The Back Pages

viewpoint

Professional Development Plans

IF Professional Development Plans (PDPs) were a chocolate bar it would be time for re-branding. For at least a decade, weary GP educationalists have been pushing, cajoling, entreating their colleagues as the PDP has evolved into its present undignified confusion. The recipients of this attention, a minority of enthusiasts aside, continue to regard the PDP as unwelcome, confusing, and suspicious.

This is exemplified by a funny, scathing article in *Doctor* magazine (no, I don t read it either, it was pointed out to me) by Tony Copperfield.[1] I agreed with a large part of it, and have no doubt that from Peckham to Penzance, GPs were nodding their heads in sage agreement. The gist of the argument seemed to be that GP prefects like me could take their collective PDPs and stick them well, you get my meaning. Better a 15-minute (dream on!) MCQ than a load of jargonistic nonsense, if I read him correctly.

The new NHS way to deal with this sort of apathy bordering on insubordination is to become ever more strident in one s demands. You must, you must, you simply must. As clinical governance lead I raised the question Are you seriously going to try to discipline someone, of known good character and reputation, with clear complaints record, because he or she refuses to produce his or her PDP? In the present recruitment climate? The only answer was the muttered suggestion that we could make the rebel s life seriously difficult .

All this is not to say that we should junk all attempts to force doctors to be accountable. But the PDP in its present guise is not the way. For a start, what sort of organisation is it that would ask you to demonstrate your competence by sending them a list of your shortcomings (sorry, educational needs)? I have heard said that these can be balanced by thank you letters from grateful patients. Can anyone take this seriously? Secondly, remember that clinical governance is about professional performance. How doctors update themselves is actually their business. The only time when it is necessary to evaluate continuing professional development (CPD) is when performance falls short.

So. What is my message? I, who spent a nine-month sabbatical assisting local GPs in constructing PDPs and am one of the local professionals most associated with them, authored a skeleton practice PDP, which forms a basis to the local PMS contract. The message is simple junk the compulsory PDP. Leave it to the minority of GPs, myself included, who are passionate about CPD, and will choose to do it voluntarily. Instead, create the GP professional competence report. This would be an annual submission from each GP providing evidence of competent performance. The following exemplifies material that would be appropriate to use: peer reviewed surgery or video (doctor to choose from approved list of visitors); audit linked to a clinical outcome, over and above that required by the NSFs; patient satisfaction questionnaire (externally organised); passing the MRCGP MCQ or equivalent, under examination conditions (let s see how many really choose this option); review of his/her education programme and a short reflection on what he/she achieved from it.; peer feedback from partners and staff; review of serious events/complaints (perhaps compulsory); and subject review of doctor s choice e.g., prescribing, chronic illness management, referrals, etc.

I would set a suggested target of 2000 words for all this, but reward quality not quantity. Each PCT would appoint a committee containing 50% GPs to review each of these reports. Passing this would in large measure contribute to re-accreditation and appraisal. All who failed to conform or who produced a document of low quality would be afforded a practice visit. Perhaps a random sample would be visited to try to trap the fraudsters.

In return, the PCT should agree to organise/co-ordinate protected learning time when the preparatory work could be undertaken, and encourage an academic buddying or mentoring scheme to facilitate that preparation. And yes, I know. It would be a PDP by any other name. But it would be exactly what it says on the tin , rather than a euphemism. It would give some autonomy back to the appraised doctor, and it would bear a clarity of purpose and outcome that is presently woefully lacking. And the GP prefects would be required to make their competence reports public.

Some chance.

David Tovey

Reference

1. Copperfield T. Can t we just knock PDPs on the head? *Doctor* 4 July 2002; page 21.

"The very success of modern science blinds us to the fact that it is only another description of reality, and moreover one which systematically excludes meaning, often fails to take into account the effect of the observer on what he observes, and is demonstrably both unprovable and incomplete ..."

Vernon exploring the limitations of natural science, page 870.

"Who in your form had the most interesting day today?"

Tovey on narrative-based parenting, reviewing Launer, page 874.

contents

From no interest to special interest — a personal reflection on the RCGP certificate in substance misuse

PREDOMINANTLY in my medical training as an undergraduate, my only exposure to patients with substance misuse was on the vascular surgery ward where we would be taught about the late complications of missed injection sites and deep vein thromboses. Not much attention was paid at that stage to their prevention and harm minimisation, nor the psychological aspects that precipitated their substance misuse. In fact I would go as far as to say that many of the patients were looked down upon as being victims of their own misdemeanours. Looking back on this now more than ten years later, makes me want to cringe. During my GP training I would, in all honesty, shy away from, and dare I say be afraid of the substance misuse patient attending surgery or the out-of-hours GP co-operative asking for help. Now with my retroscope I realise that this fear was borne out of a combination of ignorance, following others views, and some of my peers prejudices.

How things change. Approximately a year ago, when I learnt that there would be a Royal College of General Practitioners Substance Misuse course which would be accredited and validated, I took it upon myself as a personal challenge to learn more about substance misuse (or as the educationalists would have us repeat their mantra address my learning needs) and duly enroled on the course. I was allocated to the North Region and so in October last year I attended the Pre-Master class in Leeds, which was attended by approximately 100 other doctors from backgrounds as diverse as general practice, substance misuse specialist centres, prison doctors, and police surgeons. A crew from the local BBC TV station were there as well. Here we learnt more about the course structure and were given a background into the epidemiology, natural history, and causes of drug misuse. We also had presentations on drugs effects, their side effects, prevention of drug abuse, harm reduction, interaction with the law, dealing with drugs and young people, drug misuse in the pregnant misuser, and drug misuse in ethnic minorities and in the prison service.

It was a lively debate, in which a key figure from London nearly missed her train home as people from the audience vented their anger at how the good work done in stabilising people in the community was undone when they went to the prison. I do not think the prison representative from London will ever forget the response she got to her Has anybody got any questions? , when she attended Leeds.

We were also presented with a large amount of reading material, but this gave us the opportunity to review a selection of published evidence for the role of the GP in the care of drug misusers and the pharmacological therapies available. The information was in the form of a bound collection of all the keynote papers that had been published in the past ten years. We were also given books that were particularly relevant to the subject area of substance misuse, and a learning portfolio, which allowed us to log our learning experiences and tick off the tasks completed.

Between October and November, we read these articles and re-convened as a small group of ten for the first Master Class. Together we discussed what we thought of these papers. For me, the most influential period was between November and April; it was during this time that I attended a Primary Care Clinic specialising in substance misuse, where I started off sitting in with a doctor. Also I performed an audit of the service provided, as well as developing my own personal action plan to complete my learning portfolio.

Our second Master Class in April allowed us to discuss some of the issues and learning points that we had experienced in the intervening six months, and indeed all of us felt that the dedicated time that we had allocated resulted in an improved knowledge of substance misuse. We were paid a bursary of £1000 to cover work and travel expenses for attending the three-day Master Classes.

After reviewing the cases that I had seen and my learning portfolio, followed by a mini *viva voce* exam with my mentor, I was recommended that I be accredited with the title of GPwsi (Substance Misuse). I am now settling into a new partnership in a town with a considerably overstretched primary care specialist Substance Misuse Centre and where there is a predominant feeling of reluctance among the local GPs to engage in taking on substance misuse clients. I hope to continue to develop my interest in this area and possibly in time (perhaps many years), and with help from the PCT, develop a service with other fellow certificate holders, which may extend to a shared care management programme.

Contrary to earlier years of avoiding substance misuse patients, I now actively reach out to them. I am also trying to get their consent to engage them in a research project. I fully empathise with those of you who have images or memories of angry patients demanding Diazepam on Friday evening surgeries, as that is exactly what I had felt. Things have moved on and addicts know that this is not the way to access help. I have found this particular area of primary care encouraging and rewarding as well as challenging, and would urge other GPs to put aside their prejudice, address their fears, and come on board and help us deal with these needy patients.

Rahul Kacker

Course on Cross-cultural Primary Care, University College London

THE aim of the course is to equip those working in primary health care with the skills necessary to understand the health beliefs and practices of different patients and communities, and how these may differ from their own.

The course is open to all those working in primary health care settings. Topics covered include:

Patients explanatory models of illness;
Body image and interpretation of symptoms;
Family structure and family health;
Pregnancy, childbirth, fertility and infertility;
Death, dying and bereavement;
Alcohol, tobacco, and drug abuse;
Use of non-medical health care;
Cross-cultural psychiatry;
Nutrition, malnutrition and dietary taboos;
Migration, refugees, stress and disease;
HIV/AIDS and other sexually-transmitted diseases

The course will be taught by Dr Cecil Helman (Senior Lecturer, Department of Primary Care and Population Sciences, Royal Free and University College Medical School) The session on AIDS will be given by Dr Surinder Singh.

The course will take place in the Department of Primary Care and Population Sciences of the Royal Free and University College Medical School, Holborn Union Building, Highgate Hill, London N19 5LW. It will run from 4 8 November 2002 and will consist of five full-day sessions. For dates of subsequent courses, please contact the Course Office (see below).

Cost
Full-time GP and hospital consultants: £600
Part-time GP, non-principal GP, or other hospital doctors: £500
Nurses, and those working in non-medical professions (including charities, non-governmental organisations, local councils, government bodies, refugee organisations, ethnic minority organisations): £450

Postgraduate Education Allowance
A Certificate of Attendance will be given to all participants. PGEA approval applied for.

For further information please contact:
Barbara Agdomar, Department of Primary Care and Population Sciences, Royal Free and University College Medical School, Holborn Union Building, Highgate Hill, London N19 5LW; tel: 020 7288 3474; fax: 020 7281 8004; E-mail: b.agdomar@pcps.ucl.ac.uk; URL: **www.ucl.ac.uk/primcare-popsci/courses**

flora medica

from the journals, August 2002 ...

***N Engl J Med* Vol 347**
305 The latest in a long series of classic papers from **Framingham** on the natural history of **heart failure**: **obesity** is the risk factor examined here. Fat people are often big-hearted; and it doesn t do them any good.
314 Autistic children can be very hard to cope with should we give them **risperidone?** It works in the short term; which raises spectres of inappropriate use and damage from long-term chemical control of this little-understood range of disorders.
465 Why don t we become immune to the **common respiratory pathogens?** This study shows that exacerbations of respiratory disease are usually with **strains new to the patient** not of viruses, but of bacteria, such as *H. influenzae, M. catarrhalis* and *S. pneumoniae.*
498 In the UK, **snoring, gasping and daytime tiredness** are often caused by reading Government circulars on the NHS: this US review discusses other precipitating factors, consequences and treatments of **sleep apnoea**.
561 It had to come, and in fact it works: **minimally invasive coronary surgery** with scopes and probes can replace bits of the left anterior descending artery on the beating heart, with better long-term outcomes than stenting. And you can claim a minor surgery fee.

***Lancet* Vol 360**
397 A review of **obsessive-compulsive disorder** recommending SSRIs and cognitive behavioural therapy, something psychiatrists need to do again and again.
426 The brain is programmed to remember and **fear pain** in order to avoid it: when pain is unavoidable, we need ways to lessen the memory and diminish the fear, as discussed in this editorial.
427 Bone marrow mononuclear cells can differentiate into new **blood vessels**, and seem to do so when simply injected into the muscle of **ischaemic legs.** If you don t believe it, look at the pictures.
545 Angina getting its own back: glyceryl trinitrate can heal **anal fissures**, but **nicorandil** can cause them.
603 Ears have become popular for **measuring temperature,** but to do it accurately in children you need another orifice, which can sound a bit similar in vulgar parlance.
618 But always look in the ears in cases of **chronic cough**, French otolaryngologists solemnly advise: **earwax** can trigger the ear-cough reflex via Arnold s nerve. *Eblouissant!*
659 If you have to take your patients the way they were born, the alleged connection between **low birth weight and adult hypertension** may not be too exciting for you and it s largely spurious, according to this nicely argued and illustrated review.
678 Everybody seems to think that exposure to **chickenpox** may cause **shingles** except those who have looked at it, and found that it is actually **protective.**
710 Confused by **food allergy?** Aren t we all (or maybe that s a sign that you re being poisoned by bowel candida, doctor): this review helps, a bit.

***JAMA* Vol 288**
611 History may be over, but the world is still full of **refugees** from conflicts and places we would rather forget about; and we have little reliable information about the health status of asylum seekers, according to this US review.
701 It may be best to avoid tricyclic **antidepressants** following **acute coronary events,** but **sertraline** seems safe.
726 Lady docs are nicer: it s official. Or at least meta-analytical.
872 Reeling from all the bad news about **HRT** and wondering what to tell all those women you recommended it to previously? Here s the **review** you need sober and bang up to date.
963 Two or more cats or dogs are needed to make your baby less likely to develop allergies to insects or plants. An oblique strategy, but they re cuddlier than dead house dust mites and pollen.
973 The so-called antioxidant vitamins C and E are useless at **protecting the heart,** but the homocysteine-reducing (methylating) **vitamins B_6, B_{12} and folic acid** reduce adverse events following coronary revascularisation and have many other potential benefits.

Most of the leading journals had five issues in August, leaving little room for items from further afield, such as Nasal Opioids for Pain in Adults (*Acta Anaesthesiol Scand* 2002; **46:** 759). More next month.

Plant of the Month: *Ginkgo biloba* (female)
Despite the deeply improbable complexity of its sex life, *Ginkgo* managed to survive in a remote Chinese monastery garden and is the most primitive of trees. Just now its leaves are turning a beautiful butter-yellow and the females are shedding their fruit, famed for their alleged memory-preserving properties (but see *JAMA* p age 835). Alas for the gardener, they rot and stink.

Theophrastus Bombastus

Audio extracts from the interviews can be listened to as sound files on the ScHARR website:

http://www.shef.ac.uk/~scharr/hpm/GS/

WHILE a doctor in the middle of his career could claim to have GP stamped on my bum ,[1] this was neither the language nor the sentiment of the older working and retired practitioners interviewed in the Paisley study.[2] For many of the older cohort, professional identity was certainly spoken about in intimate and personal terms, but individual work identities were internalised in ways that were absent in the narratives of younger practitioners. In particular, in the interviews with retired and older working doctors, hands often feature as metaphors. There were numerous references to an extra pair of hands and a safe pairs of hands in descriptions of general practice in the years before the mid-1960s. But older GPs used hands not only to illustrate professional competency and commitment, but also to refer to the pragmatic and experientially learnt application of diagnostic and therapeutic skills.

These older doctors also frequently refer to engineering as a profession that they or their colleagues might have entered as an alternative to medicine. Engineering is one of the few examples of a profession that has material products,[3] but it is also a profession that has been claimed by engineers to be undervalued in Britain, because of its pragmatic application which arguably provides another similarity to general practice. The emphasis on pragmatism was also expressed in descriptions of DIY improvements to practice premises that an interviewee or one of his colleagues had carried out, commonly installing cabinets and sinks in surgeries and shelving for patient records in office areas. A number of practices in Paisley boasted a partner who was proficient in joinery, and one GP somewhat alarmingly displayed his electric power tools on shelves in his surgery. An earlier study found an analogous pattern in the narratives and values of city businessmen.[4]

There were exceptions in the ways older doctors talked about their work. GPs who were active College members were less inclined to stress practicality and experience as important; rather, they were much more supportive of educational initiatives and emphasised the importance of theoretical concepts.[5] Embodied skills and an emphasis on pragmatism were also largely absent from the descriptions of profession and work that female GPs provided. And both groups were more likely to accentuate a holistic approach to patient care.

Between 1970 and 1990, the proportion of female family doctors had more than doubled, from 12% to 25% of the total , although less than half were working full-time[6] and it was a trend that would continue in the next decade in both England and Scotland.[7] Only one of the women doctors in the study believed that some of her female colleagues were working as members of the pin money brigade and were playing at being GPs. The interviews do suggest that male doctors were less likely than their female counterparts to have family responsibilities, including caring for young children and ageing parents.

Female GPs recalled general practice as patriarchal and recounted examples of the difficulties women have found in the profession. Some of the women, for example, complained of the lack of space in their practices, being more likely than their male colleagues to share surgeries, even when working full-time. Nevertheless, they also shared a positive view of the profession, and the position of women in practice excited less discussion than might have been expected. There are signs, however, that among the younger women a critique is beginning to develop regarding the position of female GPs.

There was however little consensus among the women regarding their contribution to general practice, although in contrast there was a belief among the older men that it was increasingly important from the 1980s onwards as well as convenient and, of course, practical to appoint a female partner. The argument was that women were more likely to accept a part-time appointment and practices could cautiously expand by taking on part-timers rather than gamble on appointing full-time partners.

Among male doctors, and even some of the younger male doctors, there was a perception that female practitioners are suited to treating certain patient groups, conditions, and illnesses, including psychological illness. The women also felt that some patients either gravitated towards them, or that male partners referred certain patients (including children) to them, because they were women. Whether this has resulted in informal specialisation along gender lines would require a larger study, but it is clear that there was a continuing uncertainty among female GPs about the impact of their gender on patient care. There was also ambivalence, shared by some of their younger male counterparts, about patients choice of doctors according to gender, and patients assumptions about their specialties or areas of interest (that women GPs, for example, would or should be more interested in gynaecology or pediatrics).

Marshall Marinker has suggested that, in the 1950s, disdain for women doctors and hostility towards psychology was all of a piece with the robust masculine instrumentality of medical sentiment, education and practice .[8] In the interviews from Paisley, male doctors appreciation of the contribution of women to general practice has generally grown over time. However, among some of the younger men there continues to be a preference for treating physical illness, with varying degrees of hostility towards psychology and psychiatry.[9]

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12. GPP 10.
13. GPP 23.
14. GPP 17.
15. GPP 24.
16. GPP 07.
17. GPP 15.
18. GPP 16.
19. GPP 29.
20. GPP 29.
21. GPP 12.
22. GPP 04.
23. GPP 28.

The oral evidence

Retired and older working GPs often talk about the pragmatism and physicality of practice.

Patrick McC: *'The medical profession has far too much theory and very little practice; I think they should have more hands-on.'*[10]

Douglas H: *'His father had been a doctor in the town and he followed in his father's footsteps in his father's practice… I knew he was a good engineer. I'm sure at one time he must have had a problem deciding whether to do medicine or engineering, because one of them was going to have to be a hobby... He was good with his hands. He was a good and caring doctor too.'*[11]

Charles McC: *'So you had to be able to deliver a baby and delivering a baby was how good your hands were and how good your technique… I was good with my hands, I could fix things, I could deal with things, I could organise things… If you diagnosed from the foot of the bed you'd got problems.'*[12]

Robert B: *'A woman in her mid-60s had come in to see me with a generalised pruritis, but with no rash. And I had taken time to make damn sure there was no rash and I laid my hand on her belly and she had a mass. And I was pretty certain I was faced with a gastric carcinoma and an unusual neoplastic urticaria and I wanted to get an opinion. The surgeons weren't available and it was Hugh Conway* [a physician] *that came out and he said, 'Remarkable. That's a splendid diagnosis. I'm sure you're right'. And I mean I was walking on cloud nine. I don't know why I put a hand on her belly really…'*[13]

Gavin W: *'I've always very much believed the hands-on way is the best way of learning.'*[14]

Retired female GPs, in contrast, tend to be more reflective about their place in medicine. Margaret G, like other women GPs of her generation, worked in more than one practice.

Margaret G: *'Well, a lot of ladies like to see a lady doctor and it's more and more accepted now. Not like when I went to Helmsdale, they'd never heard of a lady doctor. And I probably said to you that I thought it didn't matter in Dumbarton that I was lady. But once when I had to do a Monday evening surgery, which was always done by the two men, there wasn't a lady in the waiting room. There were these twenty men looking at me when I went in. So that made me think that some men probably didn't want to see a lady … But once they know you and you're The Doctor, I don't think it matters. Well, it's for them to say, isn't it?'*[15]

Male GPs recall the appointment of a female partner as a pragmatic decision.

Robert E: '*Having a woman, particularly a married woman, in a part-time job obviously was an advantage to her as well as to us. When she left us we never advertised again. We always knew of somebody that we could approach.… Eh, we didn't need a full time partner.'*[16]

Donald W: '... *Something that had been running through my head for a long time. When you have a smear clinic you appreciate that there's a large number of women who don't want to come and see a man for a smear. And also since you find yourself as the youngest of the three having to deal with all of the emotionally upset women, you know, you think "Well, a woman would be a good idea here"* [laughs]. *And you know it was obvious that that was something that was necessary within the practice and I convinced them that this was what we should do. But we took on a woman as a fourth and equal partner.'*[17]

Discord between the genders was reported in a number of interviews. The following is a relatively trivial example.

Douglas H: *'It* [the practice partnership] *was never unduly hierarchical. No. I only laid down the law once, I think; when we had a female partner. I said, '*[She] *should wear a skirt and not trousers'* [laughs]. *We're talking 15 or more years ago now.'*[18]

Did Jennifer W recall a dress code in the practice?

Jennifer W: [Laughs] *'Bet you Douglas brought that up? Uhuh. You know he never had to complain. Once I wore a trouser suit. Did he say that? Yeah. And I got reprimanded. I did. And I think I probably told him he had to come into the 20th century. … I always did dress up.'*[19]

Later in the interview she went on to say:

'You're working to targets, your cervical smears, your immunisations. Yeah, I would end up sending out letters after they had had three reminders. You know hand written. Asking people, you know and explaining how important it was to get the follow-up... and trying to get them back and you know they honestly weren't interested some of them. And it was the same for immunisation. You know, I had umpteen weans [many children] *…there was an awful lot of time spent trying to reach these targets, which I mean initially I could. I am not into the finances of it now, but initially it was 80% cervical cytology and if you were 79 you lost a serious amount of money.*

'… We had a couple of nuns [laughs] *… that was certainly the ones you got as a female partner.'*[20]

Eleanor H applied for her first post in general practice in the mid-1970s.

Eleanor H: *'I went for several interviews and the job on offer was nominally a partnership, but it was a partnership where I would be doing gynaecology and baby clinics and I was not happy at that role at all and I turned down several jobs, ehem, on the basis of that… I didn't mind if patients chose to see me but that is an entirely different thing from being told that's your role …*

'… Somebody did an audit to see what your clientele was like and it was interesting that you do tend to attract people who are similar to you in age. I was the only female partner at that stage… it must have been about ten years ago, and I had a vast range of elderly women who came to see me. I did have the people in my own age range but I had a lot of elderly ladies who chose to come to see me.'[21]

Most of the younger male partners commented on the ways in which patient care can become shaped by having female partners.

Graham D: *'I have maybe women who attend me for rheumatoid arthritis or whatever it happens to be, but will attend one of the female partners for their HRT, which seems fair enough. I can't relate to that problem.'*[22]

Some of the younger female GPs reject having their identities and their role in practice defined for them.

Fiona T: *'Well I wasn't ever going to be a lady doctor that was the thing. I didn't want to be a lady doctor I just wanted to be a doctor … They hadn't had a female partner before they had had a lady doctor. And they treated the lady doctor very badly. Very much as a second-class citizen … don't let women sign cheques* [laughs].

'… I bully them, that's what I do. That's what they would say I am, sure. Ehem, I just go on at them … I think I am maybe fairly forceful about it. But nothing in this place starts unless everybody agrees to do it, so, so bullying is probably too strong a way of putting it.'

Achieving consensus?

'Oh, that's the kind of management garbage that would get their backs up [laughs].[23]

Graham Smith

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The limitations of natural science as applied to medicine

WHAT are the limits of natural science as applied to medicine?

Introduction

By natural science I mean the traditional methods of physics, chemistry and biology as applied to medicine, the methods of what might be called reductionist science. In this essay, I wish to explore the proper limits of these methods and what effect using these methods will have on how we perceive the world. Is this relevant to general practice? I suggest that it is. For example, last night one lady rang 12 times to tell the duty doctor on call that she could not sleep. Do we really believe that applying these scientific methods measuring, perhaps, her cerebral serotonin level is going to provide a complete explanation? Maybe looking at her purely through a scientific mind-frame is going to blind us to her genuine distress, distress that is, admittedly, being expressed inappropriately. It is also true that our consulting rooms are frequently occupied with patients with chronic multiple functional somatic symptoms , as reviewed recently in the BMJ,[1] patients whom scientific medicine from the primary to the tertiary level has failed to help, or even harmed.

The application of the scientific method to medicine leads first to wonder at what it can achieve, followed often by disillusion as to what it leaves out. It has been clear from the beginning that what it specifically excludes is any consideration of meaning. This is what George Herbert[2] explains in the following poem written in 1663, when scientific methods were the new philosophy . He describes the sense of wonder scientific discoveries can bring, followed by disillusion as we become aware of the limitations of science.

'Philosophers have measured mountains,
Fathomed the depth of seas, of states, of kings,
Walked with a staff to heaven and traced fountains:
But there are two vast and spacious things,
The which to measure it doth more behove,
Yet there are few that sound them; sin and love.'

The Agony (1633)

He is saying that natural science, while it can do marvellous things, cannot capture concepts to do with meaning and purpose in life (love and sin). The same point is made by an excellent recent article comparing quantitative and qualitative research.[3]

Qualitative and quantitative research compared

Those methodologies that do look at meaning have since been called qualitative, as opposed to quantitative methods that are based on what I am calling natural science. These qualitative methods have quite different philosophical underpinnings than natural science, but what they share with each other is an acknowledgement of the importance of the observer in what is observed, and agreement that this needs to be recorded. Moreover, qualitative researchers, typically social scientists, differ from natural scientists in that they may not aspire to give a complete and self-consistent explanation of all reality, but are willing to use a range of methodologies to shed light on the same phenomenon. To borrow terms from the literary criticism of Mikhail Bakhtin, the discourse of qualitative methods can be called a polyphonic discourse; that is to say it contains many distinct voices that, to some degree, recognise each others validity. By contrast, scientific discourse based on quantitative methods is monologising ; that is, it recognises only one legitimate discourse and reduces all other voices to its own.[4,5] Scientific discourse seeks to provide a complete and self-coherent explanation of reality. For this reason, while the various subjects which make up the social sciences are willing to interact, dialogue with them can be threatening to traditional scientists as it is at odds with their monologising discourse about reality. The discourse of our patients also is typically polyphonic; that is to say that they happily engage in discourse with the pharmacist, the natural healer, and the doctor, without feeling that any one of these is exclusive. It is only some doctors, educated into the monologising discourse of science, who are disturbed by this, and lay claim to an exclusive perception of reality.

While scientists will readily acknowledge that they have not yet produced an exclusive and self-coherent explanation of reality, the claim is that it will be produced some day. Indeed the philosopher of science, Thomas Kuhn,[6] claims that when one set of self-consistent explanations which he calls a paradigm wears thin, then scientists simply choose a new set of such explanations. Thus he would claim that Newtonian physics was one paradigm, and that it was abandoned in favour of Einstein s theory of relativity.

The limitations of qualitative methods and quantitative methods can be compared with the following analogy. Qualitative research can be likened to looking through a glass darkly (I Corinthians 13:12). This phrase of St Paul s refers to the ancients use of a polished metal surface as a mirror. If you do this you will be aware not only of your reflection but also of the reflecting surface itself, which by its imperfections makes itself visible. Similarly, in qualitative research it is important to convey both what is seen and the perspective or bias of the researcher. In this way, the fact that the

research is an interpretation of the world is made explicit. Quantitative or natural science research can then to be likened to using a modern mirror. A modern mirror gives the viewer an illusion that they are seeing something real . Yet this reality has a flaw hidden at its centre. In the case of the mirror this flaw is the reversal of handedness in every image, indeed every molecule seen in the mirror. The very perfection of the modern mirror makes it difficult to notice that the image is radically different from reality. The flaws hidden in natural science are equally hidden and equally pervasive.

The flaws or limitations of natural science

There are at least three flaws or limitations. First, meaning is excluded from scientific discourse, yet most of us believe that it is crucial to understanding human beings.[7,8] Second, natural science as applied to medicine is considered to be independent of the observer, even though quantum physics has long shown us that this is not the case, even for sub-atomic particles. Thirdly, natural science depends on the explicit hypothesis that reality can be completely described by a set of self-consistent axioms, an assumption that has been shown to be false by G del.[9] The traditional scheme was that medical science would be based on the physical sciences, the physical sciences on mathematics, and mathematics on logic. To logic itself the axiomatic method would be applied in which, from a few well chosen axioms, the whole corpus of knowledge could be derived purely from internal deduction without reference to anything else. This project is implicit in the school science curriculum. It is explicitly followed by Bertrand Russell in his *Principia Mathematica*,[10] or, on a more popular level, by Steven Hawking in *A Brief History of Time*,[11] where he describes the search for a grand unifying theory. Yet we have known since G del s theorem[9,12] that an axiomatic system s consistency cannot be proved within the system itself. Even more startlingly, G del showed that, however many axioms you use, there will be statements which are true but cannot be demonstrated from those axioms. For example, it is easy to see by trial and error that each whole number is the sum of two primes, yet no mathematician has yet demonstrated this by the axiomatic method. This could be an example of a simple truth about the system of whole numbers that cannot be demonstrated from the axioms of this system. So G del is showing that while science can clearly give a good description of reality, it is giving one whose consistency cannot be proven and which is demonstrably incomplete.

Conclusion

The very success of modern science blinds us to the fact that it only another description of reality, and moreover one which systematically excludes meaning, often fails to take into account the effect of the observer on what he observes, and is demonstrably both unprovable and incomplete. To lay out the limitations of natural science as applied to health is not to decry its use. On the contrary, it has proved a startlingly useful way of understanding reality. To use it correctly, however, it is necessary to have an idea of its limitations.

Gervase Vernon

Example — Consultation analysis 'after Bakhtin'

The consultation has been analysed many different ways. It is possible to apply the literary criticism of Bakhtin, designed initially for the novel, to the consultation. Two basic categories need to be grasped. He applies the term 'monologising discourse' to any scheme of ideas that attempts to give a full description of reality without referring to concepts outside itself. Natural science, some forms of Marxism, and Roman Catholicism are monologising discourses. The scientific paper is a literary example, and the presentation on a grand round, an oral one. Such a discourse necessarily simplifies and excludes. At the extreme, such a discourse will distort reality so that 'to a hammer everything looks like a nail'; or, to give another example: 'to a manufacturer of Prozac everything looks like depression'. A polyphonic discourse is one where many different voices giving different, and often contradictory, accounts of reality exist simultaneously in a person's head. Such is the normal condition for many people who will happily use concepts from homeopathy, conventional medicine and, say, yoga, to help them deal with the world. It is, for Bakhtin, the normal form of the novel.

Some general practice consultations can then be seen, by the doctor or the patient, as an attempt to force the polyphonic discourse of the patient into the monologising discourse of science. The following fictional consultation is analysed according to this scheme:

Patient: "I've got a terrible headache these days. My wife says I'm stressed out from all the hours I do at work." *(Wife's voice, explanation based on "stress" model.)*

Doctor: " Mmmm."

Patient: "I've also got this knot at the back of my neck. My osteopath says that my neck is misaligned, and my headache gets better every time he treats me." *(Osteopath's voice, explanation based on osteopathy.)*

Doctor: "Anything else happening?"

Patient: "Since my mum died four months ago, as well as the headache I've felt down and not enjoyed anything. I dream about her telling me I've been a naughty boy, and wake up in a terrible sweat." *(Mother's voice, explanation based on guilt and dreams. The patient has so far shared three different explanatory systems.)*

Doctor: "So you've been feeling stressed and down with a headache since your mother died. You've got all the symptoms of a reactive depression. The chemicals in your brain are low. You will get better with these antidepressant tablets I'm going to give you. They will return the chemicals to their normal levels." *(Monologizing discourse seeking to explain all the ideas so far elicited by one scheme of "scientific" thought.)*

Patient: "That's great doctor. But can I carry on with the osteopath, and my natural healing tablets from the chemist as well?" *(Patient resists the doctor's monologizing discourse and places it instead as merely an extra voice in his polyphonic world.)*

The consultation can be seen, then, as an attempt to listen to the 'novel' of the patient's world, and recast it according to the rules of scientific discourse. This transformation both requires great skill and is impossible. It requires great skill because the doctor must be familiar with both the patient's language and that of science. It is impossible because ultimately, the monologising discourse cannot capture the richness of a polyphonic world.

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Epilepsy care - the current position

OVER the past decade the care of most of the major disease groups has moved on considerably throughout the UK. However, the care of epilepsy has remained something of a cinderella . This is in spite of advances in our understanding of the processes involved in epilepsy, more sophisticated means of diagnosis, and an increase in the number of treatment options available.

There has also been no improvement in the mortality from epilepsy over this time, according to figures from the Office of Population Censuses and Surveys. Cockerell,[1] in a study of 6000 people with epilepsy, goes further and reports that there has been no evidence that the prognosis for epilepsy has significantly altered over the past 40 years (Figure 1).

There has also be no improvement in the number of patients admitted with epilepsy at the author s local district general hospital (The Queen Elizabeth the Queen Mother Hospital, Margate), with no major change in hospital catchment area or population to offer an alternative explanation for the figures (Figure 2).

Are the resources available to treat epilepsy being fully utilised?

The recent Clinical Standards Advisory Group[2] study of services for patients with epilepsy challenges this view. The findings of its postal survey reported that only 52% of the community-based sample compared with 67% of patients attending hospital (albeit infrequently) were seizure free in the previous 12 months. The medication available for use by the two groups is largely the same and yet there remains a difference in the seizure freedom of 15%.

Specialisation

The active treatment of epilepsy has become specialised, often moving out of the hands of the general practitioner or the general physician, to those of the neurologist. Some neurologists have further specialised, developing special expertise in epilepsy. The care for patients who attend specialist clinics is undoubtedly excellent, but has this reduced the number of clinicians actively engaged in treating epilepsy throughout the UK?

Grass-root change

The call for more epilepsy clinics around the country is to be commended but it is my hypothesis that there are many who could benefit from simple changes to their management. If these patients were actively identified, and indeed the entire epilepsy population reviewed in their GP surgeries, the national mortality and morbidity figures may begin to improve. There is evidence that, by reducing the number of seizures, the mortality of epilepsy can be reduced.[4] General practice holds a unique position of being able to audit all patients with epilepsy and identify those who are at risk from epilepsy. It also offers an alternative method of health care delivery for patients and may attract patients who rarely seek help and who would find a consultation in their high street surgery less daunting than a hospital environment.

The need for change and the challenges involved

Primary care has long been criticised in medical literature regarding its treatment of patients with epilepsy. However, with the care of patients moving increasingly towards secondary, and indeed tertiary centres, GPs can understandably become deskilled in the management of epilepsy. In 1969, the Reid report[3] produced a full assessment of the provision for people with epilepsy. One recommendation from the report was the suggestion that, in a group practice, one of the partners should specialise in epilepsy.

The introduction of clinical governance in primary care has opened up an opportunity for standardising and setting targets for disease management, including patients with epilepsy who could benefit from optimisation of their care. This process has occurred over the past four years in East Kent (Primary Care Clinical Effectiveness programme PRICCE) and marks a significant move forward in the epilepsy management in this region.

An extra resource? Development of GPs with a special interest (GPWsi) in epilepsy and a network of lead GPs in the care of epilepsy

Even though epilepsy is one of the most common serious neurological conditions, an average GP may only expect to see one or two new cases of epilepsy a year and have a little over a dozen established cases. The proposed model is for a group of five to ten GPs to have a lead GP in epilepsy, who would take responsibility of the care of patients with epilepsy in this larger group. In addition, a peripatetic GP with specialist knowledge in epilepsy would travel to each location where an epilepsy clinic is held, approximately every four to eight weeks. The local lead GP would sit in on this clinic and give background information on the patients seen and would also then receive, in the process, training in epilepsy. The enhanced duties ought to be paid for and recognised as being more than standard GMS.

The duties of the local lead GP in epilepsy would include:

- Overseeing the audit of patients with epilepsy;
- Selecting the patients to be seen;
- Collecting the relevant patient information ahead of the clinic;
- Ensuring that suggestions for treatment made by the clinic are effected by the patient s GP;
- With time, becoming a resource on epilepsy to the other GPs in his/her group.

Key points

- With time, a network of GPs develops with enhanced skills in epilepsy;
- The Primary Care Epilepsy Service is largely proactive rather than reactive;
- The patient s GP is the first line for patient contact;
- No waiting list the recruitment for community clinics is in the hands of the GPs;
- Low estate costs.

Requirements

Secondary care remains in the lead role for the diagnosis, investigation, and treatment of epilepsy. The recruitment to the primary care service would usually be made as a result of audit and good communication between primary and secondary care maintained, to ensure that patient care is being provided by the most suitable agency. Treatment modifications need to be carefully co-ordinated between the two.

Conclusion

Society seems to hold a taboo against seizures that other illnesses do not suffer, so for epilepsy to have remained in the backwaters of medicine is hard to defend. Why the care of epilepsy is often solely in the hands of specialists is puzzling and likely to be multifactorial. Certainly, the stakes are high in altering management and aggravating an attack. However, this could also be said of other illnesses, such as ischaemic heart disease, but the management of this lies within the expertise of most GPs and general physicians. Even if the management of relatively straightforward cases were to move to the care of general physicians. this would be still remain a reactive service. GPs surgeries, on the other hand. are convenient for patients to attend and may be seen as holding fewer stigmas.

The care of diabetes and asthma has been acclaimed by many to have greatly improved in the last decade and primary care has had a part to play in this. The next decade looks set to see the care of epilepsy come forward and my hope is that a Primary Care Epilepsy Service may well be one of the instruments in this process.

Greg Rogers

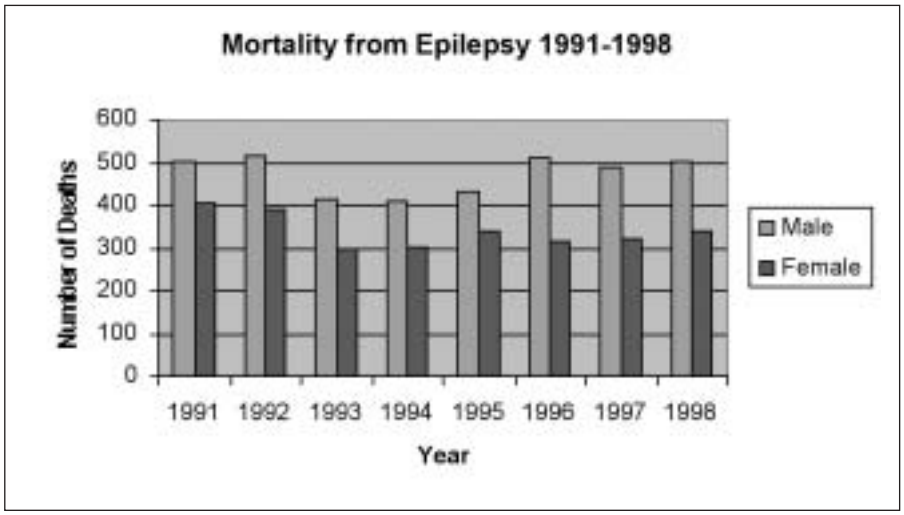

Figure 1.

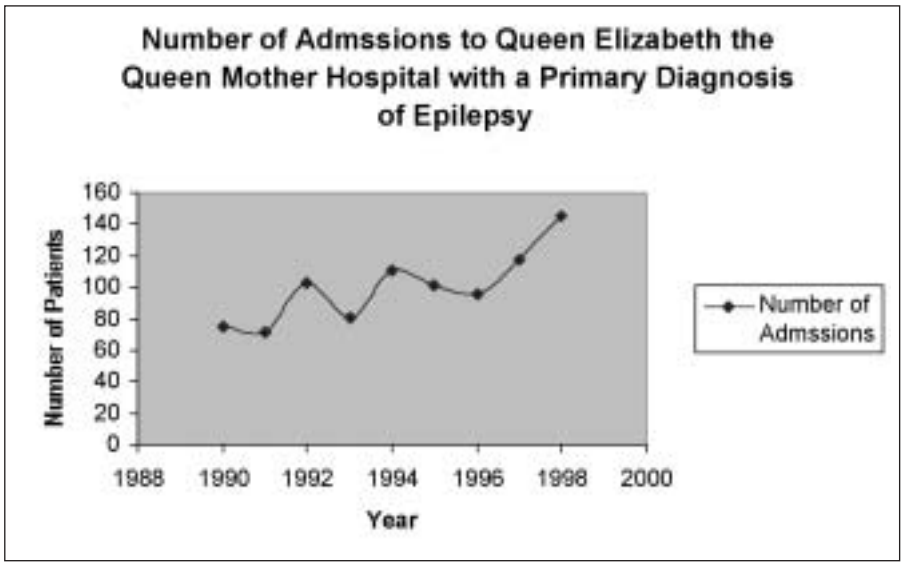

Figure 2.

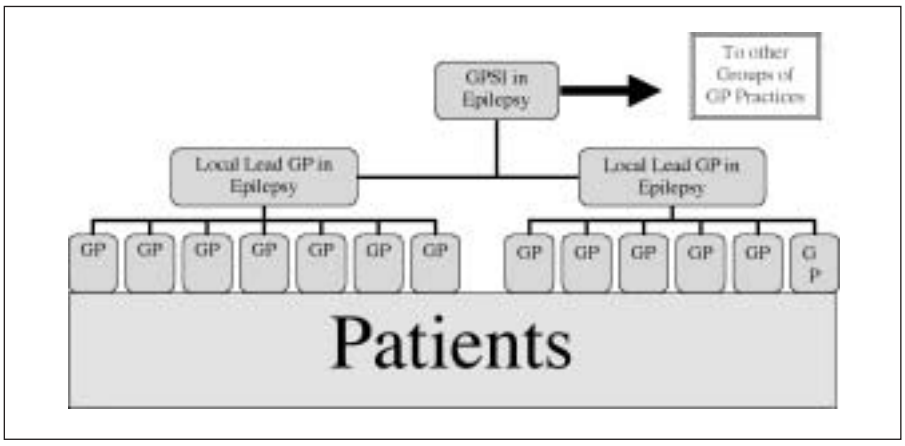

Figure 3. Flow diagram of how a GP with a special interest (GPWsi) in epilepsy could work in the primary care setting. (Hospital referral routes remain in place and are not included in this diagram.)

Narrative-based Primary Care
John Launer and Trisha Greenhalgh
Radcliffe Medical Press, 2002
PB, 264pp £21.95, 1 85775539 1

THIS is compulsory reading. If it were a thriller by a new author, the dust-jacket would read As good as Neighbour or your money back . The introduction itself is worth the cost of the book.

An expression of interest. I was part of the second intake onto the course that Launer co-tutored with Caroline Lindsay at the Tavistock Centre. It changed the course of my career, and perhaps my life.

As I have suggested, the most obvious comparison is with Roger Neighbour s *The Inner Consultation*, the first sexy book about general practice consulting and a critical influence on a generation of GPs. Lacking his predecessor s literal flourish and individualistic flair, Launer nonetheless withstands the comparison by virtue of the clarity of his thinking, his intellectual rigour, and the relevance of his approach. There is scarcely a page in this book that does not contain a gem.

Parenthetically and regrettably, Launer is probably not likely to follow in Neighbour s footsteps by chairing the MRCGP examination committee, since self-evidently it would be impossible to undertake this role without being able to accept that any question had but one answer. Characteristically he is not even able to resist suggesting to the reader different ways of approaching the book you could, for example, start with the first page and continue to the end, but, some would gain more by reading the book in a different order. As usual, he is correct.

The theoretical perspective is difficult and by its nature will be interpreted differently between readers. Building on approaches to family therapy and incorporating the post-modern concepts of social constructionism, Launer is able to both describe the narrative approach as being one of a range of theoretical approaches to the consultation, and the antidote to such classification. The major influence social constructionism requires and receives further introduction. Broadly, social constructionists believe that language largely determines reality, rather than the other way around . Launer is not unaware of the limitations; disease, disability, deprivation and death are not stories , but he is also able skilfully to demonstrate where the approach has meaning and relevance. For those of us who long for a patient who sits neatly into currently available diagnostic labels, this is vital reading.

Some readers will have seen the Tavistock label and identified it with Balint groups. Launer helpfully provides a chapter in which Balint-influenced approaches are compared and contrasted with the narrative. Sometimes, however, the two are complementary the narrative approach to questioning, eliciting a sudden sense of mutual understanding akin to Edna Balint s flash for example.

The second section which, following Launer s lead, I read first, deals with the educational approach to teaching the subject, which was illuminating to me, having been a participant. What is clear and, for me perhaps, the prevailing message, is that in order to appear fresh and spontaneous it helps to have planned both theory and practice with rigour.

However, for many readers the meat of this book is what it has to say about the consultation. There are literally scores of examples, ideas, and concepts within the pages. I will exemplify with two of my own.

When my eldest-born returned from school, it was my habit to ask how the day had gone (boring). This I assume fits into some long established schoolboy narrative. Since being a student on the Launer/Lindsay course I now ask What was the best thing that happened today? , which (believe me) is usually more enlightening. If I were more accomplished I might now ask What would Ian Richards (his friend) say was the most important thing that happened today? or Who in your form had the most interesting day today?

Secondly, last week I was watching a TV programme in which students on the accelerated medicine programme were treated to the fly on the wall documentary approach. The students were shown learning to take a sexual history. Polite and tender souls, they struggled with the dilemma of invading the patient s personal territory, but were apparently judged only on how much information they obtained. No-one, as far as I could see, questioned whether they had any right to ask personal and intrusive questions without so much as a by-your-leave or explanation of context. David Armstrong s work demonstrating the arrogance implied with such an unboundaried approach is noted.

Launer challenges something which has sometimes appeared to be axiomatic among GPs of my generation and persuasion that eliciting emotions is intrinsically

therapeutic. Those of us who have staggered exhausted from painful and tearful consultations, only to find the identical scenario replayed at each subsequent attendance will find a resonance here. Launer suggests that far from being therapeutic, such behaviour might reinforce feeling of ingrained despair strengthening the given narrative, that is, rather than helping the patient to identify alternatives. Within the narrative approach the interviewer asks questions in order to both understand the patient s story and to influence it. He describes how skilful questions can elicit information and thinking that a clumsier alternative would neglect. Attention to language and meaning is an important message.

Launer also challenges the idea of an underlying meaning . How often have we heard patients saying something like I have been going to psychotherapy for ten years and sometimes feel that I am close to understanding the underlying problem but it always escapes me . And how often have we wondered whether the underlying problem exists at all? From a social constructionist approach it might be possible to question the patients apparent need for a single, underlying, all-explaining, all-embracing understanding.

The last and most winning feature of this book is its humility. From the introduction to the last page, Launer warns against ill-advised overconfidence and gives examples of how even the best intentions can misfire the story of the patient whose ketoacidosis is diagnosed as a chance afterthought springs most readily to mind.

I hope it is obvious that I loved this book. It seems to have arrived at a most apposite time in the development of primary care. As attempts are made to break down the content of general practice into sub-groups determined by other specialties, as evidence-based solutions are imposed even where they fall contrary to the patient s wishes and interests. As NHS care is boiled down to a few hundred must-dos in an NHS Plan. It should be read by any and everyone involved in primary care, including our patients, by NHS managers, by hospital consultants, and finally by new Labour politicians who had so distinguished a vision and cannot now understand why they have been so damagingly incapable of implementing it. (Less linear, more circular I fear, Mr Milburn.)

David Tovey

Mental Health in Primary Care — a new approach
Edited by Andrew Elder and Jeremy Holmes
Oxford University Press, 2002
PB, 323pp, £29.50, 0 19850894 8

ELDER and Holmes intention is to assert the importance to primary mental health care of a narrative-based approach, concerned with experience, reflection and context, and to explore the ways in which it interweaves with scientific evidence without confusing the provenance and applicability of either . To this end they bring together a strong group of authors who come from both sides of this Great Divide, and invite them to find ways to cross it.

We start in reflective mode, in the consulting room. We find Sam Smith thinking about the construction of symptoms from an inextricable amalgam of sensation and cognition demanding explanation , Richard Wescott discovering the universal in the particular, Brian Hurwitz musing on the difference between biological and narrative time (a delightful piece already published in the April 2002 *BJGP*), and Iona Heath reminding us forcefully of the social context of mental illness. All of these pieces are buzzing with new ideas, and for me they represent the strongest section of the book.

The next two sections, on reflective practice and mental health thinking in the surgery, come straight from the traditions of Balint and the Tavistock. They consider issues, such as the difficult patient and burnout, the practice as an organisation, and the use of family systems approaches. They provide some useful but not radically different perspectives, and at times write in a rather patronising style. Aisen reminds that there are difficult doctors as well as difficult patients, and encourages us to introduce the family dimension into consultations an approach taken up and expanded in the subsequent chapter written by Graham and Mayer. Jane Milton discusses our inner lens, the internal (and often critical) observer of our own professional actions, and advises us to build effective supporting structures, including an affectionate tolerance for human foibles , an acceptance of our own limits, and developing mutual support within our practice teams. John Launer argues the case for a general mental health practitioner, while Burd and Weiner remind us of the role of therapists and counsellors in primary care.

The final part, on perspectives from secondary care, includes chapters on postnatal depression, eating disorders, serious mental illness, suicide, deliberate self harm, substance misuse, psycho-pharmacology, post traumatic stress, and psychological therapies. These are usually grounded in evidence and well presented, containing valuable information for the general practitioner. However, they do not present much in the way of new thinking, and at times verge on the ambitious: for instance, Wright and Burn s chapter on serious mental illness paints a somewhat rosy picture of the utility of case registers and chronic disease management models.

The essential problem for me is that the whole is less than the sum of the parts. The presence of different perspectives within one volume is a start, but with a few exceptions they do not engage with each other. To use Hegelian terminology, we are presented with *thesis* (narrative and Balint) and *antithesis* (epidemiology and RCTs) but the *synthesis* never really happens. Perhaps Elder and Holmes are hoping that they have given us a sufficient basis to achieve this synthesis ourselves, in our daily practice and perhaps some of us will. I was left with a tinge of disappointment, and the feeling that a stronger central direction to the book might have taken us closer to what is, without doubt, an extremely important goal.

Christopher Dowrick

Theophrastus Phillipus Aureolus Bombastus von Hohenheim (Paracelsus) — a short biography

CELSUS was a Roman estate owner who had written an encyclopaedia containing medical advice (*De re Medicina*) in about AD 30. This work was well known to doctors in the 16th century and Theophrastus Phillipus Aureolus Bombastus von Hohenheim (c.1493 1542) adopted the name Paracelsus because it literally meant better than Celsus he was not overburdened with modesty.

Paracelsus was born in Einsiedeln near Zurich in Switzerland. His father was a country doctor and his mother the matron of the local pilgrim hospital. When Paracelsus was 12 years old the family moved to Villach in Carinthia where his father had been made the town physician. Paracelsus may have attended Basel University but no records are available to confirm this.

At the age of 23 he set out to wander around Europe. He visited Montpelier, Bologna and Padua, went to France and Spain, saw military service in The Netherlands, and looked at tin mines in Cornwall. As a boy he had lived near lead mines at Villach and he was interested in chemicals and metals, especially in their therapeutic application. While he was travelling around Europe he picked up knowledge from wherever he could, and he stated that he had not been ashamed to learn from tramps, butchers, and barbers. During his wanderings he kept himself by writing and teaching and when he arrived back in Basel he was well known. In 1526 he became town physician and professor of medicine. He caused a storm by lecturing in German rather than Latin, and by wearing a leather apron rather than academic robes. He thought that the study of anatomy was useless and believed that clinical experience was far superior to book learning. He told his students that one hair on his neck knew more than all their authors and that his shoe buckles contained more wisdom than Galen and Avicenna (whose works he burned in public). Paracelsus thought that not even a dog killer could learn his trade by books and he openly ridiculed other physicians. Not surprisingly, he made many enemies in the medical establishment, and after two years he had to leave Basel and resume his wanderings. He moved around Europe, collecting a huge reputation despite his prickly character. Paracelsus died in Salzburg on 25 September 1541, at the early age of 48.

Medicine is indebted to him for the idea that some conditions, such as gout, might have a chemical aetiology. He also introduced iron, antimony, mineral salts, and other inorganic substances into therapeutics. His surgical practice was sound as far as it went, although he thought that the only operation which was justifiable was the removal of bladder stones by lithotomy. But despite this, he had some weird ideas too. For example, he believed in the doctrine of signatures or similars in which, for instance, cyclamen leaves were used for ear conditions because the leaf resembled the shape of the ear, yellow remedies were the best for jaundice, and fox s lung was good for lung disease.

Paracelsus is significant in medical history because he dared to think for himself and question ancient dogmas. More importantly, he encouraged others to do the same. The motto which appears beneath many of his portraits translates as follows:

> *'That man no other man shall own,*
> *Who to himself belongs alone.'*

Even now, Be your own person is a good enough creed for any doctor to follow. But I do not think Paracelsus would have fared very well in today s medical world. By no stretch of the imagination could he be described as having been a team player.

Edward Cockayne

roger neighbour *behind the lines*

On Shipmania

HAROLD Shipman s come and gone like a rent boy. At least you d think so, reading the newspapers. Three hundred and four column inches in *The Times* during the week of Dame Janet Smith s report, and since then nothing. Mind you, I m sure those hundreds of families lacerated with grief, doubt and recrimination haven t been able to draw so neat a line under his wickedness, nor to move on in quite so slick a fashion. And neither have we, for GPs too have been indirectly hurt in the fallout.

Much of the press initially seemed to concur with the BMA s assessment that the Shipman affair was a tragic systems error , requiring some urgent and important (but not conceptually difficult) procedural reforms. The instinctive response, said the *Independent on Sunday*, was to express horror at the unique brutality, and move on. His psychopathic behaviour, said the editorial writer of the *Daily Mirror*, should not affect our attitude to the medical profession.

So far, so sensible. But, like compulsive hand-washers or pavement crack-avoiders, the ladies and gentlemen of the fourth estate couldn t resist the chance of a free ride on some of their favourite hobby horses. In a frenzy of non sequiturs and knight s moves that, voiced by a private citizen, would have had the Approved Social Worker knocking on the door before you could say Largactil , the muddled thinking began in earnest.

It would be absurd to think a mass murderer lurked inside every doctor, the *Daily Mirror* conceded. But the *Daily Express* snarled, It is time doctors admitted their own kind were as capable of wrong-doing as the rest of us and put an end to their culture of complicity and cover-up. Complicity in covering up an almost unimaginable killing spree? Ouch!

The *Independent on Sunday* thought it could see the wider lesson: We must stop trusting our doctors so much. So did *The Times*: It is vital the government does its best to ensure that the bond of trust between doctor and patient is not lost. Well make your minds up. But either way, God help us if preserving that trust depends on a government whose reliance on spin and silly targets have done more to undermine it than Harold Shipman ever will. I d have thought it was our job the profession s job to earn and deserve patients confidence, and government s job to remove the impediments to it. The *Glasgow Herald* reckoned that the real reason Shipman got away with it was that he was a popular GP, and those responsible for policing doctors had to make sure there was never another one like him. I see: doctors scoring above average on patient satisfaction questionnaires get a dawn visit from the GMC Special Branch. The *Daily Express* was sure the death toll would have been lower had Shipman been struck off when he was caught forging pethidine prescriptions in the 1970s. And, for that matter, if the driving test examiner had failed him for not checking his mirror when overtaking a parked skip.

The outbreak of sophistry even penetrated Princes Gate. The College was invited to submit evidence to the Smith Enquiry. At the time, I was Convenor of the MRCGP examination, and someone within the College who should have known better, asked me to document the evidence that anyone who passed the examination was not a criminal psychopath. Now that s a tricky one: another example of thinking an academic tool can also be a vehicle for political posturing. To the best of my knowledge no candidate has submitted videotape of a criminal assault as part of a consulting skills assessment. The simulated surgery can t really afford to sacrifice any of its role-players. And in my experience candidates in the orals, asked whether they are homicidal maniacs, tend to say No. So I told the someone-who-should-have-known-better that the exam did not, and had no plans to, include a Serial Killer Identification Module. We could, I suggested, ask exam applicants for a testimonial signed by a Chief Constable and forensic psychiatrist. But for all I know, examined on his care of those patients he forbore to slay, Dr Shipman could quite possibly have done rather well in the MRCGP.

GPs can stand the funny remarks when, post-Shipman, we draw up the Depo-Provera or manipulate a torticollis. But when we find ourselves caught up in generic slanging that implies we re collectively untrustworthy, or accessories to slaughter, or inappropriately qualified, or dangerous in proportion to our popularity, we too have become victims not of a lone assassin but of damaging category errors. They need to be soundly refuted, and ourselves vociferously defended, by the professional bodies to whom we pay subscriptions.

So, College let s be hearing you.

Free-for-all at the point of delivery

It is mid-morning on a Thursday and I am standing at the reception desk in my local surgery. Nothing life-threatening, I hope. I have shoulder trouble and some 10 days ago a very nice GP told me that it was part muscular and part ear infection. Physiotherapy for the first; ear drops for the second and don t hesitate to come back at once if the treatment is not working.

Which it isn t. The last course I taught felt as if I was standing at the bottom of the seabed. So I have decided to take the kind doctor s advice, and come back for some more help. Can I see the doctor? Any doctor?

We re booked up today, says the receptionist. But ring tomorrow at 8.30 and we ll give you an appointment .

Tomorrow I m seeing the physiotherapist at 8.15. I could ring at 9.00.

Oh no , comes the reply. There won t be any slots left then. You could try again on Monday . On Monday I fly to Holland.

I try the collaborative approach: how are we going to solve this problem together, and that sort of thing. It doesn t work. The system is the system, and anyway, I am told, it s not their fault, it s the government and their insistence that all patients should be seen within 48 hours.

It s not the first time I have come up against our local practice s new appointments system, which now forces anyone who wants to see a doctor to ring in that morning. The trouble here, as one woman wrote in the complaints book (which I notice has long since been put away), is that you can ring 100 times (she did, and yes she was counting) only to be told when you finally get through that there are no appointments left.

It s the latest version of rationing, though this time it depends on the chance occurrence of a telephone connection and therefore gets those working for the service off the hook (in more ways than one). From free at the point of delivery, the NHS has become a free-for-all.

For those who have diseases that get better anyway, it won t matter, apart from a bit of personal pain. Those who have a real emergency will be somehow routed to a hospital, where they may have to hang about on a trolley but will eventually be seen. The real losers will be those who have something seriously wrong, as yet undiagnosed but who find the hurdles so tedious that they will stop trying to see a doctor until it is too late.

It is easy to blame underfunding, which is of course part of the problem. But not all. There is a question of priorities and organisation. From a doctor-led primary care service we now have one in which one group of workers provides care and another group controls access to that care. Doctors no longer take the lead in providing a personal service; they have instead become a product, to be allocated by others, in six-minute dollops. So the system has become ossified, with needless delays and closed loops. A few months ago I needed a drug urgently. It took me one day to get into the doctor, and another two to get the error on the prescription amended. At about the same time I called the surgery on a weekend for some urgent advice: the number of the duty doctor was completely unintelligible.

We should at least be honest about what is happening. It doesn t really matter that the National Health Service is no longer a service (after all, you do get what you pay for); what does matter is that we still pretend that it is. Perhaps we should rename it the National Health Provision, perhaps or National Health Lottery?

On a more realistic note we should start taking a much broader view of the doctor patient consultation so that it includes the whole process and not just the consultation. After all, our time with the doctor is now a tiny part of the total NHS experience, and in our practice at least, one preceded by a wide range of frustrations and challenges.

So, next time a caring, sharing doctor says to me: and don t hesitate to get in touch if you still have problems , I shall be tempted to answer: How?

Tim Albert

neville goodman

Consultants' contract

By now the vote may be in. The consultants may or may not have a new contract. It s been a murky business: five years in the offing; fifteen months in the negotiation and then months of our own negotiators trying to sell it to us. Put very crudely, the contract offers (some consultants) a pay rise in exchange for much more management control. Our negotiators tell us that the longer working week is already being worked by most consultants, so won t affect anyone. The government claim to have delivered consultants for evening and weekend sessions. Trusts even before the voting papers have gone out are organising these sessions. Meanwhile we are still cancelling lists because we can t get patients into beds.

The BMA has held well publicised and well attended road shows to explain the new contract to us. The one I went to was lively. Unless those in favour had stayed away, the omens seem poor for overwhelming acceptance. Not a few who stood up chose not to ask questions but instead to describe the contract and the negotiators in words best not repeated.

It seems to me there are three important issues to think about. All three are intangible. (I am ignoring the real extent of the pay rise, and whether it is fair or just for the government to require an extra four hours of NHS work before private practice can be undertaken without conditions.) The first issue is whether management can be trusted. Doctors are used to independent practice (I include teams under this heading), governed by professional constraints. The contract is another step on the road lined by NICE and Clinical Governance and it leads to total control of consultants practice. Whether this is a good thing depends on point of view.

The other two issues are linked by a question: why was the contract wanted? The government wanted it because they see the consultants as part of the problem of the NHS: they think consultants don t work hard enough. Thus their reason for wanting a new contract was flawed (or, if it wasn t, we don t deserve any better anyway). The BMA wanted it because they wanted a work-limited contract. But the work is not limited, and there are not enough consultants. And anyway, the European Working Time directive is already there but consultants won t use it. So their reason was flawed too. Two people each starting from wrong places are scarcely likely to agree on a destination, even less to reach the same one.

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alan munro

Mountain Bird

First call-out. I bundle my kit into the car and get away. There are hold-ups on the single track road. A minute or two will make no difference, but the anxious, eager emptiness where my stomach should be makes me want to get on. I can just make out the ridge high above the road, and tattered strands of cloud streaming through cols and off pinnacles, dragged by a freshening, wet wind. The cloud base, a grey, dark ceiling, encloses the glen.

The helicopter is leaving with the paramedics as I arrive. Experienced climbers go next; stretcher bearers and new boys on the third trip. I try to feel calm and organised, sorting out what kit to take, what to leave. Everyone else might be selecting sprouts in Tesco, so cool are they, these men.

In no time we are whisked up to just below the ridge and winched out and down towards steep, wet grass. Simple imperatives come to mind, remembered from training. Keep your arms down or you'll slip out of the strop like a soapy baby. When you land, get out of it very quickly being dragged around a mountainside by a dodgy chopper is unhealthy. Everything is happening very quickly. Just as we are all out safely, mist envelopes our great yellow bird. We hear its very, very slow descent into the cauldron of vapour, the crew apparently preferring to stay in sight of the mountain rather than standing off, and dropping blindly into the glen.

We clamber up to the summit and join the rest, who are getting the injured man onto the stretcher. I assure myself that the paramedics are happy with him and resume my role of novice. A navigation committee is formed, everyone cheerfully pointing in different directions. From high comedy emerges consensus, and we re off. Man-handling man and stretcher down jumbled, loose, slippery blocks of quartzite is strenuous, awkward, and full of potential for breaking things. At least the wind-driven drizzle is cooling. It is getting dark.

We are lucky. The cloud breaks at the low point on the ridge. We hear the throbbing rumble of our bird, the thunder of the messenger of the gods benign gods, so far. Soon the casualty and the paramedics are winched into the gaping, black belly of the beast which sinks away into the dark glen where only the silver-black meanders of the river remain visible.

I m aware of decisions being made around me. The helicopter crew change their minds moment by moment about how many of us they ll carry. It seemed chaotic at first but I guess its not quite like a 747. Precise local conditions of lift on the ridge are probably crucial. The radio crackles from down below to say that they re coming back for us. Someone has decided that the casualty can wait before flying to hospital. Consequently, we will not be left with a walk-off in the dark. A finely balanced one, I guess. Maybe the best bit of any enterprise is when you are learning fast you hope, but without much responsibility. This is fun. Big boys, and a very big toy.

Four double winchings take a while. The restless beast hangs over us, never quite still in the rushing, buffeting, grey void. Flash lights rake the ground. Raw technology roars defiance to the cliffs and into the emptiness which hangs between them, searing Atlantic air and cloud with the stench of kerosene. All that s missing is a big band, Wagner and the Valkyrie.

On another day one late summer, on the same hill, in bright sunshine and languid heat, I watched three peregrines playing. They soared and stooped at one another, as puppies or kittens practice their hunting tricks. One was a bigger bird than the rest. I wondered if they were a family group, the young birds of the summer being taught a thing or two by the female, which among peregrines is the more powerful bird. The boss bird.

I think of these graceful, strong, faintly chilling predators as the chopper arcs tightly down to its landing, rears back to halt its momentum, and settles as lightly as any bird. The pilot turns, to survey the heap of soggy sacs and bodies in the back. In the enormous helmet, only the eyes are visible unexpected eyes. Then a slightly girlie wave? The eyes crease. She has enjoyed herself too.

Next morning, tucked up safely in hospital, our casualty s main worry is whether he can get back to the hills before the end of his holiday. We have all been very lucky, this time.