letters

TO THE EDITOR

Please submit letters for the Editor's consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Thomas.Allum@rcplondon.ac.uk

Clinical guidelines... must be pertinent, brief, valid and accessible.

Editor – Dr Gill's interesting article (*Clin Med JRCPL* July/August, pp 307–8) highlights the plethora of guidelines ('2,200 in the USA'), their varying quality ('opinion-based' rather than 'evidence-based'), and most importantly that their usage averages only 55 per cent with a variation about the mean of 0–100 per cent.

Has the time come for a simple, comprehensive guide from a reputable authority, which can be carried easily in a (white-coat) pocket in book form or electronically? Perhaps the College should take a lead in this? Possibly the *Oxford Handbook of Clinical Medicine* could be used as a well-tried and tested model. Such a vade-mecum would provide an easily accessible source of information, which would be widely respected clinically, and, one might add, legally in the courts! It would also give due credit to our forebears who already invented the wheel!

STEPHEN BARBER
Consultant Physician and Elderologist, Gibraltar Health Authority

General practitioners with special clinical interests

Editor – In their recent editorial (*Clin Med JRCPL* September/October 2001, pp346–7), Roger Jones and Richard Stevens do not cover the real reason why about 4,500 general practitioners provide clinical sessions outside their practice. For the last 25 years I have done two sessions a week in chest medicine at my local district general hospital (I have the glass tumbler to prove it). I have certainly not done it for the money; I have done it for the involvement with the hospital and its medical staff. It is the cure to one's 'isolation' in general practice.

I have long been an advocate for the college's greater involvement with its general practitioner members but I do not think that the way forward is to create general practitioner specialists in the community. Rather we should be encouraged in greater numbers to work in local district general hospitals and give some good old home spun advice to our consultant colleagues.

CLIVE WALKER
General Practitioner, Weybridge and Hospital Practitioner, St Peter's Hospital, Chertsey

In response

Variety is, as Clive Walker points out, the spice of life for general practitioners. Isolation is a real problem and there is accumulating evidence that the provision of a varied job description, in which clinical care is combined with other activities – clinical, academic or policy-related – is an antidote to burnout and disillusionment. In London, for example, a number of successful experiments, involving a 'mixed portfolio' approach to job descriptions and careers structures has had a substantial effect on recruitment and retention in areas where general practice has been struggling. The advent of salaried general practitioners, under the Personal Medical Services scheme, and the widespread involvement of general practitioners in the development of Primary Care Groups and Trusts has enabled fresh thinking about the kind of job that a general practitioner should sign up to for 40 years.

Clearly the initiative to develop general practitioners with special clinical interests is only one approach. Some general practitioners, like Dr Walker, derive tremendous benefit from contact with hospital colleagues, whilst others may find equal inspiration and refreshment in activities such as undergraduate teaching, postgraduate training, research and the development of health policy. We should welcome this increasing variety in the work of general practitioners, which is likely to lead to a happier, healthier workforce and, ultimately, to better patient care.

ROGER JONES
Wolfson Professor of General Practice Guy's, King's & St Thomas' School of Medicine, London

RICHARD STEVENS
Chairman, Primary Care Society for Gastroenterology, Oxford

Ethical Dilemmas?

Editor – Mr Walker's viewpoint is interesting and controversial (*Clin Med JRCPL* September/October 2001, pp383–4). He, like many others, seems to have made a distinction between ethics and morality. Our culture is quick to insist that God is unnecessary for understanding morality. The ethical theories of Kierkegaard, Hume and Didenot have been influenced by their previous religious presuppositions[1]. Even Kant failed to provide a rational basis for ethics apart from God. Why then is the church least qualified to take such a decision on ethical matters such as in the example put forward by Mr Walker?

Science has its limitations: although most would believe that time, matter and chance could explain most things. The former two are quantifiable – but chance?

While it is true that a judiciary can act as an independent institution, yet if morality is absent then the dilemmas we face are a consequence of living in a morally suicidal society.

A reasonable and coherent ethical theory cannot be achieved without first establishing the purpose and destiny of human life. Neither science nor an independent judiciary system offers such an explanation

I fully endorse Mr Walker's claim that an independent arbiter is required to resolve these issues – I call such God.

Reference

1 Zacharias R. Can man live without God? Milton Keynes: Nelson Ward Ltd, 1995.

RP ARASARADNAM
Specialist Registrar Gastroenterology/Medicine, Central Sheffield Teaching Hospitals

In response

Editor – Dr Arasaradnam's letter illustrates an important point: God does play a central role in many people's moral

systems. However, his argument only adds strength to my own in that it highlights the need for the law to look at these issues impartially. Nevertheless, I would like to defend my position on two counts:

1. In reference to the moral philosophers of the past, it should not be forgotten that many based not only their ethical systems on their belief in God, but their epistemological arguments too. George Berkeley argued that we are only aware of objects of sensory perception because God put those ideas into our minds, not because they actually exist as material objects in the world. We no longer need God to explain epistemological phenomena, nor do we need Him or Her to explain morality.
2. A reasonable and coherent ethical theory can be achieved without appealing to God. Kant's categorical imperative, that we should treat other people always as ends in themselves and never as means, is a good example. The utilitarian school of thought, founded by Jeremy Bentham and currently defended by Peter Singer, is another. Neither system pontificates so much on the purpose or destiny of human life as on its value. Both are perfectly reasonable and coherent ethical theories.

Personally, I prefer secular thought to religious doctrine, but I am not the one to decide upon ethical dilemmas. We should look to the law.

TIM WALKER
London

Skill mix in clinical care

Editor – Your editorial on skill mix in clinical care (*Clin Med JRCPL* July/August 2001, pp259–60) illustrates an example of the innovative delivery of health care.

It is a model that is being increasingly used in a primary care setting. Our practice was awarded 'beacon status' based on the development of skill mix in primary care. In addition to nurse practitioners who work under the guidance of protocols and the enthusiastic support of the general practitioners (they see a range of patients with minor illnesses), we also offer open referral clinics for patients to access the physiotherapist with a range of problems.

The service has proved very popular amongst our patients and there were high levels of satisfaction in a patient survey. We are currently exploring the development of a Personal Medical Services (PMS) contract, which encourages practices to consider innovative ways of delivering health care. We hope to expand our services with nurse practitioners playing a key role in the delivery of high quality chronic disease management clinics in diabetes, asthma and ischaemic heart disease.

As a practice we have recognised the need for an integrated approach to health care and continue to develop this for the benefit of the patients and the organisation of health care delivery within the practice.

Our model developed in primary care may have some useful concepts that also apply to secondary care.

A WILLIAMS
St Thomas Medical Group Research Unit, Exeter

The interface between primary and secondary care

Editor – We are pleased that Professor Mike Pringle has highlighted the importance of the interface between primary and secondary care and the need to improve communication and contact around it (*Clin Med JRCPL* May/June 2001, pp172–4).

General practice has become part of primary care, the practice has evolved to become the primary health care team and responsibility for the individual patient has widened to include the registered population. The hospital physician's role has changed with increasing specialisation, a decrease in beds, greater involvement in emergency care and expanding workload.

Our experience in the North East supports the use of general practice posts to give SHOs useful, complementary educational experiences[1]. These rotations are popular and help develop important generic skills as well as give valuable insight into modern general practice.

The new Primary Care Organisations offer some exciting opportunities. General practice possesses much untapped expertise and the arrival of the Coronary Heart Disease National Service Framework (NSF) has certainly brought GPs and consultants together in our area to focus on implementation[2]. If adequately funded, collaboration between the Older Persons and Diabetes NSFs, may enable the development of clinical networks in which all services are integrated around the patient[3]. Likewise the move from a financially based model of commissioning to an evidence based activity in which clinicians sit down to discuss patient need and the effectiveness of interventions would unlock much potential to develop services.

A recent conference in Newcastle, jointly organised between the Royal College of Physicians and the Royal College of GPs, explored the bridges that are being put across the gap. It was heartening to hear about developments in the clinical, educational, research and organisational links between primary and secondary care. Speakers stressed the need for good communication, forums for discussion which bring the different agendas together, joint protocols and guidelines, using money flexibly and exploiting all opportunities for development.

Clinical governance is central to much of this work. Shared initiatives could include joint learning and significant event audit. Audit and decision support will also help to improve standards and manage demand at the interface[4].

Finally it is important to for us all to remember the multidisciplinary nature of our work and the need to include non-medical colleagues in our planning and education. Much time and effort needs to be invested for the gap to close and eventually become an overlap.

References

1 Cunningham WF, Harrigan P, Turner J, Morgan D. SHO experience in general practice. *J R Coll Physicians Lond* 1999; **33**:401.
2 Jones R and Stevens R. General Practitioners with special interests. *Clin Med JRCPL* 2001;**1**:346–7.
3 Kunkler IH. Managed clinical networks: a new paradigm for clinical medicine. *J R Coll Physicians Lond* 2000;**34**:230–3.
4 Coulter A. Managing demand: Managing demand at the interface between primary and secondary care. *Br Med J* 1998; **316**:1974–6

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