THE WONCA 2004 conference was an opportunity for the RCGP curriculum development team* to share its work with experts from around the world in order to inform the UK GP Training Curriculum, which is due to be completed in early 2005.

On the first day, we had a presentation from Justin Allen on the 'European Definition of General Practice', from myself on 'The Context and Educational Setting of the New Curriculum', and from Adam Fraser on the 'Literature Review'. These presentations were given to a packed audience — people were even standing up at the back of the room! The speakers summarised the current status of the curriculum review and answered questions about Foundation Programme GP placements and on the need for, and balance between, hospital training placements. There was thoughtful discussion about the literature review and an Australian professor brought up how much scope there was for variation in the proposed programmes, pointing out that many trainees don't need targeted help but some are not able progress without it. Educationalists from the US were surprised to learn of free movement of people within Europe and worried about the consequences given the variation in standards.

Day two started with an excellent presentation by John Salinsky about the use of patient narratives, which made the team consider their role in the wider curriculum for trainees. A symposium on the proposed UK curriculum began with a presentation by myself. I presented the preliminary results from a survey of over 2300 GP registrars, HPE doctors, trainers, and course organisers (57% response rate at the time of the conference). The survey indicates that most responders wished for change in the standard model of GP training in the UK, but that most preferred 3 years' duration with 18 months based solely in GP training practices. The delegates discussed the implications of these findings, particularly the need for high quality GP orientated hospital placements while having a mentor and base in a GP training practice.

We then looked in more detail at the learning outcomes of the WONCA European competencies. In small groups we discussed the detail of the competencies and the implications for training. This helped us to clarify some of the issues — particularly around language, which is thought by some to be rather opaque — and concerns about the levels of knowledge and how acquisition of competencies would be ensured. We spent quite some time discussing the competencies that were specific to GPs. The nature of the competencies is often very similar to those of other doctors but the degree to which they are practised sometimes has to be higher. This was felt to be true about communication and patient-centredness. Others, such as continuity of care, were unequivocally unique to general practice.

On the final day, we held a session that had a series of three linked presentations. We started with a shortened overview of the curriculum process from Mike Deighan followed by a more detailed presentation of the survey work by Adam Fraser, who talked in depth about hospital training aspects and the effect that they would have on the curriculum. Finally, Stephen Kelly gave a presentation on the implementation at deanery level and resource implications of probable changes that would come about with the new curriculum. This deanery view was followed up quite intensively in the questions, where useful contributions were made by Justin Allen and Tony Mathie. There was quite a long discussion about aspects that went into some more theoretical aspects about the curriculum and delivery of education.

The conference was very helpful for the team to test some of the ideas that have evolved from countless meetings across the UK. The delegates brought with them their experiences in GP curriculum development from across the world. There was a great sense that they wanted to help us and wanted us to help them — a theme that I believe we need to build on at future conferences. They came up with excellent ideas that we will utilise and also highlighted some issues and loopholes not spotted in the UK, such as consulting with and subsequent training of non-GP educators and the possibility of including statements regarding values and medical humanities in the final curriculum .

Steve Field

Freezing cold and bored to death

The only reason for my visit to Orlando was the meeting of editors of family physician journals but, being there, I promised myself to learn a few things and have a little fun. That was no easy task in such a huge Stalinist place as the Orange Convention Centre, running from one side of the centre to the other finding the lecture cancelled or often already finished. Too many sessions and too many boring speakers, but on Saturday afternoon when almost all congress visitors were elsewhere (Disneyland, the beach ...), I found myself in one of the small rooms listening to interesting papers on intercultural communication. Outside the congress it was at least 30ºC, but inside the air conditioning tried to simulate arctic temperatures. Maybe immigrants out of the tropics feel the same when they arrive in Europe: lonely and unable to listen because of physical difficulties.

The cold was especially noteworthy because I visited (by accident) the very 'warm' keynote lecture of America Bracho, president of Latino Health Access in Santa Ana, California, a few moments before. With dramatic expression and compassion, she told the audience of her way to tackle the problem of health inequalities. Working in a very poor

* The RCGP curriculum development team comprised Professor Steve Field; Dr Stephen Kelly, DPGPE for the West Midlands; Dr Justin Allen, Hon Sec of the JCPTGP; Dr Mike Deighan, Course Organiser from Worcester; and Dr Adam Fraser, a recent academic GP registrar from Birmingham. We gave a number of presentations over 3 days including an interactive seminar, all of which were well attended by world experts and opinion leaders in the area of GP training.

** **A beginner's guide to abbreviations** ...
UK = United Kingdom
NAPCRG = North American Primary Care Research Group
AAFP = American Assocation of Family Practitioners
WONCA. .. *Er, that's enough abbreviations. Dep Ed.*

Reference
1. Kaufmann IM. *Building healthy attitudes and coping strategies: '12 steps' for health professionals.* Toronto: Ontario Medical Association, 1999. www.phpoma.org/pdf/12_steps_04_text.pdf (accessed 15 Nov 2004).

Hispanic community, her organisation involved children as health promoters. The children learned to investigate how to live healthier lives, and how to teach their parents and younger sisters and brothers. Ms Bracho told her audience to be optimistic about the capacities of children and be happy with very small improvements in health awareness. Don't try to solve all the problems at once. One day these children will vote, and some of them may even be elected. Let's hope they will! Thinking of this, I went home feeling warm, at last!

Joost Zaat

A conference fest

It seemed like a good idea at the time to attend three family medicine conferences in a row, in the same place (NAPCRG/AAFP/WONCA** in Orlando) — it would be an efficient use of my time. However, by the time an excellent NAPCRG was finished, I was all but 'conferenced out' — and only halfway through the papers to be presented over the next 3 days.

Fortunately, help was at hand when I attended an excellent mid-conference session entitled 'Physician Heal Thyself and then the World'. This was described as a workshop on 'workaholism, helpaholism, and other physician conditions' and 'playful but effective medication for serious symptoms'. It was run by Janet Christie-Seely, one of the most respected family therapists in the world, and packed full of powerful insights and useful skills training. We reviewed some of the current understanding of the construction of personality particularly applied to doctors and, by way of a 'dynamic family sculpture', finished with the '12 steps' (after Alcoholics Anonymous) for health professionals on 'building healthy attitudes and coping strategies'.[1] This experience gave me 'permission' (if that were needed!) to take half a day off and visit the Kennedy Space Center. Here I was able to live out my adolescent fantasies of the 1960s. JFK's 1961 ambition to put a man on the moon 'within a decade' because we 'choose to go' inspired many an idealistic teenager — I thoroughly enjoyed recalling those days in the place where it had all happened.

The other highlights of the conferences, for me, were the plenaries from Barbara Starfield — who is always 'good value' on why family medicine is indispensible to the quality of health care provided to patients — and from Pekka Puska, who spoke about the classic success of the strategy for reducing the burden of ischaemic heart disease in Karelia, Finland. The bravest and most moving contribution that I heard during WONCA came from a family physician from Zimbabwe who described the conditions under which she works, where rape is being used as a tool of political oppression.

Nigel Mathers

mike fitzpatrick

The politics of smoking

It can only be a matter of time before smoking in Britain is confined to consenting adults in private. The workplace ban in Ireland has been acclaimed as a great success by politicians and public health authorities alike and similar initiatives are being introduced in Scotland, Wales, Liverpool and elsewhere. Our local hospital is planning to go smoke-free on New Year's Day 2005 and patients who now wheel their drips and drains to huddle in squalid stairwell smokers' ghettos will be banished to the streets. Our receptionists, already consigned to the bin-shed, will no doubt shortly also be forced out into the rain. The logic of New Labour public health policy points towards the erection in public places of a modernised version of the mediaeval stocks in which smokers could experience the full force of popular moral disapproval of their stigmatised behaviour.

The government has skilfully manoeuvred itself into a no-lose position on smoking. Having discreetly sponsored anti-smoking propaganda, it can now adopt the posture of reluctantly acquiescing to popular demands to introduce the sort of authoritarian measures that this government favours in a wide range of policy areas. Health minister John Reid is so confident in the strength of the consensus behind more coercive anti-smoking measures that, while he presides over the introduction of these measures, he can afford to indulge in gestures of condescension towards those for whom smoking is one of life's few pleasures.

It is now more than 40 years since the Royal College of Physicians took a public stand on the dangers of smoking and more than 20 years since epidemiologists suggested that 'passive smoking' caused an increased risk of lung cancer and heart disease. The quality of the evidence for the dangers of passive smoking has improved little over succeeding years. What has improved is the propagandist skill of public health campaigners in extrapolating from marginal increases in relative risk to claim significant numbers of deaths attributable to passive smoking.[1] Medical invective against tobacco seems to have intensified in inverse proportion to the strength of the scientific evidence against passive smoking.

The key factor in the rising profile of doctors in the crusade against smoking is the medical profession's shift away from identification with the individual patient towards a wider endorsement of state intervention in personal behaviour in the cause of improving the health of the population. The proposal (expected in the government's forthcoming public health policy) that GPs should provide patients with 'personal health plans' has provoked some criticism — on the grounds of the associated cost and administrative burden. But there has been little objection in principle to the notion that GPs should interfere in patients' lifestyles, not only in relation to smoking and drinking, diet and exercise, but also in intimate matters such as sexual behaviour, child protection, domestic violence, drug abuse, teenage pregnancy. It is ironic that at a time when doctors are widely condemned for being paternalistic, we are also encouraged to intrude in patients' personal lives to a degree that would make a Victorian patriarch blush.

It is possible that banning smoking could save lives. There is some evidence for this from the country in which the link between smoking and lung cancer was first scientifically demonstrated.[2] The government in Germany in the 1930s 'launched an ambitious anti-smoking campaign, involving extensive public health education, bans on certain forms of advertising, and restrictions on smoking in many public spaces'.[2] Women and younger people were a particular focus of anti-smoking propaganda and restrictions on sales. Furthermore, 'activists called for bans on smoking while driving, for an end to smoking in the workplace, and for the establishment of tobacco counselling centers'.[2] Although it seems that the Nazi campaign did not succeed in reducing overall tobacco consumption until the later stages of the war (when production and distribution were disrupted), it did contribute to a reduced rate of lung cancer among women, possibly preventing 20 000 deaths.[2]

For the anti-smoking zealots, the loss of civil liberties resulting from their widening range of bans and proscriptions is justified by the anticipated health gain. Yet, as the great microbiologist Rene Dubos, observed, health should not be considered an end in itself, but as 'the condition best suited to reach goals that each individual formulates for himself'.[3] By curtailing the autonomy of the self-determining individual, authoritarian public health policies infantilise society, weaken democracy, and diminish humanity.

References

1. Fitzpatrick M. *The tyranny of health: doctors and the regulation of lifestyle.* London: Routledge, 2001.
2. Proctor RN. *The Nazi war on cancer.* Princeton: Princeton University Press, 1999.
3. Dubos R. *The mirage of health.* London: Allen and Unwin, 1960.