All hands on deck

Yet another debacle looms as the gang that couldn't shoot straight, otherwise known as the US Senate, tries to snatch defeat from the jaws of victory. It is not an act of God, as some say the earthquake in Haiti was, but an act of political posturing that once again threatens real healthcare reform in the US.

You may each have your idea of the Augean Stables that has been the labour of your lives but I am rounding on 40 years as a doctor, thinking the whole time that THIS is the time it will change. And to have it crumble, yet again, is almost unbearable. Whenever the *BJGP* points out challenges for GPs in the UK, I find myself muttering 'you have no idea what it is like to work here'. Since I spent the year working as an assistant in general practice with Julian Tudor Hart in 1979–1980, I do understand some of the frustrations you face. But, honestly, you know what your job is, you are supported by both patients and the NHS in doing it, and you are valued by your society for the contributions you make. WE are appreciated by our patients, tolerated by our health systems and hospitals, and are an afterthought to our political process.

If, despite the back room deals, the \$1 billion spent in the last 24 months by lobbyists from the left, the right, and everything in between, some type of healthcare reform (depending on how one defines 'reform' of course), is enacted in 2010, none of the proposed legislation directly addresses the reality that 45 million newly insured patients will be unable to find a doctor. The uninsured live primarily in rural areas and cities ravaged by housing and economic losses — communities disproportionately affected by the Great Recession — that already face enormous difficulty recruiting doctors. The situation will be harder when overburdened doctors in shortage areas have even more and sicker patients who need services.

Family doctors are the only doctors who have distributed themselves anywhere near the actual population in this country. Family medicine and general internal medicine training positions have

decreased by 50% over the past decade: internists almost to the level of undetectable amounts.¹ Nearly as many US medical students matched for positions in anesthesiology in 2009 as family medicine. In 1998, family medicine residencies graduated over 3200 doctors yearly.² Ten years later, the number of residency graduates is not even replacing the boomer doctors who are beginning to leave the workforce. The rock will hit the hard place in 5 years time, just when healthcare reform is supposed to be complete. The disappearance of both the polar ice cap and US generalists seem to be inevitable in the next decade.

Since pointing fingers is the new national sport, one should heavily finger US medical schools as a source of the workforce problem. The free market barons of higher education continue their hand-wringing and their unwillingness to influence career choice by medical students. It would be inconceivable, it seems, to do anything that would jeopardise the approximately \$12 billion in residency training support and the \$40 billion in NIH grants that flows to their schools each year. Nothing in the reform legislation compels medical schools to change direction. Lobbyists for academic health centres are among the better-financed and better connected in health care and often appear to take the high road when they advocate for billions for basic research and training additional doctors. But they either demur or bristle righteously when asked about any evidence that all that money and all those new doctors will result in better quality or better access to basic care. On the other hand, Canadian medical schools, in a recent report to the nation, see appropriate workforce training as a component of accountability and responsibility.³ But Canadians, as we all know, are socialists.

Who, then, will take care of all these formerly uninsured people? The simple answer is: 'All hands on deck!' Until the workforce rights itself through policy change, we will need anyone and everyone who is willing to do the hard work of

community-based primary care. The past 40 years of bickering among family doctors, general internists, paediatricians, nurse clinicians, and physician assistants is over. It seems economic and political disasters, like some natural disasters, can drive groups together who were previously bitter rivals. If someone truly wants to deliver primary care — pharmacists, chiropractors, and alternative medicine types — they should become part of the grand effort in the next decade. There will be simply too much to do and not enough people to do it. We are all in this lifeboat together and anyone who can row should. The health environment and the revenue flows will change, whether subspecialists believe it or not. They can't 'revert' to doing primary care because they have differentiated themselves toward extinction.

Over a year ago my wife and I stood freezing on the Mall in Washington at the Inauguration, the single most moving day of our lives. Almost exactly a year after Obama's inauguration, Ted Kennedy's seat was handed to an avowed legislative obstructionist and healthcare reform has come unwound. No one could write a novel like this. It would be too depressing. I seem to have been angry almost constantly for the past year about the lack of urgency in getting changes done. But I try to return to Hart's suggestion that general practice education should be about teaching disciplined anger. And, as he wrote, 'Anger without discipline is mere cursing'.⁴ I feel the need to curse for a month or so, then get on with the fight and not lose hope, remembering Havel's description of hope as:

*'... not the conviction that something will turn out well, but the certainty that something makes sense, regardless of how it turns out.'*⁵

Making sense of this past year, and the first 2 weeks of January 2010 is going to take some time.

John Frey

The power of wishful thinking

REFERENCES

1. American Academy of Family Physicians. Internal medicine (primary care), 2009 NRMP Results. <http://www.aafp.org/online/en/home/residents/match/table7.html> (accessed 8 Mar 2010).
2. American Academy of Family Physicians. Family medicine, 2009 NRMP Results. <http://www.aafp.org/online/en/home/residents/match/table1.html> (accessed 8 Mar 2010).
3. The Association of Faculties of Medicine of Canada. *The Future of Medical Education in Canada (FMEC). Collective vision document, 2009.* <https://wiki.usask.ca/download/attachments/4456450/5/2.+WORKING+DRAFT+FMEC+Collective+Vision+Document+19+February+2009.pdf?version=1>
4. Hart JT. Relation of primary care to undergraduate education. *Lancet* 1973 Oct 6; **2(7832)**:778–80.
5. Havel V. The politics of hope. In: *Disturbing the peace*. New York, NY: Vintage Books Random House, 1991.

DOI: 10.3399/bjgp10X484048

In the quest to promote the new 'NHS Health Check' our PCT has invited GPs to attend a course on 'Motivational Interviewing' (MI), to empower us to work in the 'collaborative, autonomy-supporting, and evocative' manner that is apparently required by this ambitious initiative. According to the journal article circulated with this invitation, aims include not merely 'better clinical results' but helping patients to 'flourish as human beings', with 'improved satisfaction with life, enjoyment, resilience' and 'possibly longevity, productivity and disease resistance'.¹ Although this article boasts a rigorously 'evidence-based' approach, it offers no evidence for these extraordinary claims.

The author, Tim Anstiss is based at Thames Valley University, close to the Slough base of The Office where David Brent provided an inspired caricature of the sort of management psychology now being 'rolled out' in primary health care.

According to Anstiss, publications evaluating MI have been doubling every 3 years and it has been shown to achieve 'superior outcomes' in sexual health, dietary change, weight loss, voice therapy, gambling, physical activity, medication adherence, diabetes, mental health, chronic leg ulcers, criminal justice, vascular disease, stroke rehabilitation, chronic pain, self-care, domestic violence, and child health. MI is a veritable therapeutic super-glue when it comes to 'integrating' things: it can fuse evidence-based medicine and patient-centred care, physical and mental health care, treatment and prevention, treatment with wellness and wellbeing approaches, and much more. How does MI achieve these astonishing outcomes? Well, it harnesses the power of 'positive psychology' to help people 'to reconnect with their values and experience positive emotions on their journey towards improved physical and psychological health'. This sounds like the scenes in *Avatar* in which humanoid characters attach their pony-tails to the manes of exotic beasts and fly through mystical landscapes. Anstiss promises 'more frequent, intense or longer-lasting positive emotional states', a fantasy of

sexual ecstasy through talking therapy. But, back on earth, what values have people become disconnected from and what does it mean to 'reconnect' with them?

According to Anstiss the MI practitioner 'helps clients imagine a better future for themselves'. If this is a future in which people would not be brutalised and displaced by war and poverty, or brutalised further by immigration authorities, or simply a future in which they had a job and security for their families, I'm sure many of my patients could readily imagine it. But could the MI practitioner help to deliver these outcomes?

In *Smile or Die: How Positive Thinking Fooled America And The World*,² Barbara Ehrenreich indicates how the ascendancy of speculative finance capitalism over the past decade fostered the revival of the anti-rational theories of 'positive thinking' that first emerged in reaction to the punitive Calvinism of 19th century America. Blended with vulgar 'self-help' psychology, the new ideology appeared both to justify charismatic leadership in corporate rulers and to help them in 'managing the despair' of the millions of workers who lost their jobs in restructuring.

It is ironic that at the very time that 'positive psychology' began to be imported into the UK, its influence reached a 'manic crescendo' in the US subprime mortgage crisis that triggered the global financial collapse of 2007. The same combination of self-delusion and wishful thinking that united creditors and debtors and dragged the world into recession is now offered as a model for chronic disease management in primary care.

REFERENCES

1. Anstiss, T. Motivational Interviewing in Primary Care. *J Clin Psychol Med Settings* 2009; **16**: 87–93. DOI 10.1007/s10880-009-9155-x.
2. Ehrenreich, B. *Smile or die: How positive thinking fooled America and the world*. London: Granta, 2009.

DOI: 10.3399/bjgp10X484057