VIEWS & REVIEWS

The state of general practice—not all for the better

PERSONAL VIEW John Howie, David Metcalfe, John Walker

The 60th anniversary of the NHS is an opportunity to celebrate its many achievements—both in hospitals, in the treatment of life threatening and seriously disabling disorders, and in general practice, in the development of an effective and efficient primary care service. Together with many others we have contributed to the renaissance of general practice in the United Kingdom after the 1966 charter, through our involvement in the establishment of general practice as a research based discipline in universities with properly structured postgraduate training.

However, we wish to express a number of worries we have about potential harm to the care of patients and to medical education that, we think, is an unintended consequence of recent reforms. Our starting point is a statement of what we think needs to be safeguarded: the distinguishing feature of UK general practice before the 1990 contract was the long term relationship between a patient (and often a family) and an individually named doctor, whose clinical training was grounded in the diagnosis and treatment of illness but was expanded to include awareness of the importance of psychosocial factors that affect patients' experience of illness and their ability to manage it. The fact that most care was initiated by patients meant that GPs had an implicit mandate to respond to their patients' agendas and involve them in decision making. Importantly, this allowed patients to be cared for in the community to their personal advantage—and with economic benefit to the NHS—or to be referred for specialist care if needed.

Four matters now threaten this vision. The first is the population health agenda. Governments are bound to see health care as population based, whether in terms of preventing disease or in managing long term illness and disability. Population medicine is, however, not principally concerned with the agendas of individual patients consulting their doctors. Integrating the public health agenda into routine general practice means that the

A GP consultation in 1948: is the best of the past in danger of being lost?

reasons for patients wishing to consult their GP are in danger of being relegated in favour of an agenda to which patients may not give priority. Thus the benefits of the traditional consultation with a known personal doctor are at risk of being lost.

The second matter is perverse incentives. Targets have their place, and incentives help achieve them. However, the quality and outcomes framework (QOF) seems a disproportionate response to the challenge to improve the quality of care. It also has known limitations: most of the measures are processes rather than outcomes; “ticking boxes” may distract doctors from dealing with important topics during consultations; and measures of what patients value and gain from personal care are poorly represented as individual QOF items or as a proportion of the whole QOF package. Previous work indicates that patients with non-incentivised health problems (in particular, in the context of QOF, psychosocial illness) are also likely to be disadvantaged.

The third is access. The extra work resulting from implementing the public health agenda and the pursuit of QOF points has made it increasingly difficult for patients to get timely access to care from their first choice of provider. Also, in many practices the move to improve GPs' work-life balance has gone too far, resulting in few or no evening or weekend surgeries being offered and out of hours care being widely delegated to dedicated services. Already the consequences of the new culture

of “team care” include the replacement of the “known doctor” by a practice nurse or by a pharmacist or other professional outside the practice. Provision of primary care in, for example, supermarkets and railway stations is a growing trend that cannot be expected to deliver the benefits to patients of a well constructed traditional general practice.

Our fourth concern is the effect of these changes on the learning opportunities of undergraduates and general practice registrars (if they do not see the different presentations of illness in evenings and out of hours) and on their chances of absorbing an ethos of personal and continuing care.

The most serious consequences of the current reforms arise from the tinkering with the model of patient led personal care given by a known GP in favour of episodic delivery of a top-down agenda by any of a variety of healthcare workers in a variety of sites. The best of the past is in danger of being lost without sufficient proved benefit in return. Our conversations with doctors in practice suggest that many share our concerns; so too do many patients.

Allowing these trends to continue unchallenged will result in the dismemberment of a primary care system that has been the envy of other countries. Patients will lose holistic care, doctors will lose job satisfaction, and the NHS will lose effectiveness and efficiency. As medicine changes, and the society it serves changes, evolution is inevitable and desirable. But in a complex organisation such as the NHS, simplistic and unpiloted measures are likely to have unintended consequences. We believe they are already happening and that GPs need to reclaim their traditional overall responsibility for the continuing care of patients in their own practices and to make their concerns about the new system more generally known.

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**"Few fight fans are quite so gullible" as
healthcare professionals**
**Ike Iheanacho on medicines
and boxing, p 1312**

REVIEW OF THE WEEK

It's tough on the sharks

If most complementary and alternative medicines work as a placebo response, is that so bad?

All in all, it is, find two new books reviewed by **Charles Essex**

I often advise students who want to earn easy money: offer to cure crying babies. The cry-fuss behaviour which peaks at age 6 weeks and, if severe, is often called colic resolves by 12 to 16 weeks. Offer anything—massage, crystals, feng shui—and it will get better. You get the kudos *and* the money. Even if it is something serious like an intussusception or meningitis, the parents will blame the doctor(s) for late diagnosis. When was the last time you saw a headline like "£2 million payout because of blunder by reiki therapist"?

Complementary and alternative medicine (CAM) therapists pick conditions that are relatively minor, sometimes creating a disease that does not exist, such as subluxations of the spine, or they find a recognised one such as food allergy or nutritional deficiency and then "cure" it, often with expensive health supplements that they sell, even though it was never there in the first place. Better still if the symptoms fluctuate or the condition is self limiting, like in the crying babies.

Both these books explain the success of CAM, so there is considerable overlap. *Trick or Treatment?* looks at the big four: acupuncture, homoeopathy, chiropractic therapy, and herbal medicine, with an appendix describing more than 30 CAMs. Both authors hold doctorates so their approach is somewhat academic, but they explain randomised, placebo controlled, double blind trials and clinical and scientific methods in a readable way. *Suckers* has snappy chapter titles like "Junk science—with new, added junk." Both books demolish most CAMs by showing the lack of evidence that they work or have any scientific basis. The vast majority of CAMs work simply as (very successful) placebos.

So why do CAMs have such a big following and such a lucrative market? Inevitably it is down to the therapeutic relationship between practitioner and patient. Someone who can offer an hour's appointment is going to score over a 10 minute appointment almost every time. If most of these treatments are purely placebos, is that so bad? Both books agree it is: it is dishonest; exploits potentially vulnerable people; is expensive; patients may later seek CAMs when they have a serious condition; and some CAM therapists lobby heavily against conventional

medicine and advocate that their patients do not take their conventional treatment, sometimes with tragic consequences. And some of these treatments are harmful.

Some CAM practitioners become celebrities. They may be the founder of a particular CAM or a leading proponent, appearing on daytime television, national radio, and the cover of magazines like *Time*. The results—anecdotes and testimonials—prove their method works, dressed up with nonsensical pseudoscience. Rarely do they admit to being linked directly or indirectly to an expensive range of products that patients are encouraged to buy. These practitioners are not hindered by minor nuisances like scientific method or conflict of interest or uncertainties. Their books are best sellers, often portraying them as mavericks, revealing truths that the pharmaceutical industry and doctors try to conceal. They are perhaps spurred on by a George Bernard Shaw quotation, "All great truths begin as blasphemies." Both *Trick or Treatment?* and *Suckers* look at the history of medicine and how advances were made or treatments discarded—and unfortunately for CAM practitioners, not all blasphemies become great truths.

These celebrity pronouncements and sensational journalism can lead to a surge in demand for a CAM. A programme on the US television channel CBS entitled "Sharks don't get cancer" triggered a rush for shark cartilage products for a range of conditions. Sharks do get cancer, and numerous trials have shown that shark products are ineffective. Holland and Barrett health food shops told the Shark Trust that they "will continue to sell shark cartilage [products] due to customer demand, until such time that the species is classed as an endangered species."

CAMs, including homoeopathic hospitals, are available on the NHS. As doctors, we should challenge why these useless treatments are being funded. I look forward to similar books looking at many of the ineffective treatments provided as mainstream by the NHS.

Another financial tip: if you are uncertain how to invest your money amid falling house prices, buy shares in CAM products. They are a sure thing. The snake oil industry is extremely lucrative, with the sales of its products probably worth several billion pounds a year.

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Trick or Treatment?
Alternative medicine on trial

Simon Singh, Edzard Ernst
Bantam Press, £16.99,
pp 352

ISBN 9780593061299

Rating: ★★★★★

**Suckers: how alternative
medicine makes fools of
us all**

Rose Shapiro
Harvill Secker, £12.99,
pp 272

ISBN 9781846550287

Rating: ★★★★★

Brave new world

FROM THE
FRONTLINE
Des Spence

The year is 2084. Much has changed in the past few decades since the Health and Safety Executive, supported by the medical profession, seized power to prevent dissidents blocking the safety laws. This legislation freed the population by prohibiting the menaces (recognised through “top” research) of sunlight, sexual intercourse, more than 2 cl of alcohol, sausages, swimming, cooking, peanuts, chocolate, comedy, fizzy drinks, tattoos, rock music, Elvis, motorbikes, and religion.

Other enlightening legislation had followed. The Emancipation of Young Adults Act extended the franchise to children. Subsequently, a child led coalition (supervised by a responsible adult) voted to end the terrible oppression known as education and closed the schools. Unfortunately, to protect the children, all trees had been chainsawed, skate boards and bikes confiscated, and play parks bulldozed. Likewise, sport had been banned for the inherent evil of competitiveness, with the term “loser” erased from the English lexicon. Everyone was now a “winner,” with cheap looking medals awarded every day just for turning up. Regrettably, kids were left with only “esteem” counselling as an approved activity.

To help these bored children the Virtual Reality Act was passed. With the compulsory wearing of 3D virtual

reality visors, people were free to sky dive, ski, and ride motorbikes from the comfort of their sofas. Benevolent multinational fast food chains were awarded national contracts to deliver food to the door. But the consequence was obesity. Despite being safe, the people were unhappy.

The medical profession seemed impotent to help. For legal reasons, time was spent completing feedback questionnaires and listening to focus groups, but the real problem was that staff were either off sick or attending health and safety courses on the use of scissors and step ladders. Also, new anti-discrimination legislation meant that employers couldn’t ask applicants about age, gender, height, weight, address, school, qualifications, name, ethnicity, and hobbies. All CVs were therefore blank, and the only legally acceptable interview question was: “What is your favourite piece of cutlery?” Lastly, new working time directives limited work to one hour a day, and anti-bullying policies meant that no one could force employees to do anything.

But none of this mattered any more, for the compulsory injection of stem cell “hybrid” human-pig genes to cure the obesity problem had rendered humankind sterile. And no one seemed to care.

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Could have been a contender

DRUG TALES AND
OTHER STORIES
Ike Iheanacho

Whatever you think of their controversial sport, there’s no denying the bravery and commitment of professional boxers. They and their managers are a wily bunch, too, particularly when selecting opponents. Given the potential risks to life and limb, it pays to pick the right fight at the right time.

This shrewdness is crucial when building a career. The last thing a promising fighter needs is an untimely loss to somebody who is good enough to win but not great enough to provide even the dubious consolation of glorious failure. Far better to begin at the bottom: perhaps by first taking on no-hopers, then moving on to solid, unglamorous performers who offer opportunities to gain experience but no serious threat of defeat.

These comparatively easy wins inevitably raise expectations of harder bouts against acknowledged stars. However, the organisation of

such matches may be protracted (if they happen at all), especially where the risk of losing isn’t felt to be outweighed by the prospective financial rewards. The delays can contribute to a lack of clarity about who’s really number one, possibly resulting in there being several pretenders to a title-holder’s crown.

This murky situation isn’t helped by the plethora of global governing bodies, each sanctioning its own “world” championships and so fuelling the confusion.

There are unfortunate parallels here with the world of medicines. Take, for instance, the similar tendency for flashy contenders to arrive on the scene accompanied by suggestions that they’re superior to what’s gone before. Far too often, these claims are actually based on little more than the results of testing against lesser comparators (typically, placebos or obviously second rate treatment options).

The new kids on the block

may never be entered into the contests the crowd really wants to see—head to head comparisons with established first line therapy—exposure that could reveal their true limitations.

As in boxing, regulatory bodies are to blame for much of this mess. They control the licensing and subsequent promotion of new medicines, generally without requiring these products to be assessed directly against the best of the rest. Consequently, “me-toos” can be touted as true champions, without ever having to prove as much.

Some healthcare professionals might object to bracketing how medicines are judged with something as base as boxing. In a sense, they would be right. Because too many of them happily swallow undiluted promotional hype. Few fight fans are quite so gullible.

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Gunning for it

Having reached the age of wishing for fewer rather than more possessions, I still covet only one class of material object: antiquarian books of special interest.

To assist me in this irrational pursuit, several booksellers kindly send me their catalogues, which I pore over with fevered pleasure. Why books that were once held by historical figures should be so desirable to me, I leave to psychologists to discover; suffice it to say that recently I wanted desperately an early edition (1766, no place of publication) of Voltaire's *Treatise on Toleration*.

I wanted it because it had once belonged to the great French gynaecologist and supporter of Lister's methods, Samuel Jean de Pozzi, and bore his bookplate, which was designed by the painter Manet.

Pozzi was not only a famous surgeon but a renowned womaniser who had an affair (among many others) with the widow of the composer Bizet, and he was a friend of the cultural elite of France during the belle époque. There is a magnificent portrait of him by John Singer Sargent, now in Los Angeles, dressed in a scarlet silk dressing gown that makes him look like an ultra-worldly renaissance cardinal.

Sarah Bernhardt, the most histrionic actress of her (or perhaps of any) age, insisted on Pozzi as her surgeon, first to remove an ovarian cyst and years later to amputate her leg.

Pozzi is among the small number of eminent doctors who were shot by a patient. The other who springs to mind is, of course, Egas Moniz, the Portuguese neurologist who not only was one of the pioneers of cerebral angiography but developed the prefrontal

BETWEEN THE LINES Theodore Dalrymple

Pozzi is among the small number of eminent doctors who were shot by a patient

tal lobotomy, for which he received both a Nobel prize and a bullet in the back.

Like Pozzi, Moniz was a man of wide cultural and political interests: he was Portuguese ambassador to Spain after the fall of the Portuguese monarchy, and then foreign minister. He was an accomplished historian and the author of books on many subjects besides neurology.

Unfortunately, unlike Moniz, Pozzi died after being shot by a patient, towards the end of the first world war.

The patient whose leg he had amputated two years before had become impotent as a consequence, and he shot Pozzi when Pozzi told him there was nothing he could do to help. An emergency operation did not save Pozzi, and he asked to be buried in his military uniform.

The book was already sold by the time I contacted the bookseller. I was, as a patient who had just stabbed his best friend in the abdomen during a quarrel once said to me, gutted. Now I shall just have to make do with a book that I already possess about Jean Calas (the Protestant who, accused of killing his son, was tortured and executed, and who was the inspiration of Voltaire's *Treatise*) that is signed by the author, who, as it happened, was the brother of an eminent doctor: Lord Maugham, brother of Somerset and later Lord Chancellor.

After my bitter disappointment at not getting the book that was once owned by Pozzi, I discovered something very strange, that no doubt contained a moral: life went on much as before.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

The Natural History of Disease

By John A Ryle First published in 1936

John Ryle came from the school of master clinicians who walked the wards and tended the needs of patients (at Guy's Hospital, London). He was a physician who listened but was also noted for his clinical research on gastric function. "Ryle's tube" was for many years the eponymous name for that tube used for emptying the stomach and for gastric lavage.

His mentor was Arthur Hurst, the doyen of gastroenterologists in the 1920s, and he dedicated this book to him. It was written at a time when Ryle had accumulated much clinical experience and was under the burden of a large private practice. He had already also contributed widely to the literature, but most papers were written especially for *Guy's Hospital Reports*, and several of the chapters are from that quietly successful journal. Thus when academia beckoned him to the chair of physic in Cambridge in 1935 he was ready and prepared to go. The first edition was published one year later; the second in 1948. Both may be found much thumbed and still sought after on the shelves of medical libraries.

He begins the book by invoking the physician as a naturalist, an idea he used to introduce a broader approach to medicine: the study of the human animal in its environment, both external physical and inner psychological. It was thus he who first transplanted the then new idea of holism into medicine. It was semi-philosophical—his brother was Gilbert Ryle, the Oxford philosopher. He used the word in its correct sense

It was Ryle who first transplanted the then new idea of holism into medicine

(quite different from its current misuse), as invented by Jan Smuts, who first wrote about it in 1927. Ryle applied the principle of holism to medicine so that it encompassed a then novel approach, relating ill health to different factors—constitutional, anatomical, physiological,

familial, and environmental stress or injury—any of which could combine to make an uncomfortable whole called a particular disease.

If nothing else, we owe to Ryle the enunciation of the clinical analysis of pain. Similarly, what he called the "natural history" of staphylococcal, streptococcal, and *E coli* fevers were admirable descriptions of the courses of these infections in the untreated patients of the pre-antibiotic era. They are model clinical descriptions that may well be useful in the present antibiotic resistant age. Other gems are his labelling of those whom we accuse of "enjoying poor health" as having "nosophobia," a morbid fear of illness. His chapter on prognosis is as applicable today as it was when written.

Ryle was not comfortable at Cambridge, because his broad outlook tended to conflict with the narrowness of those he had to deal with in the academic world. Fortunately, his reputation allowed him to move to Oxford in 1945, to become the first professor of social medicine there. He took this book and his holistic attitude with him.

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