Letters

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Values-based care

I welcome the discussion paper on values as a useful contribution to enhancing clinical practice.[1] We have developed a training programme for healthcare professionals that has been used in primary care, undergraduate and postgraduate training.[2] The workshop type programme identifies common personal values and discusses ways of integrating them into practice. Our experience is that by reflecting and sharing our deeper values of compassion, peacefulness, respect, patience, and integrity it builds self-esteem and enthusiasm with a sense of purpose. It boosts morale in a team and leads to better cooperation. It is also useful in setting common professional standards and a vision for primary care groups.

The focus is on the practitioner's wellbeing as their health is essential in providing good patient care. The approach is to develop listening skills and reflection in an appreciative supportive group that encourages open and honest discussion. Visualisation and meditation allows for these skills to go deeper, and the programme is fun and creative.

The training pack, which was launched in September 2004, has now been translated into four languages and is being used in a broad range of health settings. Values are central to everything we do and should be an integral part of all undergraduate and postgraduate training.

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Vocational training to be spent in general practice with GPs

Roger Tisi[1] writes that funding had not been obtained in vocational training to support 18 months of practice-based training, and that he was asked to re-design his scheme to include 2 years in hospital posts.

This is a serious and pitiable situation with some similarities to that in Italy, where 18 months in practice-based training has not been scheduled yet, as it is difficult enough to find funds for 12 month periods.

The situation is wrong from a professional development point of view, and in contrast with the European indications themselves.

This situation indicates, in the UK as well as in Italy, a political dilemma: how high is the credibility and consideration for general practice?

In no other speciality are periods of training shifted or mainly based in other sectors: it would be nonsense. A GP will not specialise by spending more time in an opthalmology department, just as opthalmologists would not specialise by spending more time in orthopaedic departments.

Roger Tisi is facing a 'frankly bewildering proposal that doctors specialising in general practice will receive the vast majority of their education and training delivered by colleagues in other specialities'. This is a 'frankly bewildering' and in contrast with the European Directives, WONCA European Definition and the EURACT Educational Agenda, where a clear specialist status and a clearly detailed curriculum for teaching in general practice is described. No other specialists would be able to teach the specificities of general practice.

However, I would argue that other specialists should be obliged to spend time in practices to learn something about general practice's specificities and keep them in mind during their professional life.

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Medicalising domestic violence

Author's response

The trivialising, media version of posttraumatic stress disorder (PTSD), where everyday life events are described as 'traumatic', fails to appreciate the precise nature of trauma causing PTSD. Such trauma involves 'actual or threatened death or serious injury, or a threat to the physical integrity of self or others' AND 'intense fear, helplessness or horror'.[1] There is an implicit suggestion by Dr Fitzpatrick that domestic violence is an everyday, minor life event, similar to receiving bad news.[2] Police statistics maintain that domestic

violence accounts for about half the women murdered in Britain. Those experiencing domestic violence may legitimately believe that their partners may kill them.

For a well-researched reply to Summerfield's paper equating PTSD to 'victimhood' and an inadequate 'stiff upper lip' see Mezey.[3] Most psychiatric conditions reflect changes in human thinking over time[3] and are part social construct. Chronic PTSD has neurobiochemical and anatomical consequences (for example, loss of hippocampus volume) that can be objectively monitored.[3,4] Not everyone with PTSD is seeking compensation. There is evidence for the liberating effect for patients in receiving an explanation of their life-disrupting PTSD symptoms.[3–5] In making a diagnosis of PTSD the patient's trauma is acknowledged and their symptoms are recognised as an understandable human response to extreme events. The diagnosis can lead to the victim achieving autonomy and rejecting 'victimhood'.[3,4] PTSD can be successfully treated.[4] In a general practice study, PTSD was present in 35% of those who had experienced domestic violence, and was indicative of experiencing the severe end of the spectrum of domestic violence.[6] I agree with Dr Fitzpatrick that the outcomes of interventions in families' lives are not adequately researched.[7] However, if the framework of PTSD helps a doctor recognise domestic violence when he would not otherwise have done so, then his patient at least has the opportunity of receiving a helpful intervention. Does Dr Fitzpatrick enquire as to the cause of the black eye, PTSD, depression or the bruise on the baby's belly? Or would this enquiry erode civil liberties and intervene in family life too much? Discussing safety and options for action with a woman experiencing domestic violence may erode her civil liberties but she might prefer that to being murdered or further damaged. While Dr Fitzpatrick's rosy view of 'egalitarian and less abusive relations between the sexes' may reflect a reality, it does not reflect the reality of the battered patient in front of him.

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Travelling costs

I would like to urge your readers and their patients, particularly those with cancer, to complete the online survey into the Hospital Travel Costs Scheme (HTCS), under which those on low incomes are supposed to be able to claim back their travel expenses for getting to treatment. The Department of Health consultation aims to find how awareness of the HTCS can be raised among NHS staff and patients, and to work out how patients can claim their expenses back, bearing in mind that many receive their treatment away from the hospital. We know that many cancer patients struggle to find the money to travel to and park at hospital: on average patients make 53 trips costing £325 in total during the course of their treatment. However Macmillan's Cancer Costs report revealed that only 4% of those facing travel costs receive help through existing schemes such as the HTCS and two-thirds of those not getting help with these costs were unaware that these schemes even existed. This survey is a vital opportunity for patients to make their voices heard and could save future cancer patients hundreds of pounds and spare them the stress of trying to make ends meet. People can take part in the online survey from 1 February by visiting www.dh.gov.uk and clicking Policy and Guidance then Policy A-Z then H and selecting Hospital Travel Costs Scheme.

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What makes a good doctor?

I was most impressed by the piece of writing by Emyr Gravell[1]. It makes one reflect on what is happening to the medical profession in the UK.

What makes a good doctor? Don't most of us put the care of our patients as our first concern, and this is at the cost of our families who support us in our endeavours to be a good doctor.

We forget the endless hours each day spent with our thoughts preoccupied with what we can do better for our patients and the effort and time we put in to better ourselves to provide the care our patients expect. How can the government expect to drive our already busy schedule further (already causing burnout in younger GP's)? By turning them into tick-box doctors instead of what they really aim to be — 'good doctors' — who continue to make sacrifices at the expense of their family life? Instead of rewarding us for providing a fantastic service the government are constantly out to make life even harder. I wish there was a regulatory body for politicians, which defined a 'good politician'. They seem to think that they are 'gospel' and have absolutely no idea what an average UK GP contributes to the welfare of their patients.

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