

The end of innocence

Elizabeth Barrett reflects on how she supported a community's right to involvement

*We shall not cease from exploration.
And the end of all our exploring will
be to arrive where we started and
know the place for the first time*
(TS Eliot)

Saul Alinsky says that “happenings” become experience only after they are “digested... reflected upon, related to general patterns, and synthesized.” The primary care trust’s decision to award the contract for the surgery in a small ex-mining village to UnitedHealth was a “happening” for me. The decision challenged my most deeply held views about health care, social solidarity, globalisation, local autonomy, democracy, public service, and the future of professionalism. I was challenged to go on a journey to which, in a sense, there is no end. This is the story of just one part of it.

Unwanted Christmas present

Christmas must have seemed the right time to bury the good news about UnitedHealth. After Christmas, it was time to research. The “young, vibrant British company” was a subsidiary of a giant health insurance company in the US. Head office was in London, or Minneapolis, perhaps. The implications of this decision were profound and far reaching. Somehow, I couldn’t remember any parliamentary debate or

media discussion. Most importantly, the patients had had no opportunity to consider the new model of primary care that had been selected on their behalf.

Because I had put in a bid for the surgery, the parish council invited me to their next meeting. In a prefab in Bolsover, a long way from Minneapolis, a handful of local representatives, from an area battered by the loss of its coal and clothing industries, took the decision to go public on the right to be consulted. A human rights lawyer was contacted through Keep Our NHS Public (www.KeepOurNHSpublic.com). Pam Smith, a parish councillor, patient representative, and pensioner, volunteered to be the complainant who was deprived of entitlement to involvement under section 11 of the 2001 Health and Social Care Act. The announcement of legal action coincided with the launch of “Our Health, Our Care, Our Say” with its emphasis on local participation.¹ The irony wasn’t unnoticed by the media. The first clip on BBC 2’s *Newsnight*, that night, was me telling the country that this was a “major privatisation agenda of which the public was

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unaware.” I hated seeing myself on television; I hated my double chins, my voice, and my clothes. I was terrified of saying the wrong thing and, yes, a wide screen does add two stone (as a patient reassuringly informed me).

Rough ride

The ride was rough, at times. Although I, and many others, had been sleeping, GPs had become “profit making” and obviously no different from global, shareholding companies. We were overpaid, self serving, and opposed to change. It was time we got our comeuppance. People seemed more keen to challenge on those issues than explore the ideological assumption that

the private sector would automatically be better. The logical weakness of comparing the worst of public service with the best of the private sector seemed to go unnoticed and the irony

of the secretary of state sending a QC to the High Court to argue against her own flagship policy of patient involvement was lost on some.

In the months that followed, I told my story ad nauseam. I was driven by fear for the NHS and for participative democracy. The David and Goliath tale was compelling and attracted international attention. Despite working full time, I responded to every request for phone, radio, and television interviews. I spoke on platforms to packed meetings, and to empty ones. I arranged local meetings and made my friends attend. I used my holidays to attend the High Court hearings and dealt with the media aftermath. I wrote to newspapers, bishops, politicians, and even the *BMJ*. I must have seemed a woman possessed.



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High price

There had to be a price. I had spells of intense self doubt. I woke in the mornings worrying about the NHS. The garden was neglected. Summer came and went and I hardly noticed. My bicycle stayed in the garage. My guitar gathered dust in the kitchen corner. I dropped my weekly swimming because my evenings were full, and stopped walking before work because my mornings were full, too. My children forgot who I was. My husband remained resolutely supportive, despite my neglect, although a new recurring theme crept into arguments. My partners tolerated my antics. The patients were intrigued. I made some very good friends, and I was lucky; if I made enemies, they didn't make themselves known.

After Pam Smith, the aforementioned patient, won at the Appeal Court we submitted another bid. This time we were helped by an experienced project manager and we learnt the new language of competitive tendering. After an interview in

a baking hot, tense, and overcrowded room, we were unsuccessful, yet again; this time losing out to a contractor called Chilvers McCrea.

Moving on

In the middle of all this, I applied to do the Royal College of General Practitioners' leadership course—perceiving the need to carry on learning from this “happening.” I was challenged to learn more about myself, jump some personal hurdles, and question my assumptions. I was able to clarify my personal politics and learn new skills. I learnt that good management is a very moral discipline and that we are all part of the problems we find. I discovered a fascination for health policy. I learnt that we deal with messes and not solutions; that we must live our values, and that I have a lot to learn. In the words of Antonio Gramsci, I want to “live without illusions, without becoming disillusioned”; failure is to be cynical and walk away. Applying for PEC membership

FURTHER INFORMATION

To find out more about the RCGP leadership programme go to *RCGP Leadership Programme: Better Leaders, Better Doctors* (www.rcgp.org.uk/default.aspx?page=3469)

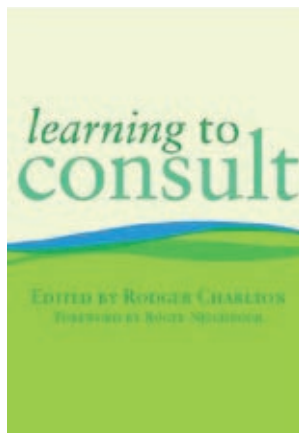
of Derbyshire County Primary Care Trust was a logical conclusion, and I have been accepted for this post, which is the start of yet another journey.

Current reality is difficult but, as general practitioners, we are in a powerful position to work collaboratively and democratically with patients and colleagues, stamp our values on how care is planned and delivered, and do what Gandhi suggested—“be the change (we) wish to see in the world.” Time is short.

1 Department of Health. *Our health, our care, our say: a new direction for community services*. London: Stationery Office, 2006. (White paper.)

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REVIEWS



Learning to consult

Ed Rodger Charlton

Radcliffe, £24.95, 2006

320 pages

ISBN: 10 1 85775 852 8

Rating: ★★☆☆/5

Before I even opened this book, I hoped its content would be more inspiring than its title. I'm glad to say it was, but with some reservations. Although it generally fulfils its purpose as a guide to consultation and communication, its key audience is perhaps too broad—that is, undergraduate and postgraduate trainees, general practitioners (GPs), and hospital doctors. This is reflected in its varying detail on certain topics, which means it might not be considered good value for money if you feel inclined to skip large chunks. This is in no way a criticism of its contributors, however, who are primarily GPs with expertise in medical education and communication skills.

For example, newer recruits to medicine might find it useful to read about the logistics of taking blood pressure described in no less than five pages, but I doubt an experienced GP or physician would find it as relevant. Similarly, how to write a prescription is given a full chapter in itself.

By contrast, there are several chapters dealing with theory of consultation and communication models, which undergraduates not interested in medical education might find irrelevant to their stage in training. However, there were two things that I thought really worked for all grades of doctor. The first was examples of transcripts of mock interviews that effectively showed differences between a paternalistic doctor consultation and a more patient centred one. Secondly, the chapter on health promotion and motivational interviewing techniques was succinct and relevantly covered the subjects,

using smoking cessation as a prime example.

I was interested in the chapter on advanced communication skills, which focused on consulting with children and adolescents, learning disability, and palliative care. It also covered customs of death for different religions. But I was surprised at the omission of patients specifically with mental health difficulties, especially as many doctors find this subject challenging because they lack confidence and skills. Admittedly, there is brief mention in the last chapter on prescribing SSRIs, but it may have been more useful to give examples of how to take an effective history and mental state in a patient presenting with depression or anxiety tailored for the primary care sub-15 minute consultation.

This book's strength lies in supplementing one's own competence in seeing patients, and encourages self reflection. There are numerous “practical points” printed in bold, which are helpful albeit rather obvious especially if you are short on time and want to absorb key points. Take this example: “If a patient falsely accuses you of misconduct during an unchaperoned examination, you will stand alone in court.” The authors also refer the reader to some useful websites and provide substantial references. So, although I stand by my initial point that this book is better suited to the wannabe GP, it would still make an interesting reference for a more senior or experienced clinician.

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