The British Journal of General Practice

‘We might consider having nothing further to do with happiness ...’

Alan Munro, page 594

Follow the yellow brick road: starting an MD

Like Dorothy (her of the whirlwind and Toto the dog) I have started on a path that will take me to a new and uncertain prospect. For her it was Oz, for me it is to complete my MD.

I am in the first year of a part-time MD. My thesis is about patient and receptionist negotiations. The research approach is qualitative. The path to register for my degree has not been smooth, but I suspect that this is a common experience.

It is estimated that only 4% of theses come from general practice,[1] and the numbers may even be falling.[2] In specialties such as medicine, an MD is an established career move,[3] but in general practice the reasons for doing an MD are more diverse, and the obstacles greater. The main problems are lack of protected time and lack of money.[2]

Most Regional Health Authorities (RHAs) and the RCGP advertise research fellowships to fund time off. I obtained funding to employ a locum through the Northern and Yorkshire RHA research practices scheme, which is supervised by NoReN.

Finding and choosing a supervisor is crucial and you will need to negotiate this with your local MD advisor. If you are lucky your supervisor will become your advisor, mentor, and friend. I spoke to and interviewed many people about potential supervisors, including postgraduate students. People were surprisingly open about their experiences, although sometimes you had to read between the lines. These efforts built up a short-list of potential supervisors. I also had a ‘trial run’ in seeking their counsel about my ideas in the nine months before registering. I chose two supervisors from the same department who had worked together. I have not been disappointed.

Formal training for the degree is now compulsory in many universities. You can also choose modules aimed at increasing your knowledge in an area of interest. Practice and family support are also important: an MD is a major emotional as well as academic commitment. The opportunities to manage anxiety and uncertainty are legion. There are anxieties about supervisors, funding, grant applications, time off from the practice, and of course, the research itself. Don’t believe people when they say you only need to do a couple of hours’ work a week — it needs a lot of work.

Be prepared for obstacles. Not everyone thinks that your idea is innovative. But the knocks are good training for later on when you have to justify your thesis. I had some difficulties in obtaining approval for the qualitative methodology. I was surprised that even senior academics were inexperienced in this methodology, and I am sure that I would have had fewer problems doing a randomized controlled trial.

The Wizard of Oz is a parable about self-discovery and self-realization. That is a good description of doing a postgraduate degree. There is industry and perspiration, but also times of discovery and elation when it all seems worthwhile. I hope to have more of these moments.

Morris Gallagher

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The Back Pages...

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news

Tackling the Quality Agenda in Primary Care

The 1998 RCGP/Boots Research Paper of the Year Award

In its December 1997 White Paper *The New NHS: Modern, Dependable*,[1] the Government stated that it would put quality at the heart of the NHS and set out an ambitious and far-reaching 10-year programme of modernization. It described how the internal market would be replaced by a system of integrated care, based on partnership and driven by performance. The document promised early, visible improvements to the quality of service that people experience in their own homes, at their GP surgery, and in hospital, focusing in particular on structures, quality, and efficiency of service delivery.

In *A First Class Service: Quality in the New NHS*,[2] published in July 1998, the Government went on to set out in some detail how it intended to implement the changes in England. The document emphasized the importance of the active participation of clinical professionals and patients throughout the NHS.

If quality is at the heart of the NHS then it was certainly the overwhelming theme running throughout the entries for the 1998 RCGP/Boots Research Paper of the Year Award. A total of 20 papers were entered, from which seven were shortlisted for consideration by the panel of nine assessors.[3-9] The papers clearly demonstrated a team approach to research, in which the perspectives of sociologists, anthropologists, epidemiologists, and statisticians are valued alongside those of patients, general practitioners, nurses, and public health doctors. The studies relate to quality in primary health care: improvement of care for particular disease groups; implementation studies, including randomized controlled trials to identify effective methods of implementing improvements in performance; different approaches to supporting or re-structuring primary care, including out-of-hours care; the introduction of primary care groups with the development of performance indicators; and getting research evidence into clinical practice. After much consideration and debate there was unanimous agreement that a qualitative paper by Greenhalgh, Helman, and Chowdhury, that set out to explore the health beliefs and folk models of diabetes in British Bangladeshis, should win this year's award.[3]

The prevalence of diabetes is rising and the burden of morbidity and mortality attributable to the disease is large. Recognizing that successful management of diabetes requires that we understand the lifestyle, beliefs, attitudes, and social networks of the patients being treated. The winning authors set out to explore the experience of diabetes in 40 British Bangladeshis living in the deprived, multicultural area of east London. Patients were recruited from three general practices and tape recorded interviews with Bangladeshi subjects were conducted in Sylheti, a dialect of Bengali spoken as a first language by all the Bangladeshi subjects. A control group of eight white British and two Afro-Caribbean subjects, who also lived in east London and had similar socio-economic backgrounds, were also interviewed. The study design used a wide range of qualitative techniques including narratives, semi-structured interviews, focus groups, pile-sorting exercises, and the structured vignette.

A recurring theme in the research was that of structural and material barriers to improving health. The findings also support the view that the similarities in health beliefs and health-related behaviour (e.g. failed attempts to lose weight or give up smoking) between minority groups and the host culture are often understated. This study was supported by a Health Services Research Grant from the Wellcome Trust. Future research programmes are needed that link variations in outcome between different social and cultural groups with diabetes and their perceptions of the nature of the condition, the opportunities for prevention and treatment, and the service currently provided.

There are a number of unanswered questions that would help us to better understand quality in primary care. These questions concern the way in which services should be organized, and how health professionals consult with patients to most effectively improve clinical outcomes and patients' experiences of care. There is a risk that the future performance indicators used to monitor quality in primary health care will be concerned only with the biomedical aspects of care, since research into other aspects of care is relatively poorly developed. Research is required to redress the balance and ensure a more complete understanding of quality.

Continuing with the theme of diabetes care, Kinmonth and her team[4] were brave enough to investigate the relationship between patient-centredness and measures of biomedical performance. This paper also takes us into a discussion of what features of primary care are those that influence the users' assessment of quality and how should the traditional model of primary care be developed to meet the changing needs and preferences of patients. We gain insight into what is the relationship between patients' perceptions of, or reactions to, care and clinical outcomes.

Research is required to define a broad range of valid indicators of quality in primary care. Since primary care provides a wide range of health and personal care, a wide range of indicators is required to fully assess quality. Clinical governance will be the principal system for improving quality in primary care groups. Therefore, several research questions relate to clinical governance. These include: does clinical governance result in

Acknowledgements

Once again, I would like to take the opportunity to thank all the researchers who gave permission to have their papers submitted to careful scrutiny during the search for this year's winner. My thanks also to the panel of assessors who freely gave their time to peer review the papers submitted and to Fenny Green who kept us running to time in this the third year of the award. The winning paper for 1998 was presented at the joint RCGP/AUDGP seminar on Academic Career Pathways in General Practice and Primary Care on 16 June 1999, and was followed by a dinner at the College to celebrate this year's award. I close by adding my gratitude to Boots who have provided financial support for both the award and the Careers seminar.

improvements to quality of care? If so, how? What incentives are used, and which are most effective in influencing patterns of professional behaviour? What aspects of care do primary care groups focus on? Are these the most appropriate? Do they include the more difficult aspects such as communication with patients? How can all practices be involved? In their paper on performance indicators, McColl *et al*[6] attempt to answer some of these questions. More generally, effective methods are required for implementing the findings of research and recognizing how practitioners process clinical and contextual information. Our shortlisted papers also address these difficult issues.[7-9]

Although research questions relating directly to the proposals in the Government White Papers are likely to have priority for future funding, it is difficult to adequately address these questions without defining quality in primary care and developing measures or indicators appropriate to the definition.

Yvonne Carter

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WONCA: Mallorca

This is the age of the Euro-acronym. This conference was organized by SemFYC (Spanish family medicine) on behalf of the European network organizations EQUIP (quality), EGPRW (research), EURACT (teaching), and EUROPREV (prevention), under the umbrella of WONCA. I was involved in a EURIPA (rural and isolated practitioners) workshop which for the first time brought together rural doctors from eastern and western Europe at a network conference.

The theme was 'Quality, education and research: working together for general practice.' As might be expected from a conference involving many hundreds of GPs and eight parallel sessions, there was a bewildering range of material presented in the forms of posters, oral presentations, and workshops.

Impressions? Huge variations in style, quality, and accessibility. None of the uniformity that sad, parochial British politicians fear from an integrated Europe. As always, the best presentations were from the enthusiasts of the profession. Paul Wallace gave an inspiring talk on building bridges between research and education. I liked his description of research as 'organized curiosity'. Frede Olesen's sessions, which turned into into problem-orientated research seminars, were impressive. Tricia Donald raised the profile of SIGN (Scottish Intercollegiate Guidelines Network) with a punchy talk on how to move evidence into practice.

Christos Lionis from Crete was the most cited author at the conference, even being required to chair two sessions at once. You have to be Greek to do that. Despite the gloom that surrounds GP recruitment, it was obvious that there are many talented and able young doctors working in general practice all over Europe.

Network meetings tend to be a little removed from the day-to-day business of general practice; this was exemplified by the chairman, who described patients as 'end-users' of health care. What are they using? An Australian delegate said that she felt a little as if she was being taught to fish without a rod a long way from water. Perhaps she was at the wrong conference.

It was good to see Eastern European delegates there, from Ukraine, Russia, Latvia, and the Slovak Republic. These doctors cope with difficulties in professional life that we in the sheltered West left behind many years ago, and they deserve our support. It was a humbling experience to hear from a Latvian GP of the dreadful health and social costs (heart disease, alcoholism, family breakdown) of economic decline since the collapse of communism and the advent of the market economy. A salutary reminder that the main determinants of health are social, cultural and economic, and that high quality general practice cannot, *per se*, produce good health.

A vote of thanks, then, to Juan Mendive and his team for a European but distinctively Iberian experience.

The 1998 Marshall Marinker Prize

Dr Diana Jelley, a general practitioner in Newcastle upon Tyne, was the winner of the 1998 Marshall Marinker Prize for Excellence in General Practice. Sir Donald Irvine, President of the General Medical Council and chairman of the judging panel, and Marshall Marinker, announced the winner at a celebration dinner held in London.

In her work with Newcastle Medical School, Dr Jelley has been involved in piloting and establishing a GP/District General Hospital clinical skills course in liaison with the local hospital. She has produced both student and GP tutor guides for the course, in addition to a communication skills package that has devolved to clinical skills teachers around the region.

In 1997, Dr Jelley made a successful bid to become a level (A) research practice for three years. Projects completed in the first year include joint work with two local practices generating research questions in primary care, and two pilot studies on deferred prescribing and copying referral letters to patients. She was appointed as the RCGP Portuguese Fellow in 1989 for a three year period, during which time she delivered papers and ran workshops on UK primary care and vocational training, and arranged for Portuguese GP trainers to visit her practice and experience a wide range of primary care and teaching activities.

Looking back on a seven-year partnership

Peter Toon, the RCGP St Petersburg Fellow, reflects on changes in Russia and Russian health care since 1992.

It is seven years since my first visit to St Petersburg. The Soviet Union had just fallen apart and so, it felt, had the Russian economy. There was almost nothing in the shops, and what food I could find was mostly bought from scruffy, makeshift kiosks or the backs of lorries. Petrol was scarce, and drivers removed their windscreen wipers when they parked for fear of theft! The rouble was almost worthless and Russians, free at last from political restrictions on travel, were instead trapped in their country by poverty.

Some of the people I met had never seen an Englishman before and my mission, to develop a partnership between those involved in general practice, seemed impossible. Health care was delivered almost entirely by specialists. There was an early training scheme for GPs — and developing primary care based on family practice was government policy — but although all the people I met were warm, charming, and amazingly hospitable, particularly in the economic circumstance, few of them seemed to know what general practice was, or believed it to be possible.

One of those few was Olga Kuznetsova, then working in emergency medicine — now seven years later Professor of Family Medicine. Her impressions of those seven years are given below. To me the changes have been enormous. Although the economy is still rocky, and many lost their savings in the crisis last autumn, economic progress has been striking. The dull shops and surly assistants of communist times have gone, and the scruffy kiosks have become bright vibrant markets. Sadly, many have been left behind by this economic progress, including doctors and many of their patients.

Family medicine in Russia is still a tender shoot, but at least there are more than a handful of people who know what it is about. There is a growing department at MAPS, with international links in the USA and Scandanavia as well as the UK, and a profile of primary care research in addition to teaching and a journal. A second Department is starting at another Academy in St Petersburg, and there is also a growing private sector. The Internet has transformed access to information and contacts abroad in Russia as elsewhere. We have been able to write successful grant applications together, as well as just keep in touch. After being isolated from Western medicine for decades and then losing their own journals when the economy collapsed, our Russian colleagues can now read medical journals on the Web.

Of course health care reform in a country as vast as Russia is a long haul, but the progress since 1992 has been remarkable. It has been a great privilege as well as a joy to be able to be a participant observer, albeit an intermittent one, in this process.

Peter Toon

St Isaac's Cathedral, St Petersburg. Photo credit: Bridgeman Art Library.

In 1992, I was expecting my second child to be born and was seriously considering my future in medicine. I was wondering whether it was worthwhile staying a medical doctor, or whether the situation had become so bad that the best solution would be to quit.

By then I had been working as a doctor for 10 years and had also seen doctors from the other side of the desk, as a patient — not very often, but often enough to find both experiences disgusting. Of course being a doctor was much more preferable, but the primary health care system was then so imperfect that attempts to help my patients were like trying to pour small amounts of oil onto a roaring ocean during a storm. But since 1992 things have changed.

In the narrow and experimental field of general practice (in St Petersburg there are about 10 small group practices) MAPS is trying to plant the seeds of a generalist approach and grow the fruits of success. Too often, our efforts are in vain — the fruit are either not ripe enough, or they turn out to be vegetables. Maybe tasty, or even delicious, but unfortunately hidden too deep in the dirty soil of practically unchanged health care. Nowadays acute financial pressures have eaten up all the possible resources (if there ever were any, which I doubt), so we let the living bury their dead, the healthy take care of themselves, and the kind and generous population of western Europe sympathize with our poor and sick people.

But speaking seriously there have been positive changes in primary care, for now we have general practice — a considerable achievement. General practice exists in the few surgeries that we have in St Petersburg, but also in an approach to patients of the many, many doctors trained as GPs at MAPS and now working in primary care. Other older practitioners have learned the new ideas.

Most of all, general practice now exists in the minds of patients, at least in some of them; a revolution that transcends lack of equipment and cash.

At the same time, in Russia as in the West, the free market has become the new orthodoxy. How will this affect fledgling Russian general practice? I am optimistic. I feel that a free market in health care can never become the only possible system in Russian primary care; the free market is so completely inhuman and antispiritual. Russia has, for the past 80 years, been deprived of all spirit (except alcohol), and it is now time to rediscover that spirit. General practice is the only system of healthcare that can help people to do so. There should be more to medicine than buying and selling a therapeutic relationship — in Russia at least.

And as for chaos? In Russia we're used to it. Perhaps we manage better in the absence of order.

Katja Shlyakhter

And two postcards ...

August 17, 1998. My daughter and I were travelling in Finland — we were on holiday and enjoying ourselves. Our family is a perfect example of a successful Russian doctor's family. My wife and I were working in the private sector of Russian primary health care; we were financially secure, and our life was full of interesting plans and hopes. Just a couple of weeks before, we had a new baby in our family — cute, beautiful Ann. Sitting in a cafe, we learned of the financial and political crises in Russia. At that moment we could not even think about the difficulties that were awaiting us at home and we continued our journey.

When we returned to Russia we could hardly recognize the country. There were long queues and empty shelves in the shops. My seven-year-old daughter asked me: 'What are we doing in that line before the shop?' What could I answer? 'I wish the crisis goes away as soon as possible,' she said.

For a whole month we received neither home calls nor office visits — our patients had too many problems. Our savings, kept in a red box, were quickly disappearing. I was afraid even to think about the day when I would open the red box and find it empty. The future seemed very frightening indeed.

We began the paperwork to apply for emigration to Germany (my wife's family is Jewish and has the right to settle in Germany with decent social support). But then, one day, one of our patients came for an office visit, than another, and then another ... slowly our 'red box' stopped emptying. In that cruel time we decided not to increase fees (although we had to a little later) — we even set up easier financial terms for our patients. The situation in Russia began to improve, and our patients were able to cover their dues and regularly requested our services again. We were back in business — except for one thing.

The situation described above is the official health care system. However, although my wife and I work in the private sector we still depend on the state health service, as we cannot readily cover the full range of our patients' health needs. I worry desperately about the situation in Russia. Doctors are still only paid the same amount in roubles that they received before 17 August 1998, so now the average doctor's salary is $40 per month. I cannot understand how we can conceivably be expected to live on this! The availability of medicines and equipment for hospitals and policlinics has fallen, and the quality of medical undergraduate and postgraduate education has become unacceptably poor.

What bothers me most are the actions (or rather the inaction) of our local and national health care authorities. They have achieved hardly anything towards the reforming of our health care system since 'Perestroika'. Each new government (and we have had more than a few in the last three years) promises to improve this system. Life shows the opposite: the health care industry is gradually decaying and I do not see even a hint of improvement. You could say: 'But this is the best time to start a private business in health care'. You would be absolutely right, and this is indeed happening, but I am afraid that soon we will be full of rather nice, well-heeled private clinics, while people die on the streets from tuberculosis. My doctor's conscience cannot accept the idea of providing the best service only for those who can pay, and nothing for those who cannot. But the truth is that, right now, I have to do this to feed my family.

It is not easy. The outlook for my career and life at the moment is unclear. But we still hope and believe in words of the new Prime Minister and try to create our own 'health care system' for our patients, while dreaming of providing it for every citizen of Russia. At the same time we understand that this is an illusion. Our application to the German consulate has been approved. We may use it, we may discard it. We are still deciding.

Andrew Lobunov

essay

Reformation?

Give me a doctor partridge plump,
Short in the leg and broad in the rump,
An endomorph with gentle hands
Who'll never make absurd demands
That I abandon all my vices
Nor pull a long face in a crisis,
But with a twinkle in his eye
Will tell me that I have to die.

W H Auden

This essay, too, is about simple objectives and mortality.

By the fifteenth century the medieval Catholic Church had become rich and corrupt, but nevertheless remained pervasively influential. Europe was ravaged by futile, inconclusive wars, catastrophic outbreaks of plague, and by a lingering pandemic of syphilis, all against a background of price inflation, poor harvests, hunger, and sometimes starvation. The illiterate peasantry, obsessively preoccupied with death and salvation, looked to the church as a reservoir of magical assistance in lives of day-by-day, mortal uncertainty. The Church responded with a popular religion of Mariolatry and cults of Saints, and of belief in the power of relics and ritual to provide safeguards and shelter in a turbulent world. The priesthood administered all this without neglect of its own needs, most notoriously in the sale of indulgences — a fast track to the sunlit uplands of the afterlife in exchange for money. The upper echelons of churchmen lived in sybaritic splendour surrounded by cohorts of concubines, the best art and every exotic luxury that the Venetians might bring from the East.

The Garden of Earthly Delights: centre panel, by Hieronymus Bosch (c. 1450-1516). Prado, Madrid/ Bridgeman Art Library.

As if that were not enough, the Church enjoyed a monopoly of intellectual authority through control of the universities. Learning was in Latin. In the thirteenth century, Aquinas had knitted together Aristotle's philosophy and Christian theology in an alliance that bestrode the minds of men. The Church, flawed though it may have been, was the very embodiment of buttoned-up medieval European-ness.

* * * *

In the late twentieth century, medicine is pervasive, influential, rich, and corrupt. Consultants' neglect of their NHS practices in favour of lucrative private work is legendary. A couple of years ago, a patient of mine with aortic stenosis and worsening angina was told that his valve would be replaced by the NHS in about a year. His children scraped together a couple of thousand quid and inquired if this would make a difference. The same surgeon, in the same NHS hospital, did the job in a week and pocketed the loot. The corruption was individual and institutional. The regulations encouraged it. I guess BMWs are surrogates for exotic concubines imported by enterprising Venetians. Are surgeons boring, or simply more discrete than the Borgia and Medici prelates?

Medicine's parish priests confront the angst of an age of tedious peace and plenty, the powerlessness born of relentless regimentation by management and the sense of inadequacy of those excluded from the global quest for meaning through consumption. Our response has been diazepam, homeopathy, counselling, antidepressants, and sheer inspired diagnostic creativity in the shape of myalgic encephalitis. Continental Europe barely struggles to the vertical each morning from under the debilitating restraint of epidemic low blood pressure. Such ritual responses to demand demean professional integrity as much as did the miraculously endowed fragments of the True Cross, that together would have built a forest of crosses. Just as religious ritual, when it drifts away from a properly spiritual context, becomes comic or corrupt, so too do our little theatricalities of therapy become faintly absurd when detached from empirical, or at least vaguely empirical, investigation and diagnosis.

* * * *

In 1452, printing was invented in Europe. The book trade was instantly immense. It is estimated that, by the year 1500, there were 7.5 million books in Italy alone. In 1453, Byzantium fell to the Turks, driving scholars and ancient Greek manuscripts westward.

Printing flooded Christendom with vernacular editions of the new classicism, challenging the Aristotelian theological establishment. The church lost control. The great European Medieval Institution unravelled, split in two. In northern Protestant lands the men and women spoke to their God directly, without ritual priestly intermediary. In the south Catholicism became radically more disciplined, less corrupt, though still insisting upon its Divine authority in earthly spiritual affairs.

Intellectual authority escaped. Copernicus observed the heavens meticulously, if a little fearfully. Rabelais observed Churchmen, revealingly. Montaigne observed his fellow men dispassionately, as did Shakespeare, peerlessly. Vesalius had a look at their insides — and Raphael, their outsides. Observation was fashionable, the first flickering of the empiricism which would drive the European Enlightenment. Astronomy, literature, drama, anatomy, and art would never again be the mere handmaidens of theology. The churches ended up doing what only churches can do. Their activities were stripped down towards an irreducible core.

In all of this, printing may have been the crucial pivot. Medicine, too, in the late twentieth century, faces challenges from newly revolutionized communications media, particularly the investigative journalism of television. So far the focus has been on specialist services but I doubt if general practice will escape for long. The profession's early response to the need for change has precise sixteenth century precursors. Sir Donald's GMC seeks to stiffen discipline from within, exactly as did the Inquisitions and the Protestant ecclesiastical authorities. (The passing of the vogue for burning people as an encouragement to rectitude in others is a welcome contemporary development.) But what if we extend the analogy? What if we too were to strip down our activities towards an irreducible core?

If we do nothing I fear that medicine will become ever more influential, more pervasive, its limits less understood, and its practitioners, seduced by priestly universalism, further divorced from empirical justifications. The media and taxpayers will not long put up with this. Like the medieval Church, the NHS is a potential casualty. Might we by being more disciplined, more aware of the limits of uniquely medical skills, salvage for the twenty-first century a socially cohesive framework for the egalitarian delivery of modern medicine?

* * * *

We might consider having nothing further to do with happiness. We might say that taking SSRIs or behaviour therapy has far more in common with taking alcohol, cannabis, or a holiday than it has with taking anti-tuberculous treatment. The former we prescribe because patients tell us to, the latter is part of a chain, each link of which requires absolutely the skills which only doctors have. It is to exercise special skills that we have professions. Beyond special expertise lies the quagmire of relics and indulgences. This is not to say that no-one should get antidepressants or psychotherapy, only that doctors have no special skill in deciding who should and who should not get them.

Are we not the willing stooges of the pharmaceutical industry, lending respect-ability to the peddling of pills, the effects of which are substantially unknown, and perhaps unknowable? For an individual, do mind-manipulating medicines make falling in love, religious experience, writing a cracker of a novel, or just being happy in the long run more or less likely? In a community, do people with bad housing, no jobs or awful jobs need pills, or a brick and directions to the offices of New Labour? In Huxley's *Brave New World*, soma, not religion, is the opium of the people. Soma is state sponsored and comes in wee white tablets.

In matters of happiness doctors are, I think, guilty of exercising fraudulent intellectual authority, with unknowable consequences. Happiness is as much medical as astronomy is theological. We might reasonably ask that other, non-medical arrangements be made for substances and ploys promoting contentment. (I am not here talking of psychosis.)

We might further wonder whether all kinds of oral contraception would be better sold in sweetie shops. I suppose I don't really mean sweetie shops, at least not for a start. Rather, I mean that grown-ups could choose between a leaflet, a word or two with a pharmacist, or a chat with their doc. Might there be other prescription-only medicines which should be entrusted to pharmacists?

Another area where we might relinquish responsibility is where we are ignorant or impotent. When I was a medical student, after a spell in Greece, I went bright yellow for a while. I still felt uncharacteristically faint and feeble a year later. No-one, thank God, anointed me with a syndrome or, still worse, told me that the sweaty weariness might last for years. Little or nothing more is known now than was known then about wobbles after viruses, yet doctors now solemnly label and prognosticate, colluding possibly, in the creation of tribes of invalids. It has become common that patients expect things of us that are beyond our powers, perhaps in part because we have exaggerated them. Should we more often say that we don't know? Do we need courses — lots of them — on saying 'I don't know' as if we mean it?

My feeling is that the parallels between sixteenth century Church and twentieth century medicine are strong enough to lead us to wonder about the scope of our work, and whether doctors should stick to what they are uniquely good at: investigation, diagnosis, and treatment based on empiricism. Although the parallels are less direct, the question of how priests and doctors work is interesting too.

Medieval priests stood between man and God. Thirty years ago, doctors did not discuss death. White coat and stethoscope stood between patient and death as surely as vestment and host between congregation and Trinity. As Protestants came to speak directly to God, so patients may see mortality as a personal, individual matter, but if we contemplate a medical equivalent of radical priestless Protestantism, the analogy breaks down, spectacularly.

It is one thing to pray directly to God and feel spiritually satisfied. It may be a rather different thing for ill people to seek help from technical medicine without human intermediary. Though we should not lose sight of our vested interest, it seems barely credible that a computer printout of treatment options and survival statistics will displace the consultation. The imperishable fact of mortality, however potent our wizardry, demands irresistibly the engagement of whatever resources of compassion we can muster, because we know that in the end we always fail. Only trust, warmth, caring, compassion, love, whatever we call it, can ameliorate that final failure for both doctor and patient, not to mention one or two less than final failures along the way, quite possibly.

* * * *

Austere, pure, evidence-based medicine is an unattractive prospect. But equally, our present efforts to do good on all fronts threaten to swamp general practice and to bring it into disrepute. We need to define a middle way. To aspire to compassionate custodianship of the means of sometimes postponing death is, for me, more than enough. To make men whole is for men themselves, or for those who, like Churchmen and healers, presume to know the shape, texture, colour, smell, rhythm, and balance of that wholeness.

If we truly have any special interest or skill it is in understanding the individual. As Voltaire said, 'It is easier to understand Mankind than to understand one man.' We are the Corinthians, the Renaissance Men, the profession of Chekhov and Turgenev, … we on honeydew have fed and drunk the drink of paradise.

Liam Farrell, *BMJ* Soundings.

Aye, fine. Just so long as it doesn't go to our heads.

Alan Munro

Evidence-based Practice in Primary Care
edited by Leone Ridsdale
Churchill Livingstone, London 1998
PB, 199pp, £18.95, 0 443 05889 X

Although evidence-based practice (EBP) is now enshrined as part of clinical governance, many GPs have not yet got to grips with it. This may be partly because of its origins in hospital medicine, and the fierce controversy it engenders in which arguments for and against (sometimes verging on the lurid, not to say ludicrous) are hurled to and fro in editorials and letters. It is also undeniable that if you want to do it you are letting yourself in for some hard work.

In *Evidence-based practice in primary care*, Leone Ridsdale has assembled a distinguished group of contributors, several of whom have tutored at the UK workshops on teaching evidence-based practice. She has encouraged each to tackle his or her chapter in their own way. This has advantages, because they illustrate different approaches to the use of EBP in different situations, but the lack of uniform presentation of items such as critical appraisal checklists can be confusing. More importantly, because the authors rightly concentrate on demonstrating principles, they sometimes skim over explanations of technical matters. I doubt, for example, whether the uninitiated reader would fully understand likelihood ratios after reading the chapter on diagnosis, although he or she might appreciate their usefulness.

The introductory chapter is a succinct and well-argued discussion of the nature of EBP, and where it might fit into general practice. The second chapter, on question forming and searching the literature, is one of the clearest accounts of databases I have read. Chapters 3 to 9 each start with a clinical problem, and the authors take the reader through the process of question forming, searching for and critically appraising evidence, before making a decision about management. Several papers are reproduced in full, so the reader can follow the critical appraisal — qualitative research, diagnosis, prognosis, clinical trials, guidelines, audit, and overviews are covered. All the problems are typical of general practice, and are addressed imaginatively and convincingly.

The chapter on audit is a real gem. It explores why audits so often fail to deliver anything useful, and shows how an evidence-based approach can help avoid superfluous data gathering in order to focus on what is relevant for patient care. It's also good that the first critical appraisal is of a qualitative paper, emphasizing that EBP is not just about RCTs and that, in general practice, understanding patients' concerns (in this case, parents' fears about their sick children) is as important as treating diseases.

The final chapter, on teaching and learning EBP, lists useful information sources (including Internet sources — but some of the URLs are misspelled) and discusses educational and organizational issues in a realistic and practical way. There is a rather perfunctory glossary.

This book can be warmly recommended as an exploration of how EBP can be used in primary care, but it sometimes lacks absolute clarity on technical matters and omits some important topics such as economic evaluation. GPs, trainers, and registrars will get the most out of it by using it with standard texts such as Sackett *et al*'s *Evidence-based medicine: how to practice and teach EBM*, and Greenhalgh's *How to read a paper*.

Toby Lipman

The Diving Bell and the Butterfly
Jean-Dominique Bauby
Fourth Estate, 1997
PB, 139pp, £5.99, 1 85702 794 9

How many of us could attempt to enter the mind and guess the thoughts of a person incapable of speech and trapped in a body which will only allow the movement of one eyelid? We have all, I'm sure, wondered about the thoughts of those of our patients who cannot communicate their thoughts and feelings through conventional means. Too often, one imagines, it would be far too easy to assume that a face or larynx deprived of the means of expression mask a brain without thought or imagination.

Jean-Dominique Bauby was, until 1995, a successful journalist — Editor-in-Chief of *Elle*; a father of two young children. He was at, or near, the peak of his career. At the age of 43, in December of that year, he suffered a brainstem stroke that left him 'locked in'. At the start of the book he finds himself in a provincial hospital in northern France, in the timeless world of the rehab patient, completely dependent on the nursing staff for his every need. Can you imagine what it would be like to be trapped in your own body — able to make only one meaningful movement — the winking of your left eye?

In the book, Bauby inhabits an almost solipsistic world in which, deprived of the

powers of speech and movement, he can only take flight on wings of memory or imagination. A philosophical point emerges from his thoughts — am I my body? Bauby is quite clearly not merely his body, as his mind and spirit soar on memory, recollection, and imagination. The paradox is that without his stroke it is unlikely that his life story would have been told. However, he is more than just a patient — he has a family, life, and friends which shape and frame. His thoughts and feelings are not, however, all sweetness and light — I would not like to be the nurse who turned off an important European football match at half-time. In the same position I too would seethe with impotent rage.

The Diving Bell and the Butterfly was dictated using a painstaking method, whereby an assistant went through the letters of the alphabet and the author winked when the appropriate letter was reached. Then the process was repeated again — letter by letter, word by word, page by page. One can only marvel at the patience of both author and assistant. How glad I am that they went to the trouble — the result is a gem.

This book is both delightful and sad. It brims with life and a love of the world and all that makes life good and worth living. The chapters, understandably short, make the book a very easy read. Yet, like the work of Christopher Nolan, the Irish writer with cerebral palsy with a similar method of dictation, they are packed with a richness of detail from Bauby's life, both before and after his stroke. After reading both authors I can only look at mute or dysphasic or locked-in patients in a new and transfigured light, wondering at the potential of their interior life.

The first time I read this book, I read greedily and finished it within 24 hours. Like tasting rich *tarte au chocolat*, it is more suited to measured, meditative reading, allowing the richness of language and experience to be properly tasted. Whichever way it is taken, the result is extremely satisfying and life-affirming

Paul Keeley

Happiness *(Dir: Todd Solondz)*
Orphans *(Dir: Peter Mullan)*

Happiness is the best fim I have seen for years: a cast consisting entirely of perverts, sexual incompetents, depressives and emotional inadequates illuminates the truths of human existence in an extraordinarily funny, squirmingly accurate depiction of a single lower middle class New Jersey family and its connections. *Orphans* is the most deeply unpleasant film I have seen for years: a cast consisting entirely of drunks, sentimental thugs, depressives and emotional illiterates illuminates nothing apart from the utter awfulness of their hopeless lives.

Both are described as comedies. *Happiness* achieves the astonishing feat of making you laugh at some truly appalling things. You may have heard, for instance, that one of the principal characters is a paedophile who, during the course of the film, rapes two schoolfriends of his son. He accomplishes the first of these two crimes by means of a drugged tuna sandwich. As you watch his farcical attempts to get the rest of his family to go to bed and to get the boy to eat the sandwich, you know that all this is leading up to the commital of a vile crime, and yet is extremely funny. Later in the film, a sad computer geek, who has been making obscene phone calls throughout the film, sit in a diner while his neighbour describes how she killed and chopped up the caretaker who raped her, her narrative interrupted by huge spoonfuls of strawberry ice-cream. Once again, you laugh and are appalled at the same time — very few people can do this.

Orphans is described as a dark comedy. The plot revolves around four children in the days immediately after their mother's death — just as the central building block of *Happiness* is a family of three sisters. The three brothers and their wheelchair-bound sister inhabit a world in which the worst excesses of beery religiosity are amplified the relentlessly crude and obscene language in which they are expressed. It should be possible to make a story set in working class Glasgow just as telling as one set in blue-collar New Jersey, but you need to have some sympathy with the characters for this to work. Solondz can manipulate you into feeling even for a father confessing the vilest of crimes to his son, while Mullan's cast are uninvolving and antipathetic. They have no more to say than the drunk who corners you in a public bar and offers to buy you a drink to put you under some kind of obligation to listen to his life story. I have not felt so strongly tempted to walk out of a film since I saw the truly dire Guccione *Caligula* dubbed into Spanish with English subtitles in a fleapit cinema in Puerto Rico

So, give *Orphans* a wide berth. See *Happiness* as soon as you can.

Frank Minns

The Very Stuff of General Practice
From Pioneer to Settler in a flat world
edited by Philippa Moreton
RadcliffeMedical Press, March 1999
HB, 201pp, £35, 1 85775 390 9

The 'very stuff of general practice' was a term used by John Hasler himself and now appears as the title of his Festschrift. All very British and home counties, though thankfully without the colonels. We have a series of ten papers celebrating his contribution to individuals and to general practice. They read like a *Who's Who* of general practice with a nice balance of the pioneers, like David Metcalfe and David Pendleton, and the settled, such as Mike Pringle and Theo Schofield.

Pendleton's contribution to general practice has been well recognized and here he is again after all those years. His paper is challenging for modern day general practice and makes a case for leadership that is, as he points out, difficult in a profession that is consensus driven and operates in a flat, non-hierarchical world. He introduces us to Bennis and Nanus's study of leaders from the public and commercial sectors. They found that, despite inevitable differences, there were four common threads in their approaches: they created a compelling vision, an aligned community, trust, and relentlessly pursued improvement. His consideration of the implications of these threads for both general practice and primary care are worth reading.

Academic general practice still has a place for pioneers and is far from settled. Indeed it is difficult to define and, in John Hasler's prime, academics rolled up their sleeves in their practices, taught students and did research in their spare time. In her paper, Ann-Louise Kinmonth makes an unashamed case for a professional, confident, relevant and multidisciplinary approach to research in general practice. She describes the British Family Heart Study and the insights gleaned from the study of Type 2 diabetes as examples of good questions arising in general practice which needed a multidisciplinary approach to find answers.

Some years ago, John Hasler resigned as chairman of the Royal College of General Practitioners and went on to contribute to general practice at the personal, professional, and educational levels. He seems to have recognized that success and failure are both imposters, which must rank as one of his greatest contributions to the future leadership in general practice.

Tom O'Dowd

uk council, june 1999

Queen's Birthday Honours
Council was pleased to congratulate a number of College members and friends of the College who were recognized in the Queen's Birthday Honours List, including:
Prof Lesley Southgate DBE
Dr Angela Lennox MBE
Dr Chris Drinkwater CBE
Lt Col Jennifer Wells OBE
Dr Gerard Dolan MBE

College Locum Rates
Tony Mathie introduced a paper setting out the difficulties faced by the College following the BMA's decision to increase the suggested rate for self-employed locums by 52% after the College had set its budget for the year 1999-2000. Tony proposes that, for the current year, the budget is increased by 5% to enable greater flexibility for budget-holders in meeting claims for locum payments and that the maximum limit for payment of self-employed locums will be increased to £250 per day and to £200 per day for practice partners. In endorsing these proposals, Council noted that the intention is that, for the financial year 2000-2001, locum payments of £250 and £200 would be met, subject to an appropriate recasting of the budget in December 1999. Tony will shortly issue a letter to members of College working groups and College examiners detailing his proposals. If you would like further details, please get in touch with Dawn Jenkinson, Central Secretariat, extension 246.

Council Membership
Council congratulated the successful candidates in the national ballot for election to Council: Dr Graham Archard, Dr Tony Downes, Dr David Haslam, Professor Jacky Hayden, Dr Brian Keighley, and Dr John Toby.

Premises for Scottish Council
Council noted that progress was being made on the purchase by the College of premises in Edinburgh and that it was hoped to take entry to the property in Queen Street later in the summer.

Changes in Access to Primary Care
Mike Pringle introduced a paper on two recent initiatives from the Government: Walk-in Centres and NHS Direct. These will cost around £280 million over the next three years and will involve the setting up of 20 Walk-in Centres, to be run by Primary Care Groups (England), Local Health Groups (Wales), Co-operatives (Scotland), general practitioners, GP co-operatives, or other NHS bodies such as NHS Trusts. In acknowledging that there have been societal changes over the last 30 years or so whereby the public had access to services such as shopping and banking 24 hours a day, Council noted that primary care had proved flexible in the past by responding to patient demand in an innovative way. There is a danger that Walk-in Centres might lead to a duplication of services and to an erosion of two of the strengths of primary care: continuity of care and equity of access to care. Experience in other countries suggests that Walk-in Centres are a negative innovation and only deal with a small proportion of patients at a comparatively high cost in terms of resources. In broadly endorsing the paper, Council asked that a revised paper be brought to September Council which will separate the issues of Walk-in Centres and NHS Direct, set out criteria for Walk-in Centres suggesting how they might be evaluated, and set out some alternatives from within existing primary care as to how the needs of a small proportion of patients, such as inner city workers, might be met.

I reported on the continuing work of the National Advisory Group on NHS Direct and of the Primary Care Group that reports to it. Council took the view that NHS Direct may have benefits for patients and primary care by helping the public make more appropriate use of health and social services. It was disappointed to note that projects such as Walk-in Centres and NHS Direct were often introduced without consultation with the relevant professions and without proper evaluation procedures being set up. I will continue to report to Council on the work of the Advisory Group.

Review of Prescribing
Council noted the College response to the Crown Review of Prescribing, Supply and Administration of Medicines. In broadly welcoming the main recommendations of the Report, such as the introduction of dependent prescribers to complement the existing independent general practitioner prescribers, Council was concerned that the central lifelong health record and its confidentiality should be maintained and that the lines of accountability between the health professionals involved, such as practitioners, nurses and pharmacists, should be clear.

Primary Care Groups and Primary Care Trusts (PCTs)
Mike Pringle introduced his revised paper on the main issues that would need to be considered by a Primary Care Group in England in deciding whether to change to the status of a Primary Care Trust. Whereas there may be some advantages in having greater freedom to develop primary care and local community and social services, there could be some difficulties with resources, the weakening of personal care at practice level, and a dilution of the influence of general practice in a PCT. Council endorsed the paper and asked that it have as wide a distribution as possible, including the Faculties, postgraduate and undergraduate departments, PCGs, and others.

Rationing
Council noted that Mike Pringle's paper on Rationing, which contains a detailed review of the issues and is intended to provide an understanding of the theoretical and academic background to the issue, would be published shortly and would be sent to Council members, the Faculties, the General Practitioners Committee, the Academy of Medical Royal Colleges, and others.

Review of Examination for Membership
Roger Neighbour, Convenor of the Panel of Examiners, introduced a paper setting out the current academic state of the Examination for Membership and the resources required to ensure its continued development. Council was pleased to note the robust health of the modular format of the Examination and that the paper would form the basis of the College's application to the Joint Committee for approval of the College's Examination for the purposes of summative assessment. Council agreed to the setting up of a working group with the remit of drawing up a plan to ensure the Examination's administrative and financial base and to the continued review of the content of the Examination by the Examination Board.

MRCGP International
Council welcomed a paper from Philip Evans, Chairman of the International Committee, setting out proposals, resulting from requests from doctors overseas, concerning the establishing of an international examination which would examine candidates with overseas qualifications in their own countries. Philip emphasized that such a qualification would not give members who become MRCGP(Int) rights concerning governance of the College or the right to practise in the United Kingdom, would not be a financial burden to the College and would be a recognition of the standard of practice applicable to each country. Council agreed to the further development of MRCGP(Int) and to the appropriate constitutional changes being submitted to the 1999 AGM.

Editor of the *British Journal of General Practice*
Council noted the timetable for the appointment of the new editor of the College

Journal. An advertisement will appear in the July issue of the *BJGP* and the *BMJ* with interviews to take place in early September. Council warmly thanked Alastair Wright on completing nine years as Editor of the *Journal* and for all his hard work in the post.

Changes to Vocational Training for General Practice

Mike Pringle introduced a paper setting out some priority changes in Vocational Training for General Practice. These are intended to increase flexibility in the duration and the end-point of vocational training and support higher professional education in the transition period after vocational training. Flexibility would include vocational training being a minimum of three years and a maximum of four with the opportunity to spend a maximum of two years in general practice. Support to higher professional education would involve the creation of a system of HPE whereby doctors on completion of vocational training would spend a half day a week for the next two years (30 days in all) in developing their professional needs, thus establishing a commitment to lifelong learning and entry to the system of validation and revalidation. Council noted that this paper was intended for the review of SHO training being carried out by the Department of Health's Advisory Group on Medical Education, Training and Staffing (AGMETS). Council endorsed a more fundamental and long-term review of VT by the Vocational Training Working Group of the Education Network.

Academic General Practice

Council approved a joint paper from the College, AUDGP, COGPED and UKCRA which sets out a model for an academic career structure. The paper states that many doctors now pursue 'portfolio careers' and that as the number of non-principals increases the link between senior academic status and principal status may limit flexibility. The paper proposes that recruitment and retention of academic general practitioners should be enhanced by comparable career structures and rewards to other academic disciplines where employment is within the university system, and that regional offices should plan the most cost-effective and co-ordinated methods of integrating funded academic primary care via SIFT, MADEL etc., taking account of the new PCG structures and their Scottish and Welsh equivalents.

College 50th Anniversary

The College's 50th Anniversary runs from November 2001-2002. There will not be a guest (non-medical) President. A working group will be established to look at possible activities for the year.

Next Meeting of Council

The next meeting of Council is set for Saturday 18 September 1999 at Princes Gate.

Bill Reith

Neville Goodman

Computer Literacy

Writing's been difficult recently. Time was when I always carried a clutch pencil; I wrote on lined paper. The pencil's inbuilt eraser was useful, but usually I just crossed out and rewrote above or below. My briefcase always contained a sheaf of half-finished articles (to be honest, some of them were better described as 'barely started') and, given an odd moment, I'd add a sentence or two to one of them.

Then came the computer, and the word processor began its seduction. Not so easy at first, having to insert _ul before and after words needing underlining, but later versions soon did away with that awkwardness — and anyway, underlining was about the most complex thing the word processor could do. The word processor had to be loaded into the computer from a floppy disk (eight and a half inches diameter and 20 Kb per side) and configured before each use. At the same time, I was writing my own programs for various research projects. I wrote them in BASIC (a computer language roughly interpretable by someone who could read English), in assembly language (a computer language requiring frequent recourse to large ring-back binders explaining what three-letter commands such as STA and JMP meant), and in machine code (a language interpretable only by people with 16 fingers on each hand to help them count in hexadecimal). I was computer literate.

I upgraded my computer. The system software was a bit more sophisticated, but all programs still had to be loaded one by one. It was possible, by knowing what you were doing (which I did: I was computer literate), to get the programs to link with one another. Modems were around; they transferred data, but only incredibly slowly (it seemed fast at the time) and only after paying careful attention to initialization strings, handshakes, and parity.

I've moved on two generations since then. The computer comes loaded with its software, modem and all, already configured in subtle ways that make it impossible to do anything unless Bill Gates wants it done that way. Alter one part of the configuration (provided you can find it), and it simply reverts unless you alter all the interlinking parts.

Once upon a time, only the computer literate could use computers. Now, anyone can. The original computer literates are strangers in a strange land, bereft of the skill to use pencil and paper legibly, and at the mercy of automatic but incorrect changes of spelling and case.

Writing's been difficult recently.

Nev.W.Goodman@bris.ac.uk

our contributors

Professor **Yvonne Carter** is chair of the RCGP Research Network

Morris Gallagher is a GP in South Shields and recently started an MD at the University of Newcastle

Paul Keeley earned his spurs as a GP registrar in Leeds and Glasgow. He is presently a specialist registrar in palliative medicine

Maureen Kelly works part time as a lecturer in the department of general practice, NUI Galway, and in clinical practice in County Clare

Toby Lipman is a GP in Westerhope, Newcastle upon Tyne. He is incurably optimistic about the potential of general practice and, within it, the role of EBM. Unsurprisingly he needs tolerant partners, required on occasions to listen to his attempts to play Paganini on his violin

Andrew Lobunov was born in the Siberian city of Kemerovo and graduated from the Medical Institute in 1986. With his wife Rozanna and two-month-old daughter he moved to St Petersburg where he worked as a paediatritian ... "But the salary could not allow us to pay our family bills and we decided to run a small business, by selling different stuff (coats, shoes, and other Chinese rubbish) for a short period of time. It was OK in terms of finance but we missed our profession very much and one day decided to switch to private medicine." In 1994 Andrew completed courses in the St Petersburg Medical Academy of Postgraduate Study) and was certified as a GP family doctor. Since then he has spent seven months in the US studying at Iowa State University department of Family Medicine, and in 1997 was awarded the RCGP Katherina Von Kuenssberg Award

Frank Minns will spend his summer visiting galleries at the behest of the *BJGP*

Alan Munro is at last on-line — alan.munro@virgin.net

Tom O'Dowd is professor of general practice at Trinity College, Dublin.

Katja Shlyakhter is a GP, and an assistant professor in the department of Family Medicine at the St Petersburg Medical Academy for Postgraduate Studies (MAPS). She loves people, her patients, her two children, medicine, English, and freedom.

Peter Toon is editor of RCGP Publications. His new Occasional Paper, *Towards a Philosophy of General Practice: a Study of the Virtuous Practitioner*, will be reviewed in a forthcoming issue of the *BJGP*

All our contributors can be contacted via the Journal office

Alan Munro

Kathmandu

Thamel is Kathmandu's Western tourist enclave. From a first floor café I look down on a busy intersection and breathe the dust of the street mingling with the stuttered fumes of motorized rickshaws and the ever-present whiff of incense. I fiddle with a pot of yoghurt and mango. I ought to write a novel, or a postcard. Tomorrow, perhaps. Or marry this waitress?

Thin, wary-eyed, dark skinned Tibetan carpet sellers, their long black hair wound round their heads like turbans, do business with tiny immaculate Indian ladies in flaming saris. Among them, lumpy Caucasians lope, inelegantly monopolizing more than their fair share of space. A policeman lets down the tyre of a pedal rickshaw for some unknowable transgression. His baton looks capable of delivering summary justice on more serious counts. In tiny shops tourists are harvested for dollars. How does she float from table to table without the least sign of mortal effort?

On the terrace opposite, among potted plants, Marlborough umbrellas, Coke signs, Kodak and Fuji ads, and sundry invitations to alcoholic adventures, exclusively pale people adopt languid poses (all thinking about our novels?). The face of the millennium gazes on the street below. Perfectly anonymous, her shades reveal only a flawless complexion delicately tanned as if by the softest kiss from the breath of the sun, or sun lamp, framed by immaculately symmetrical long, straight, blonde hair. Closer to me, another girl bends across a table, back as straight as bamboo, each movement as perfect as the flicker of a leaf in spring sun.

A lone traveller, bespectacled, fidgety and diffident, orders food. An American couple complain bitterly of the lack of garlic bread. Waiters beam inscrutable incomprehension. The eventual delivery of the missing bread nudges the vegetable curry, spilling a little just where an arm might naturally rest. The lone traveller, he must be called Woody, looks less and less at ease, unpractised in the art of waiting, gracefully, waiting.

... It's in! The American's arm is in the curry, watch strap and all! Before he draws breath, a waiter is at his elbow to wipe up, efficiently, wordlessly. Woody, who was showing signs of imminent implosion, is served with calm, deliberate, elaborate ceremony.

A body, a dead body, wrapped tightly in cloth which once was white, its contours unmistakably and shockingly human, is carried quickly past on a bare board, on the shoulders of a few men, each one thin, bony, barefoot, ragged. The waitresses have changed shift.

I pay, and find that I have tipped more modestly than I thought I might. It leaves a rupee or two for the leper outside. Getting up to go, I glimpse Woody convulsing in the corner. He'll know that chilli sauce bottle if he meets it again, in this or any other life.

Quickening

for Roísín

When you first said hello,
You were a tiny, bright, shooting star
Deep in the black
Universe of my womb.

You were the instant
Two soap bubbles
Meet and make one.

You were the minute,
Barely perceptible,
Touch of a blinking eyelash.

It was your first hello,
I knew you were there
And my heart missed a beat

Maureen Kelly

Expecting

My hands rest upon her ripening womb,
your head nudges below then between,
and your whole life slips abroad before me
until the day I will take your head
again between my gnarling hands,
kiss you finally on the lips,
and our worlds diverge.

Blair Smith