20%, which their work implies is desirable, would require either 20% more medical time or some major changes in the way consultations are organized. Medical time is expensive. To increase the number of general practitioners (GPs) by 20% would cost almost £300m in salaries alone. This may be value for money in economic as well as human terms if enablement leads to lower costs elsewhere in the NHS or to better social functioning. Too often, aspects of health care spending are examined in isolation from the larger picture. We need to measure the social as well as the human cost of illness.

Money is not the only limiting factor. There is an overall shortage of doctors, and particularly a recruitment crisis to general practice. More and more doctors wish to work part-time for all or part of their career. Community-based undergraduate medical education and GP commissioning may be admirable, but both take GPs away from spending time with their patients. Since it takes three years from entering vocational training and ten from entering medical school to produce a general practitioner, the medical workforce cannot be augmented rapidly.

It may not be medical time that is required. Some say that what we need is a change in skill mix, with greater use of nurses and nurse practitioners. This would, however, change the nature of general practice. Patients might have to choose which problems to present to the doctor and which to the nurse or nurse practitioner. Continuity of care and the patient–clinician relationship would be affected. These changes should be piloted and evaluated before being widely adopted. Too many innovations have been made in primary care on the basis of belief rather than evidence, with thought only on what will be gained and not on what might be lost. This is true of the move from single-handed to group practice and multidisciplinary teams as well as of anticipatory care, fundholding and GP commissioning. Before making further changes we need a clearer vision of what we seek to achieve as well as better evidence on how to achieve it.

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Are you a commander or a guide?

Analysing some 150 published accounts of personal illness, Anne Hunsaker Hawkins identifies two important metaphors that help people come to terms with their experiences[1]. The first is the battle, in which disease is the enemy to be defeated with the aid of doctors, nurses, and medical weaponry. The second is the journey, whereby the sick person ventures into unknown territory, undergoes frightening ordeals, and emerges with new vision and insight. According to Hawkins, these are 'enabling myths', with roots in Western culture going back to the *Iliad* (warfare) and the *Odyssey* (quest). For the battle the patient needs a general, for the journey a guide and interpreter.

In long-term illness especially, the journey myth seems to be gaining ground, and several themes in the *JRSM* come together here. For example, in January we had Christina Funnell's article on partnership in medical care, discussing the benefit people gain from having some control over the impact of their illnesses; in February there was JM Leggett's critique of 'therapeutic totalitarianism' (still being debated in the correspondence columns); and in this issue we have Peter Toon's editorial about the relation between consultation time and patient 'enablement' and Susanne Ax's analysis of discord between patients and doctors on the matter of chronic fatigue syndrome. To these I add Rampes' plea for inclusion of complementary medicine in the medical curriculum (January), on a hunch that 'alternative' practitioners succeed less by their special techniques than by offering moral support on the health journey; without this enormous prop, could a health service ever cope?

Christina Funnell invited me to a meeting in Paris entitled *Partners in the Health Care Journey*—attended by patients' representatives and a scattering of doctors, nurses, and people from the pharmaceutical industry (which helped to fund it through a group called Pharmaceutical Partners for Better Healthcare)[2]. Here are a few things I wrote down:

> How strange that in 1997 we should be discussing *whether* patients should participate in decisions about their care.
>
> Listen to the patients; we have information on what it's like to take drugs.
>
> Partnership is based on communication, but we don't speak the same language.
>
> We ought to examine the human dimensions of outstanding clinicians.

> In clinical trials, great effort goes into the information process; but what happens when the trial's over?
> At every decision point on treatment, a patient should be offered an opportunity to discuss the advantages and disadvantages relating to his or her individual way of life.
> A patient's beliefs must never be ignored, even when they seem irrational.
> Let us seek to influence the strategy of health care providers, so that patients' rights are integral.
> Patients are minorities, and to get results minorities must be political.

There was very little anti-doctor sentiment at this meeting, but neither was there any consensus that the guide on the health journey should be a doctor rather than, say, a nurse or a pharmacist. Surely it's the job of the general practitioner, I asked innocently. My question was greeted with hollow laughter, partly because many of the patient representatives were from European countries where primary care is ill-developed, so they relied almost wholly on specialists. But, even in the UK, the perception was that GPs are too short of time for this function, which brings us back to Dr Toon's reflections on the skill-mix in primary care.

Why was the pharmaceutical industry interested in the Paris meeting? Given their head, drug companies would offer patients and the public much more information; at present they are constrained by regulations that largely confine them to warnings about misuse and side-effects. Just before the Paris meeting the Royal Pharmaceutical Society, with Merck Sharp & Dohme, issued a consultative document about the failure of about half the population to take medicines as prescribed, with consequent lack of efficacy, unwanted effects, and waste. Reviewing the influence of erroneous beliefs the report declares, 'For the prescriber simply to reaffirm the views of medical science, or to dismiss or ignore these beliefs, is to fail to prescribe effectively'. Even medical scientists may have peculiar reasons for failing to comply: how many readers of the *JRSM* complete the full course of antibiotics when symptoms disappear on day 2? The working party urges doctors to abandon the notion of patient 'compliance' and work instead for 'concordance'[3].

If there was one strong message from Paris, it was that a heterogeneous group of patients' organizations is dissatisfied with existing models of care. The idea of partnership may be distasteful to some medical professionals accustomed to generalship, and the notion of entitlement even more so. Yet, if we look for improvements in our health services, the most effective pressure group might be a coalition of knowledgeable and self-motivated patients. Does the talk of myth and belief mean a flight from evidence-based medicine? Not so. For patients to get the best from medical science, qualitative information of this sort must be part of the evidence base.

Robin Fox
Editor

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2 PPBH's newsletter, *The Patient's Network*, will carry a report of the meeting. It is accessible on the Internet, http://www.ppbh.ch/ppbh

3 *From Compliance to Concordance: Achieving Shared Goals in Medicine Taking*. Report of a working party chaired by Marshall Marinker. London: Royal Pharmaceutical Society, 1997