The Back Pages

viewpoint

Impotence in Europe

The occasion of the annual conference of Wonca Europe, being held in London this month, set me thinking about the effectiveness or otherwise of the pan-European medical organisations — particularly in relation to the European Union (EU), the Commission, and Parliament.

The evidence is that most of these bodies are ineffectual. So, which organisations are we talking about? The Comité Permanent (the standing committee of European doctors — CP); the European Union of General Practitioners (UEMO); WONCA Europe — the European Society of General Practice/Family Medicine; the European Union of Medical Specialists (UEMS); and the Permanent Working Group of European Junior Doctors (PWG). The overriding feature of these bodies, medico-political except for WONCA Europe, in relation to the EU is their impotence.

The CP is meant to represent the political interests of all European doctors on behalf of the other medico-political groups. It is so ineffective that for a number of years the other organisations, while paying lip-service to the CP, have pursued their interests independently. Strenous attempts, over a number of years to reform the CP have largely failed. The UEMO suffers from lack of a permanent secretariat and a surfeit of working groups producing documents and policy statements that no-one reads. Its genuine success in the past ten years was to develop clear recommendations for changes to the GP part of the Directive on postgraduate training, but these have been delayed beyond reason or ignored by the EU Commission. The UEMS has to struggle trying to represent a multiplicity of specialist interests, again with little influence at EU level.

The PWG is perhaps the exception. Through its dogged campaign to reduce junior doctors' hours under the EU Working Time Directive it has achieved some success. WONCA Europe, although increasingly successful in assisting the development of the discipline academically in all parts of Europe has so far failed to make any impact in the important area of improving the content and quality of education and training for GPs. It is planning to do so in partnership with UEMO, to raise the profile of the discipline and to lobby for improvements at the EU Commission and Parliament. An initial step in relation to this is the publication of a new definition of general practice (details of this are included in this issue of the *BJGP* (see Matters Arising), and the full text will be available from WONCA Europe from 10 June).

The EU Commission, which is responsible for the Directive setting out the criteria for medical education, is only interested in the free movement of doctors between member states, not in the quality and content of training. In this it fails to protect the interests of individual patients throughout Europe by providing criteria of sufficient quality. Currently the Commission is consulting the profession over streamlining the operation of the Directive. This should enable the profession to improve matters but, so far, clearly argued reasons for improvements appear to be ignored. The enlargement of the EU and, in the longer term, discussions on the future constitution of the European institutions perhaps present opportunities for this to be addressed in the future.

The reasons for this impotence lie in the indifference on the part of the EU Commission and Parliament. The split with regard to health matters at EU level between different directorates within the Commission, so no coherent response is possible. The retention of responsibility for almost all health matters is in the hands of national governments. This leads to prevarication and inertia. It is likely that enlargement of the EU will compound such problems. There is a lack of professionalism, time and resources on the part of the European medical organisations and failure on their part to have clear objectives, effective management, and skilful lobbying.

It is pointless to continue as we are. Things need to change.

Philip R Evans

"The past is another country, but it is where we have come from, and understanding it may make us more aware of where we are going."

Oral history and qualitative research
David Hannay,. page 515

"When a 'public relations' bureaucracy is interposed between the medical and external institutions, then the possibility of communication inflation becomes a certainty."

Hype and spin in the NHS
Peter Andras and Bruce Charlton, page 520

contents

Viewpoint 2 — GPs and child protection: time to grasp the nettle

A perception, widely held by Social Services Departments and by child protection agencies, is that GPs currently undertake a relatively peripheral role in the child protection process. Criticism has been directed towards GPs' low rate of referral of suspected cases to the statutory agencies, participation in child protection case conferences, and attendance at training events.[1] Research has also confirmed that many GPs have not received adequate child protection training and that they have specific unmet needs in this area.[2] This low profile is not in keeping with the enhanced role that GPs currently undertake with respect to the delivery of child health care in the UK. The majority of child health promotion is performed by GPs and other members of the Primary Health Care Team (PHCT). GPs are usually the first point of reference for the majority of childhood illness. Why then are so few papers on child protection published in leading primary care journals and why does the subject receive but scant recognition in the child health curriculum syllabus agreed by the RCGP and the Royal College of Paediatrics and Child Health?[3]

The reasons may include lack of awareness of child protection issues resulting from inadequate training, fear of the consequences of involving outside agencies, and uncertainty regarding the GP's role. On the other hand, GPs may feel that it is not really their business and that responsibility for child protection lies primarily with Social Services and paediatricians.

However, GPs must acknowledge their responsibility towards the protection of children. Successive inquires into cases of fatal child abuse have highlighted the disastrous consequences of inadequate management for all involved: death or disability for the child, imprisonment for parents and carers, and censure for health professionals. A recent case is that of Lauren Wright, a six-year-old girl who died as a resulted of injuries inflicted by her carers despite numerous contacts with both social services and health professionals. Barry Capon, who chaired the resulting independent inquiry, criticised health professionals' poor levels of communication as well as their over-reliance on the actions of others.[4] A key message from this inquiry and also from that following the death of Victoria Climbié is that child protection is the responsibility of all professionals who have contact with children where everyone has a role to play.

The child protection process in England is well defined within *Working Together to Safeguard Children*.[5] Health professionals are expected to respect the paramountcy principle that places the welfare of children above all other consideration. The unique role of the GP in the protection of children is clearly acknowledged. GPs are well placed to recognise the child in need as well as the parent whose capacity for caring may be impaired. In addition, GPs, because of their knowledge of families and communities, may make a substantial contribution to the sharing of information that forms an essential part of the child protection investigative process.

GPs therefore have a clear duty of care towards individual children in that they are required to recognise and report abuse appropriately. As members of emerging Primary Care Trusts (PCTs), they now have an influential commissioning and public health function that should help promote the child protection process. PCTs, working closely with Area Child Protection Committees, should ensure that all members of PHCTs within their area have received adequate levels of child protection training and that all practices must be aware of and have access to the locally agreed child protection guidelines. Furthermore, PCTs should periodically undertake audits that seek to identify and address barriers to the child protection process within primary care. With hindsight, many child abuse fatalities are preventable if clinical indicators are identified in time and effective intervention put in place. The opportunity for GPs to fulfill their role in this respect must not be overlooked.

Yvonne H Carter
Michael J Bannon

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Overleaf the BJGP *publishes the first in a series of twelve articles documenting the history of general practice in the Scottish town of Paisley. In article one the authors describe their research techniques, those of oral history. Subsequent articles will feature the edited transcripts of interviews with the town's general practitioners themselves. Electronic versions of the articles will be available on line (from July), with audio extracts from the interviews embedded. Below, David Hannay assesses the role of oral history in helping us understand where we have come from, and where we go next.*

Alec Logan

Oral history and qualitative research

'So you want me before I'm away.' He was dead right, because I had been tape recording old people for a local history for some time, and most were now dead voices from the past. Jock was one of the last who had lived in the village all his life. There were 80 children in the local school when he started there before the First World War, but only 12 when it closed in 1964. Where had all the children gone and what stories could be told by ruined cottages and refurbished second homes? Then there was plenty of work in farming, forestry, fishing, and quarrying. Now machines have taken over manual work, few fish have been left by commercial trawling, and the last granite quarry was closed to balance the books of a multinational. Yet over 150 former pupils attended a millennium reunion and they came from all over the world.

Those whose lives spanned the 20th century have seen more changes in their lifetime than at any other period of human history — from horses and carts to men on the moon. Nowhere is this more true than for general practice — a complex craft of personal caring tossed on the stormy seas of politics and driven by the winds of new technology. Technical change invariably precedes social change, and to understand this we need information from those who were part of the process. Tape recorders and qualitative methods have made this possible. Three times I have made attempts at writing a practice history. The first attempt failed because I moved jobs after interviewing a retired senior partner about the advent of the NHS. During the second attempt, a lifetime's recording of house visits by a single-handed rural GP were thrown out by his family when he died, and the third time over 30 years of practice mortality were lost when moving premises. But there have been some higher degrees in practice history, and the new series on the oral history of general practitioners in Paisley, starting overleaf, is a welcome addition to our knowledge.

But is oral history 'research' — which literally means 'looking again at' — let alone scientific research? The answer is a qualified 'yes', the proviso being that the data should be put in a theoretical context. It is this which distinguishes qualitative research from journalism. Tape recordings of oral history give us primary data in contrast to the secondary data of historical research. Science is not just the collection of data but an attempt to make sense of the world with explanatory theories, which according to Karl Popper[1] must be capable of being disproved. In the physical sciences we can control and experiment, so that theories are deductive and predict. In the social sciences we have much less control and proceed by induction with theories which describe but are usually poor predictors. These theories may be broad ranging, such as those of Talcott Parsons[2] on social structure and Karl Marx[3] on class conflict, or they may be less ambitious middle range theories as described by Robert Merton.[4] But always there is the subjectivity of the observers and our own frame of reference as emphasised by Anthony Giddens,[5] and reflected in the postmodern approach of deconstructing reality.[6]

Oral history should help us develop middle-range theories which explain what is happening and give us insights into the process of change. For instance, what are the forces which shape new conditions for general practitioners, from those of Lloyd George and the advent of the NHS to the 1966 charter and the 1990 contract? What social pressures are behind the present new contract with its increasing complexity and accountability? What is the balance between control and trust, between professional relationships and impersonal monitoring? Although international comparisons help, we cannot easily experiment with social change, but have to wait upon events. These take place over time, that great mystery which we cannot control — especially when we are part of the experiment ourselves.

David Hannay

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An oral history of general practice in Paisley

The series...

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Introduction

Peter V: *'There are always challenges. Change is always taking place. You are really trying to find the best change that is taking place and make sure you are taking advantage of that for the good of your patients and your own practice'*.[1]

While there have been several social and political histories of general practice describing the extent of the reform under the National Health Service (NHS),[2-5] the impact of change on the work and lives of rank-and-file GPs has tended to be hidden from history. In this paper we present the methods we employed in a systematic study of the recent history of general practice in a Scottish town. In the coming months some of the evidence and findings from this study will be presented in a series of short articles for this journal.

Setting and data collection

The town of Paisley in west central Scotland is near Glasgow but regards itself as distinctively different in character. Its population of approximately 85 000 people is typical of the West of Scotland, in sharing the problems of deprivation and the associated increased morbidity and mortality. Paisley is compact enough for personal contacts to make a meaningful difference, but large enough to yield a considerable amount of information, much of which is relevant to other centres.

The town has 13 group general practices with patient list sizes close to the national average. Paisley does not have a teaching hospital and, in addition to the local Royal Alexandra Hospital, onward referral of patients is made to Glasgow which also contributes to the continuing education for the town's GPs.

Between 1999 and 2001, life history interviews were recorded with seven retired and 24 working GPs. Testimonies were gathered from at least one partner in each of the practices currently functioning in Paisley and also about three practices that no longer exist. Copyright permission and written consent to make use of the oral histories were both obtained from each of the interview partners and the interviewer in compliance with the guidelines of the Oral History Society.[6] Interview partners have also been asked whether they wish to be identified or whether their evidence should be anonymised.

The project was introduced to GPs at a Local Health Care Co-operative (LHCC) meeting for Paisley GPs at which all the practices were represented. Practitioners were asked either to volunteer themselves or to suggest others who might be interviewed. Initial contacts were interviewed and asked to suggest other potential interviewees. We included in our list of contacts GPs who, it

Table 1. Percentage of size of partnerships by numbers of unrestricted principals and equivalents (UPEs) in England, Scotland, and Paisley in 1999.

		England[a]	Scotland[b]	Paisley[c] (and of those interviewed)
Small	(1 to 3 UPEs)	36.02	31.20	23.64 (32.00)
Medium	(4 and 5 UPEs)	33.14	36.12	30.91 (32.00)
Large	(6 or more UPEs)	30.84	32.68	45.45 (36.00)

[a]Department of Health, NHS Executive Headquarters, Statistics (Workforce) GMS, http://www.doh.gov.uk/public/sb0104.htm
[b]From Information and Statistics Division, NHS Scotland, see http://www.show.scot.nhs.uk/isd/primary_care/gmp/gmp.htm
[c]From Argyll and Clyde NHS Board, see http://www.show.scot.nhs.uk/achb/

Table 2. GPs interviewed and Paisley GPs by gender and activity.

	Paisley GPs interviewed		Numbers of GPs practising in Paisley in 1999[a]
	Working	Retired	
Male	18	6	36
Female	6	1	18
Total	24	7	54

[a]From Argyll and Clyde NHS Board, see http://www.show.scot.nhs.uk/achb/

was suggested, should not be interviewed. As the study proceeded there were practitioners who volunteered themselves for interview and were added to our list of contacts. No-one refused a request to be interviewed. We requested interviews with eight of the 23 GPs who qualified in the 1980s, 11 of the 19 who registered in the 1970s, and five GPs who entered practice in the 1950s and 1960s. We also interviewed eight of the ten retired doctors who were identified as possible contacts. This strategy enabled comparison between the ways in which members of different cohorts recalled their careers.

The enthusiasm displayed by most participants generated on average over three hours of recordings. The system of recommendations we used to identify potential interview partners encouraged participation and can in part account for the lack of refusals, but cannot completely explain the level of cooperation we received. Not only did the GPs enjoy talking about themselves and their work, but they also believed that they were contributing to a much larger project. A number of the GPs who were interviewed articulated the belief that there was a lack of understanding of everyday practice among policy makers. Through the oral history interviews it was hoped that the voices of rank-and-file practitioners would be listened to in a way that would inform both colleagues and others about individual and collective experiences of practice.

Two GPs, who were in partnership, insisted on being interviewed together, but the rest of the interviews were carried out on a one-to-one basis. Most of the interviews were conducted over several sessions and in a location of the practitioner's choice. In an initial interview session, the participants were encouraged to recall their lives, including their careers, and to identify events and influences that they believed were significant in shaping their life stories. After these open life-history interviews, 25 GPs agreed to at least one additional session, in which more specific questions were put from a developing interview schedule. All of the interviews included accounts of the reasons and motives that GPs gave for their entry into practice and details of their education and training prior to becoming partners. Interviewees also provided further detailed information about family, career, and practice histories.

Study participants

Paisley's GPs have traditionally attended a narrow range of secondary schools in Glasgow and most are graduates of the University of Glasgow. In 1999, 50 out of the 54 working GPs in the town graduated from Glasgow. Three of the four who graduated elsewhere were interviewed for the study. These 'incomers' provide valuable perspectives on both Paisley and Glasgow medical networks, and in doing so suggest that the Glasgow graduates tend to take local and regional networks for granted and operate within them as a matter of routine.

There were no single-handed practices in the town when the study started in 1999, whereas around a tenth of practices in England and around a twentieth of practices across Scotland were single-handed in 1999 (Table 1). Paisley also had a greater proportion of practices with six or more partners than in either England or Scotland.

Fifteen out of the 24 working GPs we interviewed had passed their RCGP membership exam. Given that around a third of principals in England and Scotland were members of the College in 1999, this suggests a significant bias. And yet in 1999 31 out of the 54 practicing GPs in Paisley had passed the examination, while 26 were paid-up members, and two were Fellows (both of whom we interviewed). The higher-than-average number of College members in Paisley was to some extent therefore reflected in our study.

Women are under-represented in the study, especially younger women. Whereas just over a third of working GPs in Paisley were female, a quarter of working GPs interviewed were women (Table 2). In part this is a result of the late entry of women into the profession and our decision not to interview GPs who had qualified since 1990.

Data analysis

Several analytical approaches were taken, including considerations of how the oral evidence was expressed both in terms of the language used in the ways life stories were presented, and in the importance of subjectivity, especially the relationship between individual and social historical consciousness.[7] Our narrative analysis was underpinned by the constant comparative method, derived from grounded theory, requiring a cyclical process of induction, deduction and verification.[8] This process began during the collection of the interviews when we aimed to reach what might be described as a saturation of knowledge in which further recordings of life stories confirmed what we had already understood.[9] Thus we reached points at which the testimonies we were collecting were confirming the findings we had reached from the testimonies we had already collected. Assisted by the use of QSR NVivo software, ideas were tested and evidence shaped as the study proceeded. Such a strategy allowed for the ongoing comparison of the testimonies of different GPs and was valuable in understanding the ways in which GPs narrated the history of partnership and how partners practiced medicine, including informal specialisation.

A number of the GPs commented on the broad open-ended questioning employed in the first session. It was not only different from the more focused history taking that they were used to, but concerns were also expressed about the relevance of the evidence being collected. The interviewer, an experienced oral historian and a non-clinician, was able to address these anxieties and at least two-thirds of the recordings contain enough information to facilitate an understanding of the reasons why individual interviewees choose the stories they tell to illustrate their reflective life histories.

This process of making meaning, and thus determining content, was not only shaped by the GPs' efforts to meet what they perceived to be the needs of the interviewer or project, but also by their attempts to present coherent life histories, their understanding of the history of their profession, and by the ways in which current events shape the way that the past is interpreted. In analysing the recorded interviews these variations of emphases were taken into consideration. We would argue that by examining inter-subjectivity, memory and the construction of narrative in this way we can better understand the past from a range of viewpoints. And it is these perspectives that we intend to explore further in the forthcoming series.

Margaret G: *'About six months after I was there* [circa 1952] *I was running up a tenement stair and there were two wee boys playing on the first landing. And one said, 'Hello Doctor'. I said, 'Hello, Patrick'. And then as I ran on up the stairs he says to his wee pal, 'That was my doctor'. And his wee pal said, 'Yer doctor! Was that a man?'… It was inconceivable to the other wee boy that the doctor would be a lady'.*[10]

Brian R: *'The job's not as satisfying at present... No... Because I don't know what the future's going to be for general practice … The doctor is away down in the pecking order and ignored… I think we're devalued and I don't know what the future holds for us'.*

— So what would make a big difference?

Brian R: *'What would make a big difference?* [Pause] *Ehem...* [Pause] *being listened to…'*[11]

Graham Smith
Malcolm Nicolson
Graham C M Watt

Key Points:

- There are two main ethical problems that confront GPs: clinical decision making and resource allocation.
- A practical reasoning approach, derived from Aristotle, can provide a useful framework for clinical decision-making.
- This approach can integrate evidence-based medicine, narrative-based medicine, and 'complexity science'.
- This approach acknowledges indefiniteness, indeterminacy, and particularity.
- It stresses the role of perception (or 'situational appreciation') in the assessment of all of the elements of a situation.

Hippocrates' problem: decisions, decisions…

In general practice, it is said, you are only as good as your last decision. We see 30 to 50 patients every day, and have to make decisions, with or for, all of them. Should I listen or interrupt? Do I examine, investigate, give an antibiotic, antihypertensive or statin? Should I refer? Should I admit?

But how should we make decisions? We often have evidence to help us, of course, but evidence applies to diseases, not patients; to populations, not individuals. Besides, the evidence may be confusing, of poor quality or non-existent. We look at the patient in physical, psychological and social terms, but still, that doesn't tell us what we ought to do.

Hammers and anvils

Some of the complexity and confusion surrounding these many decisions is expressed in Iliffe's editorial on deciding what to do with patients with dyspepsia.[1] He suggests that, in deciding what to do, we are trapped between 'the hammer of deontology (patient-centred care) and the anvil of utilitarianism (achieving the greatest good for the greatest number)'. This places the GP in an uncomfortable place between two unyielding inanimate objects.

However, this misrepresents both the nature of the problem and the ethical theories involved. Utilitarianism and deontology are general types of ethical theory that are intended to provide general justificatory strategies and, in doing so, to capture our ordinary ethical thinking about practical issues. It is true that a utilitarian justification can be used to justify resource constraints,[1] but given that resource constraints are a real practical problem (as Iliffe points out), deontologists must also have something to say. Similarly, although the deontologist can comfortably defend giving priority to the judgements and needs of individual patients, utilitarian theories would be worthless if they had nothing to say about this. Indeed, John Stuart Mill, perhaps the most famous of utilitarians, strongly insisted that an individual's autonomy and freedom of choice should be protected (Mill, on Liberty). Thus, the hammer is not 'deontological' and the anvil is not 'utilitarian'. Instead both hammer and anvil represent real and pressing practical concerns faced not just by GPs, but by all those involved in the provision of health care. The hammer, let us say, is the problem of decision making with patients; the anvil is the problem of how to justly distribute moderately scarce resources.

Aristotle's answer: a practical reasoning approach

We suggest that an approach based on Aristotle's ethics[2-4] and, in particular, his account of practical reasoning, will provide a satisfying solution to the problem of the hammer and the anvil. Here we briefly tackle the hammer.

Nussbaum[2] suggests that in deciding about practical matters, we need to explore Aristotle's ways of addressing 'what suits the occasion'. This is not an excuse for loose thinking. It is an acknowledgement that rules (or guidelines) can only apply to what has been, and change confronts us with new situations every day. Practical situations contain many indeterminate and indefinite elements, some of which may be particular and peculiar to that situation. They may, in Nussbaum's word, be 'non-repeatable.' This means that each situation, (and this certainly applies to each consultation) is unique, and deserves individual consideration, not an unthinking application of philosophically-based rules or quasi-scientific principles. Making good decisions is therefore based on the 'priority of the particular' — making the individuality of the situation central to the process.

This Aristotelian approach consists, therefore, of two elements: first, the claims about 'particularity' — to privilege or 'pre-weigh' features is to deny the essential indeterminacy of situations and the irreducible complexity of decision making; secondly, good decision making is a matter of 'situational appreciation'[4] — of seeing or reading a situation. Rules, generalisations, outcomes, evidence and the like, feature only as appropriate and only as called for by the situation itself.

Clearly, this does not mean that evidence-based medicine and guidelines have no place in modern general practice. As the EBM gurus point out,[5] their place is in aiding decision making when the features that suggest their application are present. However, an over-concentration on this can lead to a top-down, measurement-based approach to individual patients and to the development of primary care. In contrast, narrative-based medicine[6] concentrates on the patient's story, and attempts to swing the balance back towards the uniqueness of the individual case.

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The practical reasoning approach deftly ties all this together. Decision making, Nussbaum suggests, is the result of a perception of the individual situation that takes into account all of the particulars, not only those that are easily measurable. (see example of Mary MacLean, opposite). This means the evidence, the narrative and, on occasions, the issue of resource allocation. Only through this process, described by Aristotle as the discernment of perception, can we make good decisions with our patients.

It may seem that Aristotle is a long way from the consulting room, but Schon's model[7] of 'reflection-in-action,' a shrewd analysis of professional behaviour, contains many of the above elements, and offers a useful description of that rather old-fashioned phrase 'clinical judgement'. Tudor Hart's model of patients as 'co-producers of health'[8] can only be effectively applied if based on the particular patient.

Acknowledging complexity

It is also clear that the application to clinical care of complexity theory has, at its root, these principles. Wilson *et al*[9] suggest that:

'clinical judgement in these circumstances involves an irreducible element of factual uncertainty and relies to a greater or lesser extent on intuition and the interpretation of the wider history of the illness'.

Also, by applying complexity theory, we are advised to 'use intuition and muddle through'.[9] This all has a very Aristotelian ring. However, Aristotle would never have suggested that we 'muddle through'. Instead, the indeterminacy is dealt with through serious and genuine deliberation and reflection along with an astute sensitivity to the requirements of the situation.

GPs do not need complex theories of decision making that lay down rigid, quasi-scientific rules. Instead what is required is a developed perceptual capacity — a capacity for 'situational appreciation'. It is born of experience and training and requires serious deliberation and reflection on the totality of one's context. This is Aristotle's insight — as true and applicable now as it was in the third century BC.

John Gillies
Martin Sheehan

Dr H's patient …

Mary MacLean is a 55-year-old part-time hospital cleaner who has had diabetes for ten years. Her BMI is 29.5, last blood pressure is 164/98, cholesterol 6.3, and $HbA1_c$ 8.9. She takes metformin, gliplizide, bendrofluazide and lisinopril. The practice nurse and I have been unable to improve these figures for three years, and in fact her BMI has risen over the past year. She has defaulted diabetic eye screening twice this year.

Mary doesn't smoke or drink but her husband, an unemployed steel worker, is on treatment for depression and probably drinks more than is good for him. Her only daughter, who is 20 years old, is pregnant to a man who I think is one of the local drug dealers on the estate on which they live. She goes to the diabetic clinic at our practice, but says that she can't afford the diet that we suggest. She is more worried about her husband's drinking than her diabetes, because he sometimes gets verbally abusive and has hit her once. She sleeps very poorly because her daughter gets in late or doesn't come home at night. She thinks that her daughter takes drugs, but doesn't really know.

A's responsee

Making good decisions with Mrs MacLean will obviously depend on your understanding, not just of her diabetes, but of all the other factors affecting her life. From the story above, you obviously know her well. Because her diabetic control is less important to her than other things, it's unlikely that she will be able to do much about her weight and eating habits just now. A perceptive GP (or nurse) like you will see this, and this may guide you towards discussing Mary's relationship with her husband, his alcohol intake, and the dangers facing her daughter, rather than the details of diabetic diets and blood pressure readings. By addressing these issues, she may be able eventually to find the equanimity to think constructively about her diabetes.

By the way, I have heard that the local primary care group regularly monitors the $HbA1_c$ levels of diabetics by general practitioner, and wants to publish tables of these. For patients like Mary MacLean, is this a good guide to the quality of her care?

Hype and spin in the NHS

"A premium is placed upon the skill of communicating one thing while apparently saying another."

PEOPLE increasingly expect hype and spin to be a feature of almost all the publicly available information generated by government, corporations, and institutions in general — and the NHS is fully implicated in this phenomenon. The result is that, despite the unprecedented volume and accessibility of information, an understanding of the realities of our society seems as remote as ever it was. Propaganda and factual information are presented in an identical fashion, and only a trained economist can tell whether the latest 'increase' in NHS funding is a genuine injection of resources or merely an example of creative accounting.

Inflation and translation

Announcements from the NHS political and managerial hierarchy are usually accurate, when accuracy is defined according to 'legalistic', internal professional criteria. But the 'real world' value of such announcements is unpredictable. The informational content may be hugely exaggerated, such as the year-on-year reports of continual and substantial improvements in health services. On the other hand, the informational content may sometimes be highly accurate, using external real world criteria, such as recent announcements that the MMR (measles, mumps, rubella) combined vaccine is safe.

This trend towards large but unpredictable exaggeration of informational content is termed 'communication inflation'. The fundamental reason for such inflation relates to the need for 'translation'of specialist NHS activities into publicly comprehensible terms and the opportunities this affords for more-or-less subtle distortion. Systems of specialised communications — such as those that occur within the medical profession — can be understood as comprising specific technical 'languages' used for information processing. Although such languages are often criticised as being deliberately obfuscatory jargons, they are usually crucial to the efficient activity of the discipline.

Of course, the importance of different disciplines does vary, and phoney activities may generate almost wholly bogus languages. For instance, the medical profession was for centuries guilty of using a private 'latinate' jargon to keep its communications private from those outside the 'guild'. But it is uncontroversial that even the most objectively 'real-world valid' medical disciplines require specialised technical languages.

Consider communicating with colleagues compared with patients. Communicating with a colleague in the same specialty is usually a relatively swift and unambiguous process, because both parties are embedded in the same set of practices and expectations, both are adept at using the specialised language. Communicating with patients can, of course, be done, but is a much more long-winded affair if the same amount of information is to be conveyed.

The activity of communicating with people who do not share your discipline is actually a kind of 'translation' — a specialist technical language must be converted to a shared general purpose common language. To convey fully an understanding of the treatment of a disease such as hypertension would require summarising some background physiology, a bit of pharmacology, risks and benefits of agents, published therapeutic trials in the area, relevant clinical experience, and so on. It all takes time.

The sound bite culture

But given the constraints on time (and the human attention span) what usually happens is that no genuine attempt is made at this kind of full communication. Increasingly, we receive information in 'sound bites'. There is a very selective process of simplification in which technical terms and concepts are translated into roughly (but not exactly) equivalent common language terms and concepts.

Communication inflation most frequently occurs at the interface between a specialist internal language and the general public's common language. Information gathered by the Department of Health, for instance, takes the highly selective form of numerous statistically adjusted performance indicators, whose relationship to understandable realities in the outside world is indirect and unclear. When communicating summaries of this data to politicians, the media and the public, there are almost irresistible temptations towards making a simplification that is distorted in a self-serving direction. The probability of bias during translation especially applies if the external interrogator is a person or organisation who is evaluating your performance — and making decisions about your future on the basis of the information you provide.

Fear of 'being caught' usually prevents actual falsification and fabrication of data, but still allows tremendous leeway in using language to mislead. A premium is placed upon the skill of communicating one thing while apparently saying another. Applying strictly formal criteria, a communication may be true — as, for example, when President Clinton asserted he had not had 'sexual relations' with Monica Lewinsky. He later admitted to oral sex, while claiming that he had been using the word 'sex' to refer exclusively to intercourse: 'I have not had sex with her as I defined it'.

Much the same kind of strict 'legalism' applies to the bulk of public communications in our society, including public communications concerning NHS

This article is an application of information theory and systems analysis, mainly derived from the German sociologists Niklas Luhmann and the Hungarian jurist Béla Pokol. A more technically-argued and fully-referenced treatment is available in: Andras P, Charlton BG. Democratic deficit and communication hyper-inflation in health care systems. *Journal of Evaluation in Clinical Practice*. In press.

performance. To take a relatively uncontroversial example, for several years hospital activity was measured in terms of 'consultant episodes', and in public announcements an increase in the number of these obscure and unvalidated units was reported as being an increase in provision of services. Like Clinton's denial, such communications were both technically accurate and cunningly misleading.

Public relations and the erosion of trust

When a 'public relations' bureaucracy is interposed between the medical and external institutions, then the possibility of communication inflation becomes a certainty.

Public relations groups are explicitly charged with disseminating information in ways that benefit the institution. Put bluntly, hype is the specified function of these bureaucracies, and the only constraint is that this be done within accepted boundaries of public taste and tolerance (recent government activities by spin doctors apparently overstepped such bounds, but only by a quantitative excess in prosecution of their fundamental role).

Public relations is now an increasingly significant activity of the NHS and its component institutions. But things have been going this way for many years. For example, the misleadingly exaggerated and incomplete official information about the probable risk of AIDS infection in the mid-1980s seems to have been an attempt to generate mass behaviour change in the face of widespread public cynicism about the value of official information. When the heterosexual AIDS epidemic did not happen in the UK, public trust in NHS information was eroded. Presumably, something similar will happen in relation to the new variant CJD non-epidemic.

As well as occurring at the boundary between the NHS and the outside world, communication inflation has penetrated deeply into internal clinical activity. Grant applications for medical research funding have long been notorious for their rhetorical manipulations, and most of general biological research (such as the human genome project) is currently funded on the basis of a hyped-up pseudo-relevance to the generation of future therapeutic breakthroughs. The outcome is a general environment of biased and exaggerated medical information in which everyone feels the need to shout their message in order to be heard.

Indeed, the only realm that is largely immune to communication inflation is within the small, informal, personally-linked structures of colleagues; for example, among the partners in a properly functioning primary health care team or among small clinical sub-speciality within a hospital. Within these groups honest communications occur by the medium of untranslated specialist languages. Living in such an enclosed and 'hype-free' community is one of the particular charms of practising medicine. But as soon as one of these personal groups is 'called to account' for its activities by politicians, NHS management or the media, or needs to compete for resources or tokens of esteem, then communication inflation almost invariably comes into play.

The future

Because the public cannot trust 'official' information, they have begun to take seriously alternative perspectives from 'unofficial' sources (some reputable, some bogus). These include charitable associations representing sufferers from various diseases, the Consumers Association, and lobby groups for special interest groups (e.g. women's health, the elderly, the homeless, etc.) and investigative journalists. Even 'dissident' healers and the advocates of complementary medicine are granted a respectful hearing. All this adds to the cacophony of competing voices, so that people must shout even louder.

Distrust may lead to people trying to insulate themselves from what they perceive to be a failure of the NHS system by seeking alternative providers. Inadequate state health care systems fuel the demand for 'private' providers. Since they must compete for clients, these may provide more reliable communications than the official health service. For example, advertisements for private health care provision seems to concentrate on essentially accurate claims: private care really is more convenient, and the hospitals are more likely to provide privacy and comfort.

NHS institutions might try to reverse the trend towards hype and spin by rebuilding a reputation for honest and accurate communications. However it seems unlikely that such a long-termist strategy would survive in today's political climate. Alternatively, a more truly democratic form of political regulation could impose effective controls on communication inflation. But the problems of a comprehensive and national health care system seem too large and deep rooted to be solved in this way.

In the end, if attempted reforms continue to fall short, the unified structure of the NHS will presumably break-up in favour of a variety of smaller, simpler and more trustworthy alternative health care systems. Hype and spin are seductive short-term solutions, but will ultimately prove fatal to institutions that rely on public confidence.

Peter Andras
Bruce Charlton

The expert patient

WHEN Professor Liam Donaldson coined the term 'expert patient' in the white paper, *Saving Lives: our Healthier Nation* in 1999, one of his specific uses of the term is to describe people who had undertaken one of the self-management courses developed by Professor Kate Lorig at the Patient Education Research Center (PERC),[1] Stanford University.

Background: PERC's self-management courses

The Arthritis Self-Management Course (ASMC) was successfully trialled around 1980. The course (2.5 hours per week for six weeks) contains both predictable and unique features. The more predictable sections included types of arthritis, experiential learning, physiology, exercise and learned relaxation, and medicines used in rheumatology. Two unique features are 'goal-setting' and the course delivery system. In goal-setting course participants discover what greater control they can exert over daily life. Course delivery is by pairs of course tutors, selected and trained volunteers with arthritis.

The research results[2] show persisting increases in self-management practice (exercise, relaxation and time management); reductions in anxiety, depressions and fatigue; an increase in satisfaction with physicians (although they visited less frequently); and reduction in A&E usage and the number of hospital stays.

There was no adequate theoretical explanation until the mid-1980s, when it was provided by another Stanford professor's (Albert Bandura) work on social learning[3] and the concept of self-efficacy. In Bandura's work, a key learning mechanism is the progressive development of small areas of mastery. In the ASMC, modest goals are achieved and built on week by week. This process develops the sense of control, a grounded belief that success is achievable.

PERC's work went on to investigate the potential for chronic diseases generally. They field-tested the Chronic Disease Self-Management Course (CDSMC) and in 1998[4] the first major study was published it was noted that it had strong parallels with the arthritis studies.

The UK (particularly in England)

From the 1980s on, arthritis foundations across the world promoted these courses. In the early 1990s, Arthritis Care brought the ASMC to the UK as the core of its Challenging Arthritis programme. As a UK voluntary organisation it discovered an additional bonus: a release of energy and engagement from course participants into their organisation.

The passage on expert patients in *Saving Lives: our Healthier Nation* focuses on the CDSMC. This holds the prospect of a new way of working with people with chronic disease; one that increases patient satisfaction while reducing the demand on GPs and emergency secondary care.

The Long-term Medical Conditions Alliance (LMCA)[5] developed the Long Term Illness Project, to explore the CDSMC with nine member organisations. No voluntary organisation ever enters this work without a great deal of thought, because these courses challenge the convention that self-help groups can define patient need. On the contrary, these courses imply that people need training to use their personal resources and those of the health services effectively. This is indeed what has been learnt and is of fundamental importance. The key factor is building the personal confidence of the patient in their ability to exercise effective control over their lives.

Coventry University[6] conducted the research programmes at Arthritis Care and the LMCA. The Expert Patients Task Force reported in September 2001 and recommended the setting up of an Expert Patients Programme. An *ad hoc* implementation group has recruited staff and commissioned new course content. Of the 20 pairs of full-time trainers deployed across England, all have immediate experience of chronic disease. In the next few months they will complete their training, allowing them to train Course Tutors in PCT areas this autumn. They will be supported by the National Resource that is being operated by the Long-term Medical Conditions Alliance. Over the next few years every PCT will have the opportunity to have its own course tutors trained. The whole programme will be evaluated.

Fitting the ideas to a modernising NHS

Currently, almost 30 NHS initiatives have a self-care dimension. Indeed the promotion of self-care is an NHS Plan priority. The Expert Patients Programme[7] is best understood in this wider context. To be effective the course tutors have to be role models for the communities they serve. In this way the programme will build these new competencies into otherwise socially excluded communities. It is just such people who will be needed in the advocacy and representational work now under discussion.

This legitimate empowerment of patients has to be seen alongside the empowerment of their health professionals. It may well be that this programme will allow the GPs, nurses, and all the other members of the primary care team to relate more easily and effectively to the growing numbers of people with chronic disease.

Roy Jones

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Visit **www.ohn.gov.uk/ohn/people/expert. htm** for details of PCT involvement, etc.

roy porter — an appreciation

THE sudden death of Roy Porter on 3 March has deeply affected the community of historians, as well as several generations of students, and a much wider public than most historians ever reach.

One of the most energetic and engaging scholars of the post-war generation, Roy was a historian of exceptionally wide span: his work traverses large tracts of time and diverse subjects: from the history of earth sciences, enlightenment in Britain and Europe (a recurring fascination), biography, biology, to the history of language and of London.

However, he is best known for his work in the history of medicine. Whether his subject was hospitals, psychiatry, madness, quackery, sex, dying or narcotics, Roy paid as much attention to the attitudes and values of individuals, the controversies and rivalries of a period, as he did to advances in medical theory, clinical or scientific technique. This historical empathy was matched by a remarkable capacity to bring sources to life — memoirs, diaries, journals, case books and cartoons were all grist to his mill. His formidable command of source materials was fuelled by comprehensive reading and a prodigious memory — probably unmatched in our generation.

Radio and television appearances showed him to a wide audience just as he was: relaxed, knowledgeable, intellectually agile, and completely lacking in arrogance and self-regard, too commonly the stock-in-trade of less gifted scholars.

This precocious intelligence was apparent from an early age. His intellectual capacities (he was 'always lost in thought') gave rise to the family suspicion that he was a changeling. In an all-too-short preface to his book, *London: a Social History* (1994) he describes his childhood:

'I grew up in south London just after the war. Three miles from London Bridge, New Cross Gate was not exactly the Bethnal Green beloved of Young and Wilmott, but it was a stable if shabby working-class community completely undiscovered by sociologists. In many ways, that past now seems another country: bomb-sites and prefabs abounded, pig-bins stood like pillboxes on street corners, the Co-op man came round with a horse and cart delivering milk, everybody knew everybody ... Mine was a happy childhood. And though living was cramped and people had to be careful with money, the feeling was that, with the war over, with full employment and the NHS, life was secure; within limits, you could get on, be neighbourly, be respectable, grow tomatoes, save for a washing machine and afford a week's holiday with candyfloss and cockles.'

The security of his family life and local schooling stood Roy in good stead when he arrived in Cambridge in 1965 to study history. Unfazed by the contrast between the trappings of academia and the streets of south London, he developed an interest in 18th century thought and studied for a doctorate on the development of earth sciences in Britain between 1660 and 1815.

At this time, one of us (BH) was lucky enough to spend a year attending his seminars. These were informal affairs in which Roy would talk for 90 minutes, animatedly, dipping into sheaves of notes and photocopies of source materials concerning 17th and 18th century attitudes towards landscape, and developing tensions between theological conceptions of time and theories of earth formation. Roy paid rigorous attention to primary sources — texts, engravings, figures, publication history — and had meticulous concern for the social relations of thinkers and experimenters of the time, and their intellectual and philosophical assumptions.

His interests then turned towards medicine, and in 1979 he left his lectureship at Cambridge to return to London to be nearer his parents and to become senior lecturer at the Wellcome Institute. For the next 20-plus years, he taught history of medicine to generations of medical and history students, published over 100 books (many of them collaboratively) and a plethora of papers and articles.

All who knew him wondered how long his extraordinarily productive era of engagement with history of medicine would last — major books emerged at a prodigious rate. He was at work first and last, and always busy. Indeed, driving home at 3.00 am after a holiday, we realised from the single light in an upper storey of the Wellcome Building at 183 Euston Road, that Roy was still beavering away at that hour.

As a colleague he was generous, supportive and always encouraging even when he was clearly tired (which he often was). I (RR) never saw him bad tempered. I remain deeply grateful to him for his valiant defence of me (then an unpublished author) when my own historical work was severely plagiarised. Roy's reaction was typical and revealing when the guilty person threatened libel proceedings if I publicised my complaint. This kind of thing was common, he told me: once at a conference a colleague had delivered one of Roy's papers. In amazement I asked him what he had done about it and he shrugged: 'Nothing. I figured his need of it was greater than mine.' Fearless of prosecution, Roy exposed the theft of my work in an outspoken review in Medical History.

His lecturing style was idiosyncratic. He would usually stand informally, with a sheaf of papers in one hand (to which he almost never referred) his gaze somewhere distantly over the audience. His rich voice seemed always to have a smile in it: even when talking about serious matters, a grin and a chuckle were never far away. He had an impish delight in using old sources to expose the foibles of the day or of their authors, a love of exuberant alliterative diction, and a way of undercutting convolutions of thought with deceptively simple questions. Among the most knowledgeable historians of our time, he carried his learning lightly, and never used it to show off, or to show up others' ignorance.

His capacity to explore, understand, and empathise with the mentalities and motivations of people in differing circumstances in other times — from patrician physicians to patient paupers — was remarkable. He wrote extensively about Georgian England. But he also had a firm grasp of the realities of health care today, and was bold enough to encourage us to see ourselves as historical creatures: reminding us that despite our 'modern', 'scientific' knowledge, pain, fear and suffering remain, and that we have few better answers to the existential questions of illness than did the Georgians of whom he was so fond. In *Gout, the Patrician Malady* (1998, with G S Rousseau) he remarked that: 'there is still no consensus as to what is to count as a disease, as distinct from sickness, affliction, weakness or sin: is it a state of mind as well as a process of Nature?'

Perhaps with some presentiment of his own death, Roy retired early, sold many of his books and went to live near Hastings with his partner, Natsu Hittori. In one of his last letters he wrote:

'Unaccountable though it may seem to some, nearly six months into the new life, I've neither hanged myself nor asked for my job back; nor even regretted moving down, within sight of the sea, to the home of the ragged-trousered philanthropists. Hastings/St Leonards is so full of dubious playwrights, unhung painters, ex-skiffle band performers, junk shop owners, illegal immigrants, asylum seekers, seedy language schools, unfrocked clergymen, piercers, druggies, hippies, veggies, luvvies, unpublished novelists, old salts, dossers, dozers, dosers and their doxies as to make me feel that the law of plenitude required a superannuated academic to round it out, so I felt instantly at home (as, too, did Natsu)'.

He died, suddenly, while cycling home from his allotment. He had daffodils in his arms.

Brian Hurwitz
Ruth Richardson

MatissePicasso
Tate Modern, until 18 August 2002
http://www.tate.org.uk/modern/exhibitions/matissepicasso/

EXHIBITIONS coupling Matisse and Picasso are not new; the first took place in Paris in 1902. Previous shows have tended to present the two of them as leaders of opposing tendencies in art, whereas this new exhibition focuses on the effect each had on the other. Some pairings or groups are more convincing than others. In the small landscapes shown here, for example, you would be hard pressed to know who painted which if you didn't have the captions to help you, and when both turn to monumental depictions of the human figure — Matisse in bronze and Picasso in paint — the interplay is striking.

The portraits are the most difficult, because both painters seem to be at their most varied in this genre. Matisse paints a skeletal Mme Yvonne Landsberg surrounded by swirls of paint in a way that appears to have no parallel in his work, while Picasso produces his famous portrait of Gertrude Stein rather in the manner of Ingres. Matisse depicts his wife with the blank eyes and smoothed features of the African masks to which he was the first to introduce Picasso: he apparently took this little further, while for Picasso African art was one of the profoundest influences on his development. Part of the problem is that a work may show a deep influence by one on the other, but we lack the context to know if this new style was subsequently found to be a dead end by the 'borrower'.

I can't help feeling, either, that we have here the very best of Matisse (apart from the paintings in Russian collections) while the Picasso selection is not quite top notch. This is especially noticeable when the catalogue reveals that in Paris and New York Picasso's 'Demoiselles d'Avignon' will be part of the show, while it is not part of the London exhibit. We are not quite in Hamlet without the Prince territory here, but the absence of one of the most important paintings of the 20th century must mean the exhibition has less to say at Tate Modern than at MOMA.

Pablo Picasso
Boy Leading a Horse (1906)

Oil on canvas, 72 7/8" x 51 5/8"

The Museum of Modern Art, New York. The William S. Paley Collection

Photo: MoMA New York 2001
© Succession Picasso 2001

For all that, this is a hugely illuminating show, and proves once and for all that these two artists should be seen not as rivals, but as developing in parallel and full of the profoundest respect for one another's genius. Nothing shows this more movingly than a sombre painting by Picasso from the aftermath of Matisse's death in 1954: an interior modelled on the classic Matisse 'template'; some furnishings, some sculpture, and a view through an open window. Picasso takes these tropes and darkens them in striking contrast to Matisse's own light-filled canvasses. Set beside his hommages to Vélazquez and Delacroix, the meaning is clear.

We do not often have the chance to see so many works by two of the greatest painters of the Western tradition. Even if their interplay is of only academic interest to you, do not miss the chance to see some of the most wonderful art of the last century.

Frank Minns

“

They’d have made good GPs

Oh, and Doctor, if you’ve got another minute …” Not for the first time, it occurs to me that not everyone’s cut out for general practice. Alarmingly and increasingly few young doctors, it would seem.

“… I must just update you on the ongoing saga of my catarrh.” I press a mental button and engage the trusty Sympathetic Noise Generator (SNG). A stream of gently modulated ‘mmm’s and ‘uh-huh’s eases automatically, yet with uncanny timing, into the interstices of my patient’s monologue. Most GPs can do this in their sleep, and many do. I drift off into a favourite daydream — figures from history who would have made good GPs. The prophet Job, for one.

“Ooh I kno-o-ow!” Who said that? It sounded like Sybil Fawlty, on the phone to her friends. I awake with a start. Heavens, it was me. The SNG must have slipped into overdrive. But actually Sybil would have made a great GP. Not just for her mastery of the ‘Ooh I kno-o-ow’ school of counselling, but because she could turn on the charm to the customers when necessary while preserving an effective degree of barely controlled rage at the idiots who everywhere beset her. A useful survival skill when so much of our professional life is regulated by Basils and Manuels.

Remember the Inner Consultation, I tell myself. You have, as it were, two heads; one conducting the business in hand and another monitoring the process. Tune in to the internal dialogue between the two. It’s not always easy, is it? Joan of Arc would have been good at it, though. Unable to contemplate life without her ‘angel voices floating on the wind’, had she taken up doctoring rather than the deliverance of France she might have been a great healer (or Chair of Council) by sheer force of consultation skill. I suspect, given her fortitude at the stake, she would have drawn strength from the flames of abuse and misunderstanding which lick around the reputation of contemporary general practice.

Nevertheless, there is something to be said, in these days when ‘number of patients seen per hour’ is a statistic more highly regarded than ‘numbers satisfied per career’, for a consulting technique that, cutting the crap, pins down the presenting problem with a ruthless efficiency which no amount of Balintian squirming will obfuscate. For GPs of this persuasion Vlad the Impaler would be an ideal role model. What’s more, aside from his notorious tetchiness, Vlad apparently hated being bullied but liked a bit of flattery …

“Anyway Doctor, I know you’ve been doing your best but I am in BUPA …” Yup, Vlad would have had a good stab at general practice.

And if he, then why not his cousin-at-heart Margaret Hilda Thatcher? As a GP she would have brought to the job a disdain for time-wasters, a reverence for only that evidence that suited her purpose, and a scepticism concerning the softer fluffier bits of social theory that are such a bore if the snivelling sick are to be made suitably apologetic for daring to have inconvenient needs.

Or Ivan Illich. Remember him? *Medical Nemesis*, 1975: “The medical establishment has become a major threat to health.” On the grounds that the best doctors are those racked with self-doubt (and on the more dubious grounds that it would serve him jolly well right for once to be on the inside pissing out), Illich would have made a passable GP.

No, but seriously. If you’re a trainer, it’s your business to inculcate in your registrars an attitude that questions assumptions and is not afraid to challenge accepted wisdom. By these lights, the philosopher Socrates would have made, if not a good GP, at least a terrific trainer. He, you will recall, was put to death for encouraging the young to ask awkward questions, such as “What does merit consist of in a professional?”, or “Is popularity a virtue?” Well *I* think he’d have been good; but actually Socrates would probably have failed his trainer selection interview on the grounds that he didn’t adequately audit the outcome of his tutorials.

But actually my favourite nominee for an alternative career is the man who said, “Where there is officialism every human relationship suffers.” E M Forster. As depressingly large numbers of our colleagues take Blair’s shilling and, nodding like dogs on the parcel shelves of Ford Fiestas, help nail political patches on the rusty colander of the NHS, we need — the RCGP needs, general practice needs — people who know exactly what Forster meant when, in *Two Cheers for Democracy*, he wrote, “If I had to choose between betraying my country and betraying my friend, I hope I should have the guts to betray my country”.

How do we help young doctors understand that? And the causes of catarrh, of course.

Web sites dealing with uncommon diseases or specialist groupings are one of the better features of the internet. Patients can teach each other and keep up to date. Communication between patients and their doctors can be done without time or geographical constraints. As more of the literature migrates to the web these sites are further enhanced.

A recent addition to the electronic literature is *Herpes*, the journal of the International Herpes Management Forum which can be found at **www.ihmf.org**. It has academic papers on herpes and related viruses and has an interesting paper proposing cytomegalovirus as a possible trigger for atherosclerosis.

The patients’ site for herpes, Viruses Association at **http://www.herpes.org.uk/** is well designed, with all the links and information you need. As well as conventional medical treatment, it recommends teabags as an astringent application (Earl Grey is said to be best) and quotes a controlled study that demonstrated that ginseng reduces recurrences. A subgroup site for shingles **(http://www.herpes.org.uk/shingles.htm)** concentrates on the treatment of postherpetic neuralgia, with links to other sites for chronic pain, such as **http://www.painsupport.co.uk/**. Self-help treatments for postherpetic neuralgia include TENS, aromatherapy oils, bandaging, and pills and creams made from chilli peppers. I would have thought this would be too painful, but the fact sheet recommends application of EMLA first!

Trefor Roscoe

matters arising

The European Definitions of the Key Features of the Discipline of and core competencies

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Introduction

A new statement on the definition of general practice is to be published by WONCA Europe at its conference in London on 10 June. The text that follows this introduction sets out the new definitions of the discipline, the role of the general practitioner, and the core competencies required. The full publication sets out the analysis and discussion regarding the need for a new definition.

The authors have had regard to previous definitions by the Leeuwenhorst Group, WONCA, Gay, World Health Organization, and Olesen *et al*. The essential features of these are included in the new statement, but additions have been made to reflect both the principles of the discipline, the role of the GP today and the needs of health systems throughout Europe.

The purpose of publishing the new definition is to inform and contribute to the debate on the essential role of family medicine within health systems at both national and pan-European levels.

The European definitions 2002

The discipline and specialty of general practice/family medicine

General practice/family medicine is an academic and scientific discipline, with its own educational content, research, evidence base, and clinical activity, and a clinical specialty orientated to primary care.

1. The characteristics of the discipline of general practice/family medicine are that it:

(a) is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned;

(b) makes efficient use of health care resources through co-ordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialities taking an advocacy role for the patient when needed;

(c) develops a person-centred approach, orientated to the individual, his/her family, and their community;

(d) has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient;

(e) is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient;

(f) has a specific decision-making process determined by the prevalence and incidence of illness in the community;

(g) manages simultaneously both acute and chronic health problems of individual patients;

(h) manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention;

(i) promotes health and well being both by appropriate and effective intervention;

(j) has a specific responsibility for the health of the community; and

(k) deals with health problems in their physical, psychological, social, cultural, and existential dimensions.

2. The specialty of general practice/family medicine

General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care, irrespective of age, sex, and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural, and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease, and providing cure, care, or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care.

3. The core competencies of the general practitioner/family doctor

General Practice: the role of the GP

A definition of the discipline of general practice/family medicine and of the specialist family doctor must lead directly to the core competencies of the general practitioner/family doctor. Core means essential to the discipline, irrespective of the health care system in which they are applied.

§1. The 11 central characteristics that define the discipline relate to 11 abilities that every specialist family doctor should master. They can be clustered into six core competencies (with reference to the characteristics):

1. Primary care management (a,b)
2. Person-centred care (c,d,e)
3. Specific problem solving skills (f,g)
4. Comprehensive approach (h,i)
5. Community orientation (j)
6. Holistic modelling (k)

§2. To practice the specialty, the competent practitioner implements these competencies in three areas:

—clinical tasks;
—communication with patients; and
—management of the practice.

§3. As a person-centred scientific discipline, three background features should be considered as fundamental:

Contextual: using the context of the person, the family, the community, and their culture;

Attitudinal: based on the doctor's professional capabilities, values and ethics ;

Scientific: adopting a critical and research-based approach to practice and maintaining this through continuing learning and quality improvement.

The interrelation of core competencies, implementation areas, and fundamental features, characterises the discipline and underlines the complexity of the specialty.

It is this complex interrelationship of core competencies that should guide and be reflected in the development of related agendas for teaching, research, and quality improvement.

The full text of the European definition including the fully referenced academic review and analysis is to be published in booklet form by WONCA Europe on 10 June 2002.

neville goodman

No future

THE European Working Time Directive was always a suspect device. Set up to prevent exploitation on production lines, it is entirely unsuitable for doctors and will destroy the NHS. How long will it take? Thanks to Derek Wanless's endorsement of funding by taxation, and to Gordon Brown's budget largesse, a bit longer than it might have done. At the moment we have, as it were, brass in pocket. It's interesting watching people trying to take the cash. The nurses are asking why they are paid so much less than teachers. There is worry that the surge in negligence claims will eat up a large chunk. But these are small matters compared with the effect of the Directive.

Some say that the Directive is now law and we will just have to obey. Perhaps: but where are the doctors to do the work? Years ago, I wrote that various proposals, such as *Achieving a Balance* and JPAC, were a set of simultaneous equations without a solution. Simultaneous equations come in the form:

1) $x + y = 5$ 2) $10x + 5y = 40$

Rearranging and substituting gives solutions for the values of x and y. This pair of equations might represent the work done in a clinic, x being the senior medical staff and y the trainees. Over the years, the amount of work in most clinics (the right-hand side) has increased, and shows no signs of reversal. Not only have the numbers on the left-hand side not quite kept up, but the Working Time Directive is about to reduce the arithmetic value of x and y in a legally binding way. And that is without the effect of the third variable z, which is what is paid for excess hours working.

Meanwhile, we are all jumping up and down shouting, 'I want candy' — candy which is rightfully ours and which successive governments have denied us for 20 years — and Alan Milburn's tactic is blackmail. 'You can have this money,' he says, 'only if you improve productivity.'

Tony ('Should I stay or should I go?') Blair has promised to carry the can if the NHS does not improve. True to form, he's set out yet another set of targets for the distant future, cutting deaths from cancer and coronary heart disease by the sort of percentages that could be proposed only by someone who believed there were such a thing as a germ-free adolescent.

All pretty vacant, if you ask me.

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jill thistlethwaite

I am leaving my practice after 15 years

'DOCTOR Jill, I certainly thought you'd see me out,' says my oldest patient, three weeks younger than the late Queen Mother. I am leaving my practice after 15 years. This has nothing to do with appraisal or revalidation; there has been some burnout — or rather, a little singeing around the edges of my job satisfaction.

Days devoted solely to delivering patient care were never quite enough for me. Though I served on the FPC (Family Practitioner Committee as was) and the LMC, I was hardly interested in the cut-and-thrust of medical politics. Fund holding came and went and with it a large part of my altruism. Naively, I wanted the best for patients without the contract negotiation around what I perceived to be an inequality in available resources. I often said in the infancy of the purchaser–provider split that the logical conclusion was to give each patient a budget and let them negotiate their own health care and priorities.

So I became a trainer, and subsequently a course organiser. While I read about adult education and attended induction courses for vocational training gurus, I, like general practice itself, learnt most about teaching, or rather 'facilitating learning' on the job. As usual, these extra-patient-curricular activities had to be fitted in somewhere. Patient demand nibbled around the edges of protected time. Every so often I had a chance to reflect and almost scared myself to death. Here I was, feeling like a novice myself, passing on my wisdom to surgery-wise trainees who knew more about the latest drugs than I did (but much less about making a profit). I am not alone in suffering from 'impostor syndrome' — the fear that one day someone will recognise me for the fraud I am and divest me of all my hard-earned certificates.

In 1996 I took on an academic post in medical education with an interest in community-based teaching in Leeds, a post created in response to the GMC's 1993 document *Tomorrow's Doctors*. This full-time work was married pragmatically to a half-time post in my practice so that I could continue to enjoy the benefits of clinical work. This is a dilemma for all academic doctors: how much real doctoring is necessary to both keep up-to-date and to convince one's colleagues that there is an escape route from the ivory tower into the real world of work and hassle? And medical students thrive on clinical anecdotes (which are also a rich source of material for columns).

I soon realised that university work is firmly rooted in the real world. Extra tasks are handed out without any increase in resources or decrease in other duties. Remember general practice before it metamorphosed into primary care? Sometimes (whisper this softly, because it sounds like a golden era to our younger colleagues) there was a spare hour or even two before evening surgery that was not filled with diabetic clinics or clinical governance meetings. Similar mushrooming of responsibilities happens where new medical undergraduate curricula are spawned.

One day I looked around and saw that something had to give.

Pressure: we are all aware of its side effects. Reflection and thinking time and just gazing into empty space while inspiration jump-starts the muse become casualties of targets and marking schedules. I began thinking about student problems in consultations, and then, feeling guilty, patient problems at night. Empathy slithers away.

So I am leaving my practice. I have started thinking of all the patients I will miss and the ones I certainly won't. The patients begin to tell you they will not cope without you. I do not allow myself to wallow in indispensability. Other partners have left, medical care has not deteriorated in the Calder Valley and the patients soon latch on to another caregiver.

I am leaving and intend to sign on a non-principals' list and work in practices that wish to experiment with medical student attachments. That is if I can find all those certificates I haven't needed for years. I have them somewhere … honest.