraction through the way the exhibition is arranged. Budding artists please note — you have to be able to draw before you can abstract!

As an art student in the 1950s I recall heated arguments regarding artists 'selling their souls' for commercial commissions. We admired Nash, and saw his work for the Shell guide as escapism from awful war images, so loftily forgave him. One now suspects he really did take it on to put bread on the table as some of the documents on view (albeit in such dim light one almost needs a torch to see them!) reveal a more commercial character trait! Notwithstanding this, he produced images of the countryside to tempt people out of the towns, demonstrating a love of nature and a wish to share its beauties widely.

This exhibition provides a small window through which one can glimpse a fascinating artist with immense talent — hopefully reminiscent of a medical student's first experience in a GP surgery!

Lyn Brown

The Menin Road by Paul Nash

reflection

Carol Shields

Advances may have been made in reducing the mortality from breast cancer but this cruel disease continues to strike women down, often at the height of their creativity.

Carol Shields, one of Canada's literary giants, was one such woman. Despite a mastectomy, chemotherapy and a very public 5–year battle with breast cancer she died on 16 July 2003.

Never cowed by the disease, Shields wrote one of her finest works during this period, *Unless*, nominated for the Booker Prize and reviewed in August's *BJGP*. She has said of the sceptre that threatened to dominate her:

'Cancer is simply another part of life I now understand, like childbearing, sex, choosing curtain fabric.'

A pragamatist, having raised five children, she was also a philosophical and astute observer of the domestic detail which forms the substance of most of our lives.

Her consummate ability to write about 'the arc of a human life', as Shields described her absorbing passion, is what she shall be most remembered for.

Publicly honoured by her adopted state of Canada, she leaves a beloved husband of 46 years, five children, a goodly number of grandchildren, and an international following of readers whose lives have been marked by her work.

She will be keenly missed.

Jane Roberts

Primary care training and development: the tool kit
Lynn Talbot, Denise Pora
Radcliffe Medical Press, 2003. PB, 144pp, £21.95, 1 85775 909 5

Work based learning in primary care
Jonathan Burton, Neil Jackson (eds)
Radcliffe Medical Press, 2003. PB, 184pp, £24.95, 1 85775 996 6

Make your healthcare organisation a learning organisation
Wendy Garcarz, Ruth Chambers, Simon Ellis
Radcliffe Medical Press, 2003. PB, 176pp, £23.50, 1 85775 988 5

PUNs and DENs: discovering learning needs in general practice
Richard Eve
Radcliffe Medical Press, 2003. PB, 128pp, £17.95, 1 85775 807 2

Primary care training and development — the tool kit is largely directed towards primary care managers and is less likely to be of interest to other healthcare professionals. It aims to help the manager implement change and address training and development issues in relation to each individual and also to the team. Although the book is aimed at all primary care managers, it is more likely to appeal to those who have been in post for some time and have a basic understanding of the management of change and training and development issues.

Talbot and Pora are not averse to the use of managerial and educational jargon. They broadly cover the needs of the individual and the team, but such breadth does weaken the detail — for example they discuss concepts such as the Boston Square technique but do not offer any explanation as to how this might be used or a reference. Their book offers an overview of the theoretical aspects of training and development but there is much less on the practical management of change. In relation to some of the tasks, it is assumed that the practice dynamics are satisfactory and that each member of the practice is on board. It may be difficult for a manager to set the goals of the practice if the GPs and other staff are not in agreement.

In summary it is only likely to be useful to a well motivated practice team with a fairly skilled practice manager.

In *Work based learning in primary care* Burton and Jackson aim to address what, and how people learn. They also try to look at how learning can result in improved performance in the work situation and deal with the individual and team. The book has an easy style and although littered with some evidence it has a large number of anecdotes which are rooted in practice.

A few things stand out as being particularly useful. The chapter on learning from patients is a welcome addition and is both relevant and thought provoking. The chapter on under-performance provides a useful overview. The book tries to show how learning can and does take place in the work place environment. Most people will be involved in aspects of this all the time but may not recognise it as such, as courses and meetings are often seen more formally as forms of education. The book does make the (useful) distinction between education and learning, and between work-located learning and work-related learning. It is difficult to know how real the latter distinction would be for the majority of professionals in primary care to whom it may not matter.

Make your healthcare organisation a learning organisation (Wendy Garcarz, Ruth Chambers and Simon Ellis) deals with a very important concept that has much to offer the health service — the learning organisation. It supplies a competent overview of health service structures, bodies, organisations and policies in England, with information on the learning organisation concept that could be useful for those who want to increase their understanding of this field. These individuals will probably be at administrative or managerial level, rather than within day-to-day general practice.

The concept of the learning organisation has been written about for over 20 years, mostly in the United States and in relation to business. A major problem has been turning theory into practice and initiatives have not always been successful. Often the focus has been on outcomes with less attention paid to process.

Garcarz and colleagues discuss these issues in an overly simplistic yet over-ambitious way, as they try to cover the entire health service. They help a little in increasing understanding, but it will take a lot more than this for the learning organisation concept becomes a reality in our health service. Those involved in primary care policy should read this book, but the primary care workforce itself may have more pressing priorities.

Finally, *PUNs and DENs; discovering learning needs in general practice* by Richard Eve. As a working GP he has come up with a simple framework that has a very practical application in day-to-day work.

Learning-needs assessment is a very difficult area. The author describes one method that can be used by GPs to identify

learning needs which can either be put into their personal development plan or can be met as they arise, for example, in learning what is required to manage a particular patient. With appraisal, and revalidation looming, we will all need to find out what we don't know, and then what to do about the gaps.

PUNs and DENs (**P**atients' **U**nmet **N**eeds and **D**octors' **E**ducational **N**eeds, since you ask) reads well, with amusing cartoons. It is written from the heart and gives a very personal view with the author sharing his own feelings and problem consultations with the reader.

I think the key area which will be useful to GPs is the DEN. The basic premise is that it is possible to identify a personal learning need from an area of uncertainty in day-to-day work e.g. during a consultation, during a discussion with a colleague. However, in order that it can be more easily met it is important that the need is defined as specifically as possible and unfortunately in the book, this was not always the case.

I like the emphasis on reflection throughout the book. With appraisal, reflection is a skill that we shall all require to develop and it may not come naturally to some of us. The author concludes that a PUN is in fact also a significant event analysis (SEA). As SEA will be part of appraisal and revalidation it therefore may be more appropriate to use the SEA format particularly for those who are already aware of this type of analysis.

Within primary care, learning and development are becoming important issues for practices and primary care organisations and it is likely that this will continue. It is not surprising that the educational literature is increasing and some of the titles above offer useful techniques for practices and individuals. There is however room for confusion with the burgeoning volume of literature and before too many techniques are adopted, there needs to be an increase in educational evaluation with papers submitted for peer review, so that practice can increasingly be informed by evidence.

Diane Kelly

roger neighbour *behind the lines*

On parsnips

The RCGP has its motto — '*cum scientia caritas*'. And it has its heraldic crest — an arrangement of assorted fauna, pressed flowers and bric-a-brac. What it has hitherto lacked (and I speak as one recently congratulated by Richard Maxwell on having been elected to dine for the College) is a signature dish. Michel Bras has his *gargouillou de jeunes légumes*, Heston Blumenthal (it wouldn't surprise me) his *raviolo of marshmallow on an oyster coulis*. True, the College does a very decent full English breakfast, healthily defiant of any guideline ever published. But can we match our sister College of Surgeons' *tripes à la chirurgique*, or the spotted dick reputedly so popular at the RCOG?

I think every institution worth its salt should make a unique contribution to world gastronomy. So, on behalf of our own College, (and, as ever, in search of a half-decent metaphor), I propose *panais au beurre* — buttered parsnips. Let me explain.

The profession has accepted the new contract by a majority that will be interpreted by its supporters as a resounding 'yes', and by dissenters as a heavily qualified 'yes but'. It would be hard, indeed churlish, to argue against the principle of rewarding us GPs in proportion to our performance in delivering consistent and high-quality clinical care. Moreover, we should know by now that the present government, like every other 6–year-old, wants to hear the loudest possible bang for its buck.

But there remain plenty among us who fear that, in too headlong a pursuit of performance markers, many of which are mere eye-candy or window-dressing, some of the precious, delicate and subtle characteristics of good patient-centred doctoring might get trampled underfoot. Skills that presently give substance to the speciality of generalism are in danger of atrophying until they are no more than the fine words which proverbially butter no parsnips.

The first Elizabethan age saw the geographical world explored and its diversity harvested. Foods once exotic — tomatoes, potatoes — were brought back from remote lands and quickly adopted as staples. In the new Elizabethan age, it is the world of ideas which has been similarly opened up, not least by general practice. We GPs have a long tradition of navigating successfully beyond our own territorial waters. We have made reckless but profitable raids into the homelands of psychiatrists, psychologists, family therapists, social workers, educationists, accountants, novelists, mystics, priests — and have brought back a booty of techniques and philosophies to enrich our patient care. Look along your bookshelves and see the names of the Walter Raleighs and Vasco da Gamas of our own time: Pickles, Balint, Byrne, Horder, Widgery, Pendleton, Willis, Heath …

Probably the key quality possessed by explorers in every domain is curiosity — a passion to know why and how things are as they are, and whether they couldn't be better. If we try to carry this attitude into the more mundane world of the new contract we have a difficult balancing act to bring off. We have to be at once cooperative and critical, constructive and curious, challenged and challenging.

But if anybody can be good at reconciling so many tensions, it ought to be us. GPs thrive on the kind of fuzzy thinking that can on the one hand do *this,* while on the other not forgetting *that*. The parsnips of good clinical governance need to be dressed with the butter of curiosity. But the case for preserving curiosity — for flair, for individuality, for creativity, for (let's face it) style — is going to need sustained advocacy. I think that is one thing the College should lead on. If CAMRA can do it for beer, I'm sure the RCGP can be an effective focus in a Campaign for Real General Practice. The resources of a national College like ours can, I suspect, be put to no better use than encouraging and promulgating original thought within our discipline — and seeing that it trickles out past Princes Gate, past Alexander Fleming House, past Downing Street and Westminster, and into every consulting room in the land.

In his piece on the new contract in last month's *Back Pages* David Hannay lamented 'the end of general practice as we know it'. To the extent that the old contract camouflaged the odd pocket of sloppy or shoddy practice, or the occasional self-indulgent or self-deluding doctor, we should not mourn its passing. But for the new one to be worthy of support and respect, it must not stop at deterring the worst of us: it must encourage the best in us.

It should be to the College that colleagues, patients, politicians, and administrators look in order to know what is 'the best in us'. It is up to us to be worthy of that expectation. Or, if you like, to be the butter on the parsnips.

The College Heritage

WHEN Dr Michael Linnett and I started to collect the first College archives in 1954, shortly after the foundation, the librarian of the Royal College of Physicians commented: 'I only wish this College had started to collect archives long before it did so'. It did so only from 1800, missing 350 years of records.

Why did this matter? Why do institutions like Royal Colleges retain their archives, such as the Minutes of their Council? Why is the past still important for people who are pre-occupied with the present and with thinking and working for the future?

Every ongoing institution needs to retain for its own future use a record of its own past members, decisions, achievements and failures. The same information may be needed to answer enquiries from historians or from other institutions. But the Heritage Committee shares with the College Library a wider responsibility — to preserve the history of generalist medical practice in this country and in others and the memory of many inspiring personalities whose ideas and achievements may still prove relevant and valuable in future. Historians will seek to trace what has changed and what does not change.

So the Heritage Committee seeks to preserve as archives the College's most important documents, together with obituaries, portraits, photographs and audio-visual recordings of Fellows and Members of the College and others who have contributed to the development of general practice in the past.

The history of general practice is represented by the College's collections of valuable books and letters and of medical instruments used in past centuries, most of them donated by past or present members.

In these and other ways this committee has been very active since it relieved the Library Committee of such tasks 6 years ago. It played an important part in planning last year's 50th Anniversary celebrations. It organised a public open-day at Princes Gate for anyone wishing to see and hear about the building and the College.

Successive chairmen have been two past presidents, Dr Alastair Donald and Dr Lotte Newman. One of their first actions was to appoint a full-time archivist. Penny Baker and now Claire Jackson have taken up the task started by Margaret Hammond, when librarian, of sorting out a half-century of unsorted papers and committee minutes, and deciding which of them could be destroyed, while ensuring the preservation of essential items, such as the Minutes of Council.

The large collection of old instruments has been the devoted work of Dr Peter Thomas (South East Wales Faculty) for almost 50 years — an exceptional contribution to the College. He now has the help of Dr Kenneth Scott (North West London Faculty). Dr David McKinlay (North West England Faculty) has been responsible for the growing collection of books relating to the history of general practice.

The past still matters. The present brings constant change in the influences that play on our work, especially in the application of new knowledge, but there are basic elements in generalist practice which change little.

The principles of personal care for people who are ill, or think that they might be, do not change in any essential way. Nor do the principles, as distinct from the methods, of diagnosis, prevention or quality assurance. They need to be remembered and maintained.

College members are a constant source of ideas, but some will already have been tried, implemented or rejected. Trained researchers always start by searching for what may already have been published about their chosen question. Wheels are less likely to be reinvented if the past is remembered or recorded. It is easy to forget that today's actions are invariably influenced by the past and that we are always dwarfs travelling on the shoulders of giants.

John Horder

RCGP Archives and the Heritage Committee

The archives are open between 9 am and 5 pm from Monday to Friday. Access is strictly by appointment and at the discretion of the archivist.

To contact the college archivist
tel: 020 7581 3232 ext. 275,
fax: 020 75841992 or
e-mail: heritage@rcgp.org.uk

The Heritage Committee's prime focus is to agree and recommend future plans for the wellbeing of the College's historical archive collection and museums collection of medical instruments and other objects. The Heritage Committee are:

Chairman:
Dr Lotte Newman

Members:
Dr Alastair Donald
Ms Margaret Hammond
Dr Helen Sapper
Dr Peter Thomas
Dr John Horder
Dr David McKinlay
Prof Sir Denis Pereira Gray
Dr Kenneth Scott
Dr Ian Tait
Dr Alastair Wright

For further information about the history of the College, its Archives or the Heritage Committee, visit:

http://www.rcgp.org.uk/rcgp/history/rcgparchives/index.asp

BJGP 2002

Each year the Editorial Board reviews our performance compared with standards stated on the website (http://www.rcgp.org.uk/rcgp/journal/info/index.asp), as part of a more general review. This is a summary of the data presented to the Board's meeting in April. We have set three standards for handling papers:

- Replies should be received within 3 months of first submission
- Replies to revisions should be received within 1 month
- Papers should be published within 3 months of final acceptance.

The *BJGP* has had an unenviable reputation for inordinate delays on at least the first and last of these, and a few years ago an important target was to try to improve both performance and reputation. The delays are frustrating for authors, but some readers have also commented. Sometimes with fast-tracking we can manage more quickly, but the different components and 3 months for revision (not unusual) add up to a 10–month interval.

In 2002 we received just over 600 submissions, the same as in 2001. This is lower than the peaks of 1998 (662) and 1999 (705), but since the rejection rate remains high we don't think we should worry about the fall. Sixty-six per cent of submissions come from the UK. Of the 34% from overseas, the largest proportion are from The Netherlands and Nordic countries. Thirty-four per cent come from academic primary care and 17% from GPs without any obvious academic affiliation. Eleven per cent of papers were accepted in the form submitted, and a further 6.5% were offered acceptance in another form, such as a brief report, so that the overall acceptance rate was 1 in 5.5. The time taken for first response had improved: the median time was 63 days compared with 76 days in 2001. Eighty-seven per cent of authors received a response within 3 months and 91% within 4 months, compared with 2001 figures of 80% and 96%.

At the time of the Editorial Board meeting we had fallen far short of the final target of 3 months between final acceptance and publication. Much to our surprise the gap has fallen significantly since then. For example in the December 2002 issue the median gap was 187 days, with an average gap from first submission to publication of 13 months. By August 2003 the equivalent figures were 103 days and 9 months. There are two inferences. First it now looks as if the target is unrealistic. Even with us still falling short of the target, we feel uneasy with so little in the pipeline awaiting publication. Second, for the first time since I have become editor the pressure on space in the BJGP has definitely eased. This means that there is room to treat our policies more flexibly, and potential authors should bear that in mind when wondering whether to send us a piece of work.

The authors represent one of the two major stakeholder groups. Next month we shall publish a report designed more for the readers.

David Jewell

neville goodman

Contractual ruminations

AND so we return to the consultants' contract (this column, October 2002). When it was rejected, he-who-must-not-be-named went off in a huff: under no circumstances would he meet with the BMA again. His own schemes (this column, March 2003) were even less popular than the rejected contract. It is odd, really, because the outstanding issues were not all that difficult to sort out. Within 2 weeks of new Secretary of State, John Reid, coming back for talks, there was a new agreement on the table, even if some paragraphs of the *Heads of Agreement* document of 17 July are far from ideal. It is difficult to see what was gained by the months of inaction and uncertainty.

Pinning down what really irked consultants, and a concerted effort to compromise, could have got us to where we are now, but by the end of last year. Perhaps it is all an illustration of the different temperaments of Voldemort and his replacement, or perhaps an indication that the government as well as the BMA needed to change negotiators.

I still have an underlying unease about the whole business. The revised contract tones down the degree of management control, which will probably win the day. But management control is not, as is implied by what many consultants say, the antithesis of clinical freedom.

There is a problem that consultants have to sort out. It is contained in paragraph 15 of the *Heads of Agreement* document. The second shortest paragraph of all, it states that: 'The contract will operate on the principle that the NHS patient comes first.'

I suspect the government's subtext to this paragraph is private practice. It is the wrong subtext. The paragraph has the wrong emphasis. 'The NHS patient first' resonates with 'patient-centred medicine' and 'doctor–patient partnerships'. There is too much emphasis on the singular. NHS consultants are highly trained and develop sub-specialist interests. They serve their (singular) patients well, but by doing so sometimes fail the community. If they do one complex operation to give themselves professional satisfaction (and that one patient a good outcome), they are not able to do the six simple operations that perhaps would have been the better outcome for NHS patients (plural).

The new contract is seen by government as a way of getting more work out of consultants who see themselves (and mostly are) working too hard already. There really is no getting away from it: as a society we have to sort out what we want the NHS to do for us. Those are the management constraints within which we must work, but we don't know what they are.

our contributors

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Martyn Evans is the most elegant foetal part of Durham's baby medical school.

David Gelipter is a GP and lecturer in Sheffield who complains that: 'Sheffield Back Pages contributors seem to be falling off a bit', despite the fact that we fill them with champagne, albeit slowly.
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Paul Hodgkin, like **James Willis**, has written enough for the Back Pages to qualify for transportation to the Outer Hebrides, in his case to Eriskay, May past. His real enthusiasm remains the social engineering of coffee ...
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John Horder is mentioned in the same sentence (in this very issue of the *BJGP*) as Vasco da Gama and Walter Raleigh, not a conjunction to be ignored. Even at this late stage, however, someone should buy John a computer ...

Diane Kelly is a GP in Kirkintilloch and a lecturer in the Postgraduate Deanery in Glasgow.

Jane Roberts is a lecturer in medical education at the University of Durham, and a GP on Teesside. She has patiently endured mis-identification with her non-existent colleague, Jane Gordon, whose name will never again feature in these pages.
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Wendy-Jane Walton enquired recently as to fees for reviewing at the *BJGP*. An honourable request, but a hopeless one, for fees there are none. All we can offer is minimal embellishment to CVs plus unexpected commissions to exotic locales ... See future issues. What we do value above everything else is the Shock of the New!!

If that's not too pretentious ...

aleclogan@dial.pipex.com

saul miller

Evolution?

The ascent of man, the onward march of science, continuous quality improvement, lycra: it is hard not to be caught up in the inevitability of progress. To try arguing against some new development or another is to risk appearing inelastic, unable to stretch one's mind to the possibilities inherent in the future that new initiative will entail.

Certainly everyone at Nissan's Sunderland factory must be convinced since they can now make 99 new cars a year per worker, having last year managed only 95.[1] Were I one of them I might just be pondering how peripheral humans must now be to their manufacturing progress. Luckily I work in the National Health Service where the march of progress is still believed in, but not quite so mechanised.

Of course we do have computers and the odd other electric machine besides, but they have hardly helped us improve our throughput; it often feels like they have slowed us down. Still though, we believe in progress and are ever more moving into a culture of trying to prove it by setting, and then trying to surpass, targets.

Without specifically thinking about it, I have generally felt that the future holds more than the past. Targets have seemed reasonable since there was little doubt they would be passed, it was just uncertain when. But the truth is, the better we get at achieving targets, the more workers we seem to need to do the work. New developments in car building may tend to streamline the process but new developments in health care tend to complicate it. In our field, progress is additive.

But then, cars are getting more complex too, and yet still Nissan manage to make more per worker per year. So maybe our excuses won't wash. Perhaps it is time to copy some ideas from the car industry. Certainly it would speed things up if patients could be delivered more quickly to the consulting room chair.

I envisage a roof-mounted grabber, based loosely on the idea of the traditional stair-lift, that would obviate the need for the elderly to creak through on their protesting pins. Such automation could then be extended to include the return trip to the waiting room at a precisely timed interval of, say, 8 minutes. A recording device that would slip a transcript or tape of the consultation into the patient's pocket on that return trip might help minimise the number of re-runs of the same problems that GPs currently often experience. The final act could be the administration of a laser-guided satisfaction survey as the patient is exiting the building.

However, just as we have all been persuaded, evolutionary theory has itself moved on from ideas of the inevitability of human progress. The general idea now is that evolution occurs in adaptive steps on from occasional random catastrophes. No matter how well adapted creatures may be, every now and then something happens that changes the rules, most famously the meteorite that wiped out the dinosaurs.

The parallels with the evolution of primary care are striking. We all do our best to adapt to the prevailing conditions and then every now and then something big happens that just changes those conditions: the Bristol scandal, Harold Shipman, PMS, PFI, the new contract, and so on. These things aren't part of any logical sequence; they just happen out of the blue. In their aftermath some struggle through no fault of their own and others find themselves grabbing a slice of fortune.

It is in this sense that I begin to understand why some of my elders view life as cyclical and not evolving at all: it probably does eventually begin to feel as though each new meteorite is like one that hit before. The key to survival then is not perfection now but adaptability for future hits.

So it matters to know: are we evolving or revolving?

Jay A. Nissan Sunderland retains top spot for productivity. http://www.telegraph.co.uk/money/main.jhtml?xml=/money/2003/07/09/cnsund09.xml (Accessed 7 August 2003)