The Back Pages

viewpoint

Flying too close to the sun

ANOTHER Saturday morning surgery and what should I find on the desk but a BTS STATEMENT (sic), hot off the pages of *Thorax*. 'Managing passengers with respiratory disease planning air travel: British Thoracic Society recommendations.[1] It is a classic of its kind: 'There is currently insufficient evidence to produce formal guidelines', but that's not going to stop them trying. The authors term their conclusions 'recommendations', not guidelines, and assume that lawyers will respect the difference. (One day, when I grow up, Daddy, can I be a National Service Framework?) The guidance is for respiratory physicians, who are naturally the first port of call for wheezy bronchitics with angina before they head for Disney World. For primary care there is a 'summary of recommendations' available online at *Thorax* (**www.thoraxjnl.com**, though the day I subsequently look it up *Thorax* insists that I subscribe) and also at the British Thoracic Society's (rather excellent) site.[2]

Some of it is quite sensible — passengers to carry inhalers in hand luggage, discourage the actively tuberculous, etc. Then things start to go downhill. Who, for example, needs pre-flight assessment? Among others, severe COPD/asthmatics (though definitions of severity are not supplied). That's an awful lot of people for starters, then even more when you add 'co-morbity with other conditions worsened by hypoxaemia' (cerebrovascular disease, coronary heart disease, heart failure). We are now accounting for a significant proportion of the population of Lanarkshire (approximately 500 000), a population served by six respiratory physicians.[3] And what pre-flight assessment is recommended?

1. History and examination 'with particular reference to cardiorespiratory disease, dyspnoea, and previous flying experience'. Fair enough, but when, and where, and who pays?
2. Spirometric tests (but, thankfully, 'in non-tuberculous patients only') Present waiting time for spirometry in my area is six to eight weeks, and rising.
3. And the punchline, 'measurement of SpO_2 by pulse oximetry, though blood gas tensions are preferred if hypercapnia is known or suspected'. If SpO_2 is less than 95% further testing may include the 50-metre walk test, or 'regression equations predicting PaO_2 or SpO_2 from sea level measurements', or hypoxic challenge simulating cabin conditions using 15% oxygen. In Scotland, hypoxic challenge is available at only two locations, at the Western General Hospital in Edinburgh, and at Glasgow Royal Infirmary — general practitioners do not have direct access to either clinic, and the waiting time for patients via their local respiratory physicians is approximately three months.

What is the evidence base for all three recommendations? Every recommendation in the report is graded A to C, with A at the RCT end of the spectrum, and C as 'evidence from expert committee reports' (such as the British Thoracic Society Standards of Care Committee, perchance?) 'or opinions and/or clinical experience of respected authorities' (ditto?). All three components of recommended pre-flight assessment are awarded straight Cs. Into such a soft bog sinks the NHS's less than world-class respiratory services. (Inevitably this vital information has to be recorded somewhere, and the authors usefully include British Airways' medical information sheet, MEDIF. Well, sheets actually, though only page 2 need be completed by an 'attending physician'. 'Completion of the form in block letters or by typewriter will be appreciated', and there are over 30 data fields to doodle in. I could reproduce the form here, but attending physicians everywhere will get the chance quite soon to contemplate an original.)

Finally who are these 'respected authorites', and to what extent was primary care consulted? Well, there are 11 authors listed, including one wing commander and two professors, and not a GP in sight. Listed separately, are 18 members of the 'reviewing group', including the excellently named Professor Spiro of the Respiratory Medicine Group, Royal College of Physicians, London; and just two GPs.

Perhaps a healthier dose of primary care reality could have improved matters, producing a slimmer document of some utility. As it is, the BTS recommendations are a steaming pile of unachievable nonsense. For patients, GPs and hard-pressed grassroot respiratory physicians, life becomes more complicated, not simplified. Just Say No!

Alec Logan

References

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2. Summary of recommendations for general practitioners at website of British Thoracic Society. URL: **www.brit-thoracic.org.uk**
3. Tan S, Consultant Respiratory Physician, Wishaw General Hospital, personal communication.

"Dour Puritan views that if you are not miserable you must be sinning are so powerful still in our post-Protestant society that many people find it hard to accept that doing right does not necessarily involve suffering."

Peter Toon *on virtue ethics*, page 694

"In daily practice we continually encounter the phenomenon that people do not fit neatly into boxes built for pigeons, and so, inevitably, pigeon-holing patients is frequently impossible."

Wendy-Jane Walton, Cum Scientia Caritas, page 696

"When he wanted to be tactful he gave patients the bad news in Latin."

Iain Bamforth, *digressing on Charcot's communication skills*, page 700

contents

Quality care through clinical evidence — The SAPC Annual Scientific Meeting in Birmingham

THE **Society for Academic Primary Care** (SAPC) is the new name for the Association of University Departments of General Practice (AUDGP). The SAPC aims to promote excellence in research, education, and policy development in general practice and primary health care and membership is open to any individual who supports this aim. This change of name was instigated by the membership and reflects a desire by the Society to be inclusive, welcoming members from any corner of the field of primary care. In this, we hope to continue the progress of primary care teaching and research, strengthening the educational and evidence base of our discipline, and contributing to improving patient care.

For two or three decades, the AUDGP has been present at most stages in the advance of the discipline now recognised as academic primary care. From humble origins and a few enthusiastic individuals, this discipline has now expanded to include at least 35 university departments of primary care in the UK and Ireland, hosting at least 100 professors. Over time, primary care has grown in capacity, increased its profile, and changed its composition. University departments have contributed to and reflected these changes, and are at the heart of primary care research and teaching, leading activity that now also extends beyond the walls of these institutions. The change to the SAPC represents mainly a change from membership based on university departments to individual membership. Many of these members will be based in universities, but others will come from research or teaching practices, research networks, postgraduate deaneries, and other organisations involved in primary care, including many disciplines other than medicine.

The SAPC influences and is consulted by decision makers on matters important to the conduct and funding of academic primary care, and wider issues. The Annual Scientific Meeting (reported in this issue) is one of the premier primary care conferences. The SAPC also supports its individual members through educational and career development. Finally, the SAPC provides a network of people with shared aims and common experiences throughout the UK and Ireland.

For further information, contact **office@sapc.ac.uk** or see **www.sapc.ac.uk.**

THE flagship of the Society for Academic Primary Care (SAPC) is its Annual Scientific Meeting. This acts as a showcase for the SAPC, and is the forum in which high quality research and educational issues are aired. As such, it provides a benchmark for assessing (and indeed celebrating) the development and current state of the discipline of academic primary care. For academics and other interested parties who attend it provides a forum for presenting and disseminating work, for learning and for networking, and for socialising with colleagues. This year's gathering was held in early July and hosted by the Birmingham department in the splendour of the International Convention Centre in Birmingham. Over two days there were 120 oral papers, 80 posters, nine workshops, two keynote presentations, and royalty thrown in (it was so nice of Her Majesty the Queen to coincide her Jubilee visit to Birmingham with our meeting).

Good keynote speakers are hard to find. Their task is to entertain, educate, and stimulate. Richard Dawkins did exactly that. The media-friendly Chair of the Public Understanding of Science at Oxford provided the assembled throng with an understanding of how natural selection is important to patients and to pathogens. Given that the purpose of every organism is to 'become an ancestor', a need to survive to parenthood is necessary. Many examples of how natural selection played a role in this process were presented. These included how developing a fever in response to an infection confers an evolutionary benefit to the host by providing a more hostile environment for the pathogen to attempt to survive in. Perhaps true Darwinians should keep the Calpol on hold for the benefit of the species. Questions followed, and this led into a surreal discussion on the advantages and disadvantages (from an evolutionary perspective of course) of the possession of large testicles. Overall it was a provoking keynote speech that set the tone for what was to prove to be an excellent meeting.

As ever, clinical topics predominated. However there was an unequal distribution of papers between clinical topics. Cardiovascular disease predominated, followed by diabetes and mental health (quite a bit), respiratory illness (a fair smattering) minor illness and women's health (not much), rheumatology and ENT (a few papers), and cancer (none). This disparity may be the result of the nature of research funding, of researchers choosing easy areas to research, or of true primary care research priorities. You choose, but I don't think it is the latter. Rather disappointingly, there was much research *about* patients, but very little research *involving* patients. This reflects the nature of our specialty, but is especially stark in comparison with other medical specialties, and is something that we need to address.

There were many highlights. Probably top of my list was the series of papers from Chris Salisbury's team in Bristol on the evaluation of NHS walk-in centres. Data were presented on all aspects of their use and clinical outcomes from them, and demonstrated the richness of different methodological approaches that typifies primary care research. While the results were in many ways predictable (such as, that middle-aged white men used walk-ins proportionately more than they did general practice), many were not (such as, that walk-ins seemed to create a new demand, rather than to mop up demand from elsewhere). Other findings were more controversial: the comparison of nurses' versus doctors' performance provoked vigourous defence of general practitioners on methodological grounds. Let us hope that the future of walk-in centres is a more evidence-based policy decision than their introduction was. The evidence is clearly there for this to happen.

In terms of designing a relatively simple study whose findings will have potentially profound implications, the prize goes to the Paul Little's Southampton team for their work on GPs' recording of blood pressure. GPs' sphygs may soon be relegated to museum exhibits. Lastly, a mention of Tom Kennedy for his work on CBT in irritable bowel syndrome. His wit and repartee combined with a robust study (research *involving* patients) showed us all how we should present our work. And I thought there were only so many bowel jokes.

Academic primary care appears to be thriving. Primary care academics should also be thriving after a particularly excellent battery recharge in Birmingham.

Richard Neal

Next year's ASM is in Manchester. Details of this and all other SAPC activities can be found at **www.sapc.ac.uk.**

Anthropology and the Health of Populations — global trends and local contexts

MEDICAL anthropology is the fastest growing sub-discipline of anthropology. It intersects with medicine, not only in its field of study but also in a shared deep interest in the combination of academic research with activism, the application of knowledge. Many of the leading medical anthropologists in the world, such as Arthur Kleinman, Cecil Helman, Robert Hahn, and Paul Farmer, are medically qualified. The latter two were keynote speakers at the Third International Medical Anthropology Conference, held at Brunel University in June. The subject of the conference was 'Anthropology and the Health of Populations: Global Trends and Local Contexts', and it brought together some 230 scientists from more than 30 different countries to discuss anthropological research on issues pertaining to health systems, public health, and medicine.

Anthropology can bring perspectives that are vital to the theory and practice of public health, from its traditional focus on ethnomedicine, to more critical political economy approaches to current public health issues.

One of the ways anthropologists can contribute is by querying 'who is the public in public health?', a question raised by Hahn in his opening address. For his part, Farmer focused on the health of the most impoverished and marginalised, a 'public' who suffer from systematic 'structural violence' that denies them equal access to 'First World' levels of health care. The health situation of marginalised people, and the challenges posed by HIV, tuberculosis, malaria, mental illness, and child malnutrition, were themes common to many presentations at the conference. Farmer emphasised the importance of analysing, not just risk disparities in a population with respect to a given disease, but also the odds of surviving risk (since it is overwhelmingly the poor who die of risk exposure).

Anthropologists explore not only health inequalities but also the innovative responses, coping strategies and social networks that people call upon to deal with them. However, at the conference it could be said that 'global trends' were often emphasised at the expense of such 'local contexts'.

One issue highlighted at the conference was the relationship betweenh anthropology and public health. Anthropology as a discipline tends to adapt chameleon-like to the disciplines with which it works (probably in the same way many anthropologists 'go native' in the field!). Some question the title 'medical anthropology' altogether and suggest 'health anthropology' or 'the anthropology of public health'. By becoming absorbed into public health or medicine in general ('anthropology for' rather than 'anthropology of'), there is a danger that the strengths of 'traditional' anthropology — long-term, in-depth qualitative and ethnographic research — are lost. Yet these are the very methods necessary if we are to describe and analyse the situation of the marginalised people Farmer champions.

Identity issues aside, the conference reflected the breadth and diversity of this growing sub-field, and the welcome involvement of many GPs and other UK health professionals in its development.

Doreen Montag
Catherine Panter-Brick
Andrew Russell

Intermediate care: where are we now?

INTERMEDIATE care (HSC 2001/01: LAC [2001]1) encompasses a range of residential, domiciliary or outpatient health and social care services at the interface between hospital and community to prevent admission, support discharge, and optimise independance. We gathered hopefully at the RCP in London to work out what happens next.

Gareth Jones, DoH Team Leader , shared his vision for the direction and pace of travel but acknowledged current services are patchy and lack coherence. He failed to justify the targets and milestones set out in NSF Standard 3 but vigorously countered the 'ghetto service indeterminate care marginalising older people' myth. Intermediate care is a response to a specific gap in the continuum of care and not a panacea for chronic disease management in the community. Or so he thought.

Ray Tallis championed older people's right to evidence-based specialist-led acute assessment and rehabilitation services, contrasting the level of evidence with the degree of investment in Intermediate Care. We were urged to read the Age Concern and British Geriatrics Society joint statement supporting an incremental approach integrating specialist services and targeting key groups where there is evidence of impact and outcomes. We heard about the role of a geriatrician in the community (isn't that what geriatricians are supposed to do? — Discuss. *Ed*) and about successful partnerships in community hospitals, care homes, nurse-led units and in community teams.

Alison Kitson of the RCN Institute chaired a panel discussion. No simple formulae for the clinical governance, training, accreditation, and resource issues are available.

Varying demography, geography, baseline service provision, and team dynamics may limit the transferability of local solutions. Or, in translation, let's be pragmatic and talk to each other.

A useful day, but the absence of multidisciplinary and multiagency participation was disappointing. And what about users and carers views? Surely these various stakeholders would have been best placed to answer the original question: Intermediate Care — where we are now? Or am I being too person-centred and joined up?

Anne Hendry

An oral history of general practice 3: Partnerships

Transcripts of interviews can be downloaded at the ScHARR website:

http://www.shef.ac.uk/~scharr/hpm/GS/

As I listened to Paisley's GPs talking about their partners I began to recognise the existence of practice-based oral traditions[1] that chart developments, including the changing pressures on partnerships. Before discussing these oral traditions in more detail, I want to make some general points about the history of partnerships.

In the second half of the 20th century, general practice experienced a long-term decline in the numbers of single-handed doctors and an increase in group partnerships, with the Family Doctor Charter accelerating 'the decline of single-handed practice'.[2] The new fees and payments introduced after 1965, including the group practice allowance that encouraged the emergence 'of larger partnerships of five, six and more doctors',[3] improved conditions, especially for younger partners whose exploitation prior to the Charter is so often recalled by older GPs.

The age profile of partnerships has also been significant in the experience of GPs. In one of Paisley's larger partnerships, five out of seven of the principals were around the same age and the practice only began to innovate when the last of the older GPs retired around 1992. A younger partner waited over ten years to make the changes he wanted — including the introduction of an appointments system.[4] However, almost all of the other practices in the town had partnerships with principals drawn from different generations and this not only influenced the ways in which practices responded to change, but also provided the basis for the transmission of oral traditions.

Most of the GPs talked about their early years in practice as apprenticeships, including those who became doctors after the 1960s and joined practices in which assistantships and working to parity had become limited, and even abandoned. And all of the youngest doctors in our interview collection could detail the range of mores and values that they were introduced to by older partners when they first began in practice.

The oral histories also typically contain a meta-narrative of improving partnership relationships, from earlier years when senior partners played an often authoritarian role that was often combined with paternalistic ways, to more recent egalitarian partnerships that are markedly less hierarchical and more democratic. Within this there are memories of comings and goings, mergers and splits. There are foundation myths describing the origins of a practice — sometimes involving a doctor whose eccentricities became retrospectively celebrated. Then there are narratives providing continuity in the shared values and beliefs of partners. There are the stories of conflict and compromise between those who sought and those who wanted to resist changes, especially in the ways practice was organised and patient care was delivered.

While medical family dynasties have been less of a major feature of general practice than might be thought,[5] the descriptions of partnerships in the GP interviews are similar to accounts of relationships found in family histories. It is usual, for example, for doctors to describe the history of a practice with a litany of the names (and the fates) of practice partners. Such lists commonly include details from a period prior to the interviewee's involvement in practice. These are partly based on details from patient records and partners' stories, although the memories of other members of the practice team and older patients are also passed on by word of mouth and play an important part in contributing to these, often unpublished, histories.

The descriptions of partnerships also contain metaphors drawn from family life and, to borrow a phrase from anthropology, suggest that partners think of one another as fictive kin (or members of psychological families). Fictive kinship occurs when people who are not related by birth or marriage have emotionally significant relationships. That partnerships involve emotional investment, as well as outlays in finance and labour, is evident in most of the recordings with Paisley's GPs. Recollections of practice splits repeatedly involve expressions of pain, bitterness, confusion, and anger for all involved.[6] Furthermore, it was observed over and over again that in the early years of joining a practice younger partners were treated like favoured sons or daughters. And successful partnerships are said to be like happy marriages, whereas divisions and splits are 'divorces'.

The existence of oral traditions describing partnership arrangements in terms of fictive kinship, along with the meta-narrative of progress, frames the ways in which changes and continuities in practice ideology can be discussed by doctors and other members of the practices. And these oral traditions also contribute to the identities of individual practices. So, for example, one practice in Paisley that had experienced an early increase in partnership size was known as 'the crazy gang'. More generally partnerships gain particular reputations both internally and externally, including as 'money makers' or 'carers' and as 'functional' or 'dysfunctional' groups.

Finally, a number of the GPs suggested that the most serious disputes between partners have occurred since the introduction of the 1990 contract and that problems are likely to arise as a result of disagreements about practice finance or workload. The fees and allowances system, that improved conditions after 1965, may now have become a source of conflict.

Graham Smith

The Wellcome Trust History of Medicine Programme funded the study.

References

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5. Thompson P. Introduction. In: Bornat J, Perks R, Thompson P, and Walmsley J (eds). *Oral history, health and welfare.* London: Routledge, 2000: 1-20. Only one of the Paisley's surviving practices has had three generations of a single family as partners, although there were instances of sons following fathers (pre-1965) and there were at least two practices in which husbands and wives worked as practice partners.
6. Many of the GPs have asked that the descriptions of partnerships are either reported with care or not released for specified time periods. Some of the recordings of practice splits cannot be revealed and some I have chosen not to recount, because of the impact they might have.
7. GPP 10.
8. GPP 23.
9. GPP 27.
10. GPP 16.
11. GPP 29.
12. GPP 22.
13. GPP 02.
14. GPP 24.
15. GPP 22.
16. GPP 25.
17. GPP 19.
18. GPP 28.
19. GPP 05.
20. GPP 08.
21. GPP 21.

The oral evidence

Charles McC: *'The old man* [his father] *went on until he was 90. Memories of the old man in practice? …He would move heaven and earth for somebody, but he also would throw somebody out the practice that annoyed him. …He wasn't easily beaten by things… He used to do blood sugars on diabetics in the 1920s… and he was doing this in the surgery'.*[7]

Robert B: *'I'll never forget it, because I was a bachelor for the first six months and got married in my second six months* [1964]. *But I was reprimanded for buying a fish supper when I finished my evening surgery* [laugh] *… This was, you know, infradig, you know for a doctor to go in and buy a fish supper …'*[8]

Looking back after many years of experience as a trainer, Gerard D recalls the role his partners had played in making him the doctor he is today.

Gerard D: *'I spent a fair bit of time asking and talking to partners at that time* [the early 1970s]. *More room, more time to do that in those days. So perhaps my kind of training was much more the old apprenticeship, although I was a partner …and I probably got my training that way.'*[9]

Paisley's GPs have tended to recruit potential partners among the University of Glasgow's graduates.

Douglas H: *'If you were tending to look for a partner in theory you would want to get someone you could work with and thought something like yourself. … When I joined Dr H* [in 1954] *he was someone I was already well acquainted with and knew I could work with therefore it was sensible to make a group practice of four. He was a year ahead of me in University.'*[10]

There were other routes to partnership. Jennifer W was returning to practice after the birth of her second child.

Jennifer W: *'Somebody was having a Tupperware Party … and Betty* [the wife of Douglas H] *said, "Oh Douglas is always looking for … people to help out". And I said, "Well tell him to give me a ring". So he did and I went to see him and he asked, "Is your family complete?" I said, "Yes it is"* [laughing]. *We chatted and I worked there for two or three months and then became a part-time partner. So I worked there from '73, until, I think, '92.'*[11]

Most GPs can report the partnership histories of their practices with ease.

Colin R: *'I was, I think, about the fifth or sixth new doctor since the practice started way back in about 1913. The earliest record we have on a patient is 1913, the earliest actual scribble written down on the old medical record envelope.'*[12]

Others recall the joys of entering practice. Christopher J, who began working with his first partners in 1987, remembers:

Christopher J: *'They were stuck in their ways, wild treatments. Sort of hated all change, disliked the College and all that sort of stuff. But at the same time open to change. They were aware of their own failings and what they were like. And they were fine and they were good and they were caring. They looked after patients and they had a good reputation. And it was just nice; it was nice coming to work for them. … The one who went part-time practiced more the medicine I fancied and the other one, who was the full-time one, kept it on the straight and narrow as regard to money and stuff like that. But he was very good, if I came along with hair-brained schemes he would say to me things like, "You haven't convinced me go away." Or he'd say, "Right we'll do it for six months and see what happens."'*[13]

Margaret G recalls working with her husband and a younger partner, Colin R, who continues to work in the practice:

Margaret G: *'He* [Angus] *was a very humble person really … I hope Colin didn't think we lorded it over him but I don't think so. We just were his equals.'*[14]

Colin R: *'There's no hierarchy. I am in name the senior partner because my name's at the top of the board. …The decisions are all made kind of, well, either unanimously or at least majority-wise when we have practice meetings. You know I don't have any more votes than anyone else. And that's always how it's been.'*[15]

In 1979, Andrew K joined two partners who had spent almost three decades together. His problems grew after one of the older partners retired and the other, who was in his 70s, stayed on. They were joined by a newly trained GP.

Andrew K: *'I turned the guns on what was my friend, my old partner and friend, and we had quite a close relationship before … it went a bit cold, … I distanced myself from, eh, more or less letting him know that you're not going to run the show here… My* [younger] *partner he was quite attached to him; he was a loveable rogue. … So I was then cast as the, eh, Big Daddy. That's what he used to call me, Big Daddy. I was the bad guy, if you like … and he was able to divide and rule very effectively. … My partner that I have now … we've been in partnership for about 18 years together. Stormy initially … I felt the draft from him. Initially I sided with this older doctor and the old ways, the comfort of it. Then I realised this is not practical and I shifted allegiance to the new, younger chap and from then on we were a very good relationship.'*[16]

Damian S entered a seven-handed practice in 1978. The practice was one of the largest in Paisley and unusually all the partners were around the same age.

Damian S: *'Because there was a group of these guys all the same age, the way they ran the practice was the way the practice was run for long enough. And really the major changes in the practice only occurred within the past three or four years … Again because you've got to respect these guys. They've been here a long time. ...Of course you have. And you can't just waltz in and expect everyone to change simply because you think what you think is right … and you'd be bottom of the popularity stakes if you tried to. So it was in a way very interesting practicing here when all around you everyone else was following the path of appointments, computers — computers, Good God — computerisation and things like that.'*[17]

Others have also found promoting change difficult.

Fiona T: *'There was a fair bit of conflict, because of wanting changes and* [I've] *not been willing to wait till everybody was happy ...ehem, probably a fair bit of conflict between her* [another partner] *and I over that. ...Ehem, although at the time I thought it was just the two of us, but it turned out it was everybody'* [laughs].[18]

Brian R: *'So we started talking about things like maternity leave and, ehem, that was just a conflagration, so we basically fell out at the practice agreement meetings. So the practice agreement meetings then became practice disagreement meetings and then they all just fizzled out. So basically we've got no written practice agreement.'*[19]

And disagreements can escalate.

Carol S: *'They* [splits] *weren't very common at all up to the 1990s. Then there were splits all over the place. …It ended up a two/two split and when there's a two/two split there's very little you can do, although there was a Practice Agreement. So it was a very unsettling and not a happy time. Ehem, there are quite a few break-ups in practices. I think a lot of changes. There was a difference in philosophy between John and myself. And* [pause] *it wasn't very pleasant, but anyhow, ehem, it actually worked out. It was amazing the coincidences that happen. From me being almost a nervous wreck and wondering what the future held …we had amalgamation. This was quite a bit of time after the break-up.'*[20]

John H: *My wife was pregnant just about to deliver. Ehem, I had bought a house in Paisley, I was settled here. I made friends here. My wife had made friends, and we weren't going to just sort of uproot all that. But all that was under threat, I think my whole life seemed to be under threat at the time.*[21]

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At one time medical ethics were thought of as including medical etiquette: not criticising colleagues, not consorting with unlicensed practitioners, and if you were a specialist, not seeing patients without referral from a GP, and — taking the precautions needed to avoid problems with the GMC — avoiding advertising, abortion, and sexual liaisons with patients. Anything else could safely be left to the good sense and character of doctors, who were generally thought to be 'good chaps' (and a handful of good 'chapesses').

In the 1970s concern that these chaps were not as good as they thought they were led to a more formal approach to the moral problems of medical practice, which drifted across the Atlantic from the USA as 'bioethics'. This involved applying the Enlightenment tradition of moral philosophy — Kantian deontology and the Utilitarian tradition of Bentham and Mill — to problems of clinical practice. There was (and to a large extent still is) a naively rationalist view among medical educationalists that having the philosophical skills needed to analyse the rights and duties in a situation, or to evaluate the consequences of a course of action, will make doctors behave better. Some even believed that it was unnecessary to grapple with the complex meta-ethics of deontology and consequentialism — all you needed was to clutch the 'four principles' of autonomy, justice, beneficience, and non-malificence,[1] like some secular St Patrick's Breastplate,[2] and all would be well.

Sadly, as Bristol,[3] Alder Hey,[4] a demoralised medical profession, and a society increasingly critical of doctors demonstrates, this is not so. Ironically, while medicine was embracing Enlightenment with its act-centred ethics, philosophers were becoming increasingly disillusioned with it and turned back to the older, pre-Enlightenment tradition of virtue ethics. This sees the central question of ethics not as 'what should I do in a particular situation?' but 'what sort of a person do I need to be to act rightly and to live a good life?' Character, not reason or duty, lies at the heart of the moral life, and acting rightly involves not suppressing the emotions by rational analysis of a situation, but aligning reason and emotion so that the whole person acts rightly, as naturally as breathing.

The optimistic hypothesis of virtue ethics is that the qualities needed to live a life good for the person living it, ('eudaemonia' in Greek, often translated as 'to flourish' — a pleasingly horticultural metaphor) are also those that are required to act rightly — a win–win situation.

To GPs exposed to Balint from birth, and so conscious of the impact of feelings and perceptions of doctors and patients on health and health care, this shift from Enlightenment rationalism will come as no surprise, but rather as a welcome acknowledgement of what they already know. To do what is right for our patients is not a matter of respecting their autonomy and acting beneficently towards them, but involves trying to see things from their perspective, understand what they are feeling with our feelings, and not just doing good to them but liking them (especially when they are particularly dislikeable). Acting justly in a health service where resources are limited (and that means all health services) is not merely a matter of counting quality-assured life years or having a rationing policy. It requires us to be able to judge justly on relevant grounds in each individual case, and not on whether we like the patient or they can exploit our sympathy.

This does not mean a return to ethics being just what good chaps do, neither does it mean abandoning rational thought about moral issues. Practical Wisdom, discussed in the first article of this series,[5] is a central component of the virtues (both a moral and an intellectual excellence, according to Aristotle).[6] It is necessary but not sufficient to ensure right action, which involves many other less rational virtues, such as temperance, courage, and benevolence.

The word 'virtue' has a rather prissy feel in popular usage, and it is important to be aware that this is not what it means in this context. Also, I must stress that for the virtue ethicist, the good life means not just a life that is good for other people, but also the best life a person can live for themselves. virtue is not about self denial or self

negation. On the contrary, the virtuous life is the one that is most personally fulfilling. Dour Puritan views that if you are not miserable you must be sinning are so powerful still in our post-Protestant society that many people find it hard to accept that doing right does not necessarily involve suffering. Nor does being virtuous mean being superhumanly good, but being humanly good. True, cultivating the virtues may not always be the easiest route (if a shrub is to flourish and bear its best flowers and fruit it does after all have to be pruned) but in the long term it is the best route to follow.

The distinction between claims of fact and claims of value is crucial to clear thinking about moral issues. Claims of fact are hypotheses about how things are; claims of value are statements about how things ought to be. In medicine it is common to find people trying to test a claim of value by empirical data collection — a method appropriate to claims of fact. Conversely, one sometimes finds philosophers trying to analyse claims of fact — for example, that a particular quality is needed to flourish in a particular context — by rational argument. The result often gives the impression of a slightly pompous Oxford don pontificating in the senior common room.

Macintyre, an important figure in the renaissance of virtue ethics, argues that the virtues can be seen as the qualities needed to obtain the 'internal goods' of 'practices'[7] — a term he uses for cooperative human activities. One practical implication of this idea is that virtues are the qualities needed to flourish in the practice of medicine. What flourishing as a medical practitioner means is an issue of value which needs philosophical analysis, but defining the qualities needed for such flourishing is at least partly an empirical issue, requiring the collection of data. Since medicine is a cooperative human activity, this data needs to be collected from those engaged in it. A preliminary attempt to do this will be described in the last article of this ethical quartet.

Peter Toon

Example: Dr A and Dr B

'See how the fates their gifts allot, for A is happy; B is not
Yet B is worthy, I dare say, of more prosperity than A.'

WS Gilbert – *The Mikado*

Dr A enjoys being a general practitioner. He looks forward to his surgeries, and the fascination of never knowing quite what the next patient to walk through the door will bring. Visits are particularly interesting, because though the clinical issues are usually fairly straightforward, they let him see the remarkable variety of ways people live. Of course not all problems are new and interesting — every day brings its crop of worried mothers with febrile children. But he finds that if he imagines what it feels like to be a mother with a crying two-year-old he can understand why she is anxious and needs his reassurance. He likes listening to patients — sometimes too much — and looking up the background on things he has just seen on the Internet in his consulting room. The receptionists complain that he often finishes late because of this.

True, the job has its drawbacks. Sometimes his heart sinks when he sees a name on the list and knows he will find it hard to cope with this demanding person. Saying no to drug addicts is always difficult, and he got beaten up once for his trouble. As he gets older he finds that he can't stay up late on Sunday nights or in the week, or drink more than a couple of G&Ts — if he does he is too tired to concentrate in surgery and finds himself getting tetchy. But he makes sure he always gets his half day when he plays squash, and he always returns refreshed from his holidays, skiing, lying on a beach or visiting cities to enjoy the architecture. He is a virtuous doctor and his patients love him.

Dr B is a conscientious general practitioner. He went into medicine because he wanted to spend his life doing good in the world, and he is sure that working in the deprived area where he has chosen to practice is the best way to do this. He runs his practice efficiently, and meets most of his targets for access and screening. He is punctilious about keeping to time in his surgeries. He finds this difficult, as he always takes care to be thorough. Firm policies on prescribing and using leaflets to promote self-care for minor ailments help to keep surgeries under control. His clinical competence is highly respected by his colleagues, and he spends several weekends each year on courses to fill gaps in his personal development plan. He is careful to keep up to date with the latest research and he is meticulous in implementing each National Service Framework as it comes out. He works hard in the evenings and at weekends, making sure the recall systems in his practice work well and that his team do all they can to

Cum scientia caritas

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LATIN as a language has the ability to encapsulate, in a neat three-word phrase, a weight of meaning that beggars easy translation. Is this 'caritas' love, as in the sense of charity expounded by Saint Paul ('So faith, hope, love abide, these three; but the greatest of these is love.'),[1] or does it simply imply caring in a more imprecise sense? And with 'scientia' — of which the literal translation is 'knowledge', are we in fact talking science, or does the sense of this word encompass more than mere facts?

Let us then suppose that an approximate rendition of this laudable sentiment might be 'caring with knowledge', and reflect on its implications and application in 21st century general practice.

We live and work in an age that has all the information in the world at its fingertips. We have instant access to billions of bytes of data that purport to give us the resources to practise evidence-based medicine, to prolong life and prevent ill health, to eliminate disease by the dissemination of knowledge and by education on lifestyles, to deliver instant, consumer-friendly health care to a population obsessed with the nuances of every bodily function and malfunction.

How does this burgeoning flow of information help us in our quest to deliver care to our patients? Or does it, in fact, help at all?

I visited a colleague in his consulting room recently and my attention was drawn to a quotation on his notice board: 'Where is the wisdom we have lost in knowledge? Where is the knowledge we have lost in information?' These words could have been written as a lament for the new millennium, but in fact, were penned by TS Eliot in 1934.[2]

How can we know our patients, so that we can truly care for them? Certainly without knowledge, and without information, we cannot begin to deliver a service, nor to claim to be practitioners of the art (rather than the science) of medicine. Getting to know someone takes time. It takes more than a ten-minute appointment under pressure. It takes years of learning and listening, of understanding the family dynamics and knowing the complex histories and inter-relationships that affect those who come to see us. It requires an understanding of cultures, belief systems and local geography and demography, and it requires the ability to question, to listen, and to watch.

The modern drivers of medical care emphasise the importance of measuring, of analysis and quantification, of the application of best evidence to any given collection of symptoms and signs. But in daily practice we continually encounter the phenomenon that people do not fit neatly into boxes built for pigeons, and so, inevitably, pigeon-holing patients is frequently impossible. It would be folly to try to categorise everybody while dispensing with those elements of knowledge about a person which cannot be conveniently coded. Per Hjortdahl, in an editorial in the *BJGP* said 'continuity of information and records is unlikely to replace continuity of care. The record contains mere information, while the doctor possesses integrated knowledge, much of which is tacit and gathered from several sources over time.'[3]

Browsing through a magazine recently, of the type found in doctors' waiting rooms, I read an interview with a very well known young female media star. I cannot remember who she was, and her identity is not really relevant. The only thing that stayed with me from the article were her final words. The interviewer had asked a question about her consumption of drugs and alcohol and her response was 'Oh no, never. My body is a temple and I worship it' My immediate reaction was 'sensible girl' and I thought no more of it at the time. Those words, however, subsequently came back to me with alarming clarity as the epitome of the modern culture of worship of the body that is echoed and reflected in 'evidence-based' health care. 'I worship … a temple'. I rush to the dictionary and look up the word and it is just as I thought. Temple: 'a building devoted to the worship, or regarded as the dwelling place, of a god or gods or other objects of religious reverence'. So worshipping the building itself, as opposed to the spirit that is housed therein, has become the modern day heresy, with which the 'science' of medicine, partially at least, and perhaps inadvertantly, colludes. The cult of the temple has become a religion in itself. Pursuing the analogy, in which all our efforts and energies are devoted to housekeeping, or temple maintenance, the establishment of National Service Frameworks for Coronary

Heart Disease and other physical ailments is the equivalent of a prescriptive programme of buildings maintenance and upkeep. Monitoring and reducing ischaemic heart disease equates to cleaning out the gutters and having the boiler serviced annually, keeping up the paintwork and interior and exterior decoration. Eminently sensible, and indeed desirable, if the purpose of the work involved is to honour the structure of the 'temple', thereby optimising its ability to function in its primary role, that is, as a dwelling place for the spirit. Ascetics might choose to argue against even the necessity of bodily sustenance, but the concept of maintenance loses all credibility if we fail to acknowledge that the body is the house or dwelling place of that much more needy and enduring entity, the human spirit. Maintaining empty temples and churches is a game for archeologists and historians, (or in medical parallel, perhaps, specialist surgeons), whereas our work daily brings us face to face with human beings in need of physical maintenance and restoration, which can only be fully achieved if conducted alongside a recognition and nurturing of their (and our own) spirit and humanity.

These are not things that can be achieved in walk-in centres, or by an out-of-hours telephone advice line. Of course, it should not be the doctor's role to provide a personal face-to-face service for every query and minor ailment, to every patient registered on the list; this would be neither desirable nor achievable. And yet, while patients still value a personal relationship with their doctor, GPs are encountering, in increasing numbers, 'a new brand of impatient patients'.[3] Much of the ill health of the people we serve stems from an obsession with maintaining the fabric of the temple at all cost, or at least effecting instant and urgent, patch-style repairs, while neglecting to acknowledge the presence of an inhabitant within the walls, and to recognise that the spirit requires nurturing, just as the body requires nourishing, if full health is ever to be attained.

10.20 pm at our local out-of-hours primary care centre. I have already seen nine patients whose complaints were unmemorable (for me, if not for them) and easily resolved in the short term. Hoping to make a prompt getaway I begin to tidy the bags and prepare to log off the computer, when another call appears on the screen. The name is very familiar to me although I realise that this girl probably left our list at least two years ago. The triage notes contain the essential information; 'distraught, can't cope, history unintelligible, may be suicidal'.

Laura is 20. Adopted in infancy from a deeply disadvantaged and abusive background, she was raised by caring parents who strove continually to contain her wayward behaviour, and were disappointed at her educational under-achievement. By the age of 15 years she had a promiscuous lifestyle, laying herself open to victimisation and abuse at the hands of a series of older men more than willing to take advantage. By 17 years she was a mother herself, looking pale, vulnerable and bemused when I visited her in hospital to carry out the neonatal examination. Congratulations were received with a big grin, but encouragement to breast feed might as well have been spoken in a foreign language as I looked for any spark of comprehension. She insisted on going home to the 'boyfriend' of the moment and it was not long before the health visitors were expressing concern about the baby's welfare, the attitude of the father, and Laura's ability to cope. Another baby followed after an interval barely consistent with the possibilities implied by the gestation calculator on my desk. Laura's parents, not in the best of health themselves, took over much of the care of the children while social services watched keenly as they observed bruises and scars each time the babies returned to their parents. Laura, determined to try to love and be loved, made fierce efforts to protect herself and the children, and attended her own wedding with facial bruises, directly after leaving a child protection case conference.

My own involvement with Laura and the children had ceased shortly after that as they moved out of the practice area, although I occasionally heard from her mother, who remained on our list, and I knew that things were not going well.

So on the evening in question I was equipped with some knowledge, and a background of trust as far as Laura was concerned. She sat in the waiting room, cowed, racked with sobs, a pitiful spectacle for the receptionist who had also been hoping to get home on time. I called her in and saw the spark of recognition as she heard a familiar voice and looked up to confirm the face that went with it. I put my arm around her shoulder and led her into the consulting room where for many minutes I sat and held her until the sobs quietened to a whimper and she was able to update me on her story. Her husband had continued to beat her and the children. She adored the babies but was locked into the cycle of abuse, and was unable to demonstrate a sustained ability to care for the children. They had been taken away for adoption, and she had drifted from her marriage to another abusive relationship, only to be abandoned once again to a solitude of which she was absolutely terrified. She had not eaten or slept for two days and was completely penniless. She expressed ideas of wanting to kill herself but had neither the means nor the motivation to carry it out. I offered up a silent prayer that the receptionist would tolerate some overtime, and let her talk. She was held and heard by a pair of caring hands and listening ears that returned neither judgment nor cruelty. She was offered words of condolence, hope and encouragement that were not to be found in any NICE guidelines or National Service Framework, and were probably based on no evidence whatsoever.

I recently heard it said that it is a mistake, and a potentially fatal one at that, to believe that mental illness can be cured by kindness. But there must be a proportion of patients who are labelled and treated as mentally ill because we do not have the time or the inclination to hear them out, and to try and understand. Laura was not mentally ill, but she was deeply wounded by life's cruelty.

When she left, sometime after 11 pm, it was with a smile on her face, almost dry eyes, and a small brown envelope containing something from the doctor's bag. I have often wondered about her since then, and, although I have no illusions that her life was changed, she did leave with a spark of hope where previously she had none. And I wonder which may have done her the most good; thirty minutes of being held and listened to, two tablets to help her sleep, or tomorrow's breakfast in the form of a £5 note. Cynics might say it would have been a breakfast of cigarettes and cider, but I have more faith than that, and I'm sure she'll remember. I just wish, in retrospect, that I'd left out the diazepam.

Cum scientia caritas. Cum tempo caritas.

Homelessness: a primary care response
Nat Wright
RCGP Books, 2002
PB, 174pp, £16.20 (members), £18.00 (non-members), 0 85084 277 8

On a recent night call, I was paged to the emergency room for one of 'our' patients: a 48-year-old homeless man, an alcoholic and cocaine abuser, who lived somewhere in town. He would show up every few months in the emergency room of our hospital with a blood pressure that terrified any new nurse who didn't know him. He was chronically ill with biomedical as well as socioeconomic and psychiatric problems.

As I read through Nat Wright's book I was encouraged to think differently about this vexing patient and his vexing problems. My practice, in Wright's taxonomy, is somewhere between a model 2 (interest in dealing with homeless but no systematic approach) and model 3 practice (an urban practice with many homeless by default and little interest in their care). The chief obstacle to transforming any practice in the United States to the model 1 (a general practice exclusively for the homeless) that Wright outlines is that GPs in the US function in a system that, unlike the UK, is not obligated to care for all citizens. Homeless patients in the US are either the objects of volunteer — usually religion-based — clinics with good intentions and few resources, or academic medical centres which function as the final common pathway for those who don't fit in society. Neither of these 'systems' are comprehensive and both patch holes in the medical care for homeless patients without being able to integrate these patients in the mainstream of community care. So I read Wright's book with both admiration and jealousy, knowing that it is unlikely that the US will see anything like the Personal Medical Services Scheme that the book presents, supported by either our government, insurance plans or society.

Although I know something about the origins of homelessness in our country and try to work with homeless patients in my own practice, the social history and overview of homelessness in the first section of Wright's book helped me gain some perspective on subsets of patients with particular problems as well as an individual patient who needs care. The chapter on the conflicts between a GP practice and homeless patients — of values, of behaviours, and of needs — takes the most feared (violence in the workplace or aggression of patients toward staff) or the most soul-depleting issues (non-compliant patients with mutual misunderstandings) and offers guidance and helpful options to managing these problems. In our practice recently, a young, suicidal, chronically mentally ill woman took a razor blade from her purse and threatened to cut herself. I sent the staff involved and my colleagues, the section on violence and aggression in chapter three of Wright's book.

Anyone who cares for patients with chronic mental illness, drug addiction or dependency, on top of many chronic health problems can benefit from the book's clear and accessible reviews of approaches to managing these problems. The sections on clinical problems are both thoughtful and practical. While well done, these sections are not the reason to have a copy of the book in one's office.

The 'primary care response' of the title is Wright and his colleagues' practice organisation in the Leeds Primary Care Centre for Homeless People. They describe in detail how what they have learned might be used by other practices to manage patients of a general practice who are homeless. The value of the book is less so that many others will replicate the Leeds model — they admit that it is a pilot programme which needs study and time to see its effectiveness — and, more so that lessons from the chapters on practice organisation, teamwork, and working with communities, can be applied to all practices.

We all can learn, for example, from Wright's suggestions for managing patients who don't tend to make appointments, who can be unruly or unco-operative, or who tax staff and physicians in ways that can be disruptive to team function. Wright also offers us ways to act hopefully with patients whose hopelessness can often wear down and harden their health care providers.

Homelessness: a primary care response is a book whose plan will be replicated by a few, whose approaches to patients will be used by many, and whose lessons and experiences should be read by all who work with homeless patients in communities. Shortly after finishing the book, I sent my copy to a new junior faculty member who is the medical director for a health centre for the homeless in a big city nearby. I told him that, if he is to turn his passion for the care of the homeless into scholarship which will affect health care in this country, he should model his work on Wright and the team from Leeds. And some day, rather than live off of foundations and charity, my young colleague might even be supported by our health system in his work. But neither he nor I are counting on it.

Meanwhile, we keep doing what we can.

John J Frey

david carvel

Out on a visit

A home visit was requested one morning for a man in his twenties. The receptionist logged it with the message 'unwell, cannot look at light, dehydrated, cannot get out of bed'. I had never met him but he was registered with me, so as soon as my surgery had finished, I got his file and checked his computer records. I reached his semi-detached council house, where he lived with his mother, within an hour of the request being made. There was no answer at the door so I rang from my mobile, only to hear it ring out in the house. All of the upstairs curtains were drawn and a car was in the driveway. Visiting the surrounding houses the neighbours described them as "private people' and said they had seen him the previous evening and that his mother was a domestic cleaner.

After half an hour of enquires, by which time I felt more like a detective than a doctor, I telephoned the police. The burly policeman who appeared stated a passing knowledge of my patient. Between us we phoned various people and places suggested to us in an effort to contact the mother but failed to find her. I explained that I was sufficiently concerned that my patient was unconscious or dead and felt that I had to gain entry. The rear door proved stronger than it looked. The overweight sergeant was probably rueing his lack of fitness, as by now he was as red as the door, his hat was askew and he had a respiratory rate giving me yet more cause for concern. A neighbour helpfully provided a crow bar, which until then I had never considered a useful tool for an on-call doctor.

Stepping gingerly over broken glass we discovered the house was empty and untidy which, with the door swinging on a single hinge, made it seem as if it had been burgled. Seething at this presumed misuse of medical services by the patient and his family I left the good policeman to keep guard and find a good joiner.

I returned to the surgery and, to my horror, discovered that the given address was elsewhere. It emerged that the patient had stayed overnight with a girlfriend. As I had duties elsewhere by this time, a colleague visited him, only to diagnose a self-limiting 'flu-like illness.

I spoke with his mother the following day to apologise about her door and explained that what I did was in her son's best interests, given the information I had at the time. The door was duly repaired at the local council's expense, despite my offer to them to contribute.

In the past, if a patient is out I leave a note requesting that they contact me as soon as possible. On these rare occasions it is usually because the patient has simply forgotten. Alternatively, the patient may have gone straight to hospital, but I had excluded this by checking with ambulance control.

My defence union had not heard of a similar situation but were aware of the converse, where a doctor had failed to see a patient only for him to be later found dead. With our system as it was, such scenarios could arise. The computer and paper records have the permanent given address but if the patient is said to be elsewhere this may be overlooked in the rush of retrieving notes for a myriad of visits. People, especially young adults, may have 'informal' sleeping or living arrangements or, at times of illness, stay elsewhere and we don't always have time to phone ahead to establish the facts.

Our receptionists now, when a visit is requested, note the telephone number and current address. Any discrepancies with our records are checked. Any changes, whether temporary or permanent, are highlighted in the visits book. When there is a possibility of a patient having meningitis or sounds very unwell the duty doctor is informed as soon as possible.

I believe I acted appropriately in these unusual circumstances. I telephoned the surgery confirming I had the right patient on the right day but unfortunately didn't confirm the address. I thought I had 'covered all bases' in the search for my patient, but perhaps not the most obvious.

My partners encouraged me to see the funny side of it. I suspect it is still talked about in the local pub.

In the Land of Pain
Alphonse Daudet (edited and translated by Julian Barnes)
Jonathan Cape, April 2002
HB, 87 pp, £10.00, ISBN 0 22406267 0

ALPHONSE Daudet (1840–1897) is a largely forgotten writer these days, even in France where, in his heyday, he was as well known as Zola, Maupassant, and Flaubert; poet, journalist, dramatist and novelist, he was acclaimed for his brilliantly sunny Provençal *divertissements*, such as *Tartarin de Tarascon* and *Lettres de mon Moulin*. Henry James called him 'the happiest novelist of his day'; Daudet's secretary said of him that he wanted to be 'nothing more than a vendor of happiness.'

If Daudet was a chronicler of the manners of civilisation, he also, along with many of his generation, suffered its alliances: he was a syphilitic. Probably infected shortly after arriving in Paris at the age of 17, the first symptoms of tertiary stage illness began to appear — in a time where conventional medical opinion was still sceptical about the link between early syphilis and its late manifestations — as 'rheumatism' in the early 1880s. In 1885, the great neurologist Charcot pronounced, with typical bluntness (when he wanted to be tactful he gave patients the bad news in Latin) what in effect was a death sentence, telling Daudet he was 'lost', though it took his tabes another 12 years to finish him off, causing him ever more pronounced pain, debility, and indignity. Daudet did the round of all the top medical men, went to the finest spas, suffered the latest treatments; one of which, the Seyre traction method, involved being suspended by the jaw alone; to no avail. Taking the waters was a ritual scented with euphemism: 'not once', he noted, 'has it ever been given its name.' At least he was a star patient, surrounded by scores of fellow ataxics to whom he administered encouragement and good cheer. He read Montaigne; and in private consumed huge amounts of morphine, chloral and bromide in an attempt to palliate his sometimes excruciating symptoms.

His other response to his illness was to keep a notebook of his sufferings, which was published in France only in 1930: this short book of observations on the social rituals of the spas, anecdotes about other patients, and comments on his own fears and hopes is what Julian Barnes has brought into an admirably unfussy English. Daudet called his intermittent jottings *La Doulou*, the Provençal word for *douleur*, pain. They may have been intended as notes for an essay, or even for a novel (Maupassant had set *Mont Auriol* in a spa); Daudet left them incomplete. And their tentativeness seems right: too much art would have been blunted their freshness. His remarks are not what we, in an age that has sentimentalised illness and therapy, might expect. 'Suffering is nothing', Daudet told his secretary, 'it's all a matter of preventing those you love from suffering.' Only an abominable egotist, he says in a dialogue that dramatises what he calls 'training' pain, would want to spoil the innocence of his children's lives by leaving them 'the memory of an old dad who was always moaning and complaining.' His sympathy enables him to be both sad and funny: 'I've come to understand the panicky indecision of some poor piece of human wreckage in the pool. Also the sad little cry of "Wait while I check" from some poor wretch feeling to see if his legs are still there.'

In taking pain as his subject, Daudet was as much commenting on the enterprise of being a writer as on his (we assume) unchosen fate of being a patient: he is obsessed by the duplicity of being what he called 'the second Me', an observer of the suffering, living, acting Me. This is his relationship to pain too, when he's not suffering it. For Daudet is no dolorist. One of his early comments makes it clear that pain as such is the enemy. If pain is a land, it is one without language or civility. Words, as Daudet notices, always come later, as a second-order phenomenon: indeed he comes to question the Greek motif 'Suffering is instructive' which stands as his epigraph. Suffering is ontological, on a quite different level of thought and memory from the felt experience called pain; and no, lots of it doesn't make anyone a better writer. It is perverse to imagine that life's meaning and mystery reside there, even if certain kinds of religious thinking, mind–body distinctions, or even the Marquis de Sade suggest pain is to secular civilisation what beauty was to Greek antiquity. It may now be that pain, as Thomas Szasz once suggested, is a communication system adapted for attracting attention in a society medicalised as never before. But that is another land; or more precisely, another polity.

In the Land of Pain is an attractive little book which will engage anyone who is a fan of the fastidious Julian Barnes (who came across it when he was researching for his novel *Flaubert's Parrot*), though it stands on its own as a chronicle of late 19th century responses to syphilis (less moralising and more complex that we might think, despite the euphemisms) and of a bravely self-critical response to a debilitating illness. That Daudet drills holes in his book by doubting about its purpose is to his credit. Who brings along a Baedeker to a place that doesn't just resist language, but wrecks it?

Iain Bamforth

roger neighbour - behind the lines

On contracts and panopticons

I love a nice metaphor, don't you? The 'Caritas' rose, for example, specially developed and named to mark 50 years of the College's presence on the block. *Cum scientia caritas*: 'where there is science, let flowers bloom' — how very sixties. I bought two of them. They are now flourishing in tubs on either side of the steps leading down from the decking where, Pimms in hand, I sprawl of a warm summer's eve, planning a little light gardening tomorrow. And the metaphor? The College rose, I discover, has a lovely scent but drops its petals in the slightest wind.

Equally deserving of being shoved outside in the rain and liberally sprinkled with manure is the new draft Contract, whose potential to transform the fortunes of general practice our negotiators have invited us to endorse in the first part of a two-stage referendum. Stage one: 'Is it a basis for detailed financial discussion?' Stage two: 'Finance being agreed, shall we go for it?' I and every colleague I've spoken to have been agonising over whether it's best to give the proposals the thumbs down right from the start, in order not to waste anybody's time, or leave the *nolle prosequi* until later, on the grounds that at least the powers that be can't then say we never even considered them.

June Council debated the proposals, which was good of it, given how little effective input the College has had into them. Council on these occasions always puts me in mind of the old Punch cartoon showing father and son on the beach, the former posed heroically at the breakers' edge. 'Roll on, thou mighty ocean, roll!', he apostrophises; and the boy gazes up at him admiringly, saying, 'Oh look, daddy, it's doing it.'

Members seemed all set to salute the new contract, early speakers 'Good show'-ing and 'Just the ticket'-ing in appreciative chorus. Then one of my favourite ladies, Iona Heath (whom I once delighted by nicknaming 'Tinkerbell', after the irascible fairy in *Peter Pan*), sprang to her incisive feet. If concrete-sounding things like outcome frameworks, quality ladders, controlled workloads and money were to be dumped on us, she suggested (and I paraphrase), general practice would in consequence suffer a debilitating loss of abstract nouns, such as freedom, humanity and — her own particular favourite — mystery. Attagirl. In the stiffening breeze of Iona's rhetoric, Council shed a few petals and adjourned to the kitchen to cook up some fudge.

All of which brings me naturally to Jeremy Bentham (1748–1832), English philosopher, economist and theoretical jurist, and to his best-known scheme — a design for a model prison called the 'Panopticon'.

Picture, if you will, a ring of individual cells each containing a single prisoner. The cells are well lit, having a large window in their outer wall and an even larger one facing inwards. The walls between adjacent cells are, however, solid; no inmate may catch sight of any other. At the centre of the ring is a control tower containing the guards, with blinds so arranged that, although every cell is at all times completely visible from the tower, the guards themselves cannot be seen. A prisoner in the Panopticon never knows for sure whether or not he is being watched. Indeed, the tower may often actually be empty. But the belief that he is under constant and omniscient scrutiny leads the inmate, in effect, to police himself. Isolated from his fellows, unable to organise or collaborate, and under conditions of constant visibility, real or imagined, his undesirable behaviour would wither and his errant spirit be tamed. The Panopticon, Bentham crowed, was 'a new mode of obtaining power of mind over mind, in a quantity hitherto without example'; its effects would be 'morals reformed, health preserved, industry invigorated, instruction diffused.'

Although the Panopticon was never built, we can be sure it would in fact have resulted in atrophy, not ennoblement, of the spirit — mindless compliance with the regime's expectations. Sullen acquiescence is not the same as endorsement freely and joyfully given.

Remember this when you read our proposed new Contract, especially the bits where it says that a light touch of central control will 'revitalise general practice and rekindle GPs' enthusiasm', while being 'based on high trust, low bureaucracy principles.'

Although Bentham conceived his Panopticon for the corrective discipline of criminals, the principle of 'the unseen overseer' can, as Michel Foucault points out,[1] be applied wherever many are to be controlled by few; for example, where recalcitrant children are to be controlled by teachers. Or disruptive demonstrators by police, or inefficient workers by time-and-motion consultants.

Or independent general practice by the Department of Health. I love a nice metaphor, don't you?

Reference

1. Foucault M. [Trans. Sheridan A.] *Discipline and Punish: the birth of the prison*. Penguin Books, 1991.

Teenagers and Primary Care

In view of the forthcoming National Service Framework for children and teenagers, we feel that training in this area would be particularly valuable and timely, and would enable GP trainers and Course Organisers as well as clinical governance leads in the PCTs to get a head start on this essential area of work.

A one-day training course, entitled 'Getting it Right for Teenagers in Primary Care', is therefore being held at the RCGP on 1 October 2002. Led by the RCGP Adolescent Working Party (PGEA applied for), the cost of the course is £80 and includes a resource pack, entitled 'Trust', a video, and lunch. Please contact Natalie Hutson in the Conferences and Courses section of the RCGP, tel 020 7581 3232 ext. 223; E-mail: **nhutson@rcgp. org.uk**

The Adolescent Working Party of the RCGP is also looking for new 'young blood' to join us. If you have a particular interest and/or experience in this area and would like to join this active friendly group please contact **ann.mcpherson@dphpc.ox.ac.uk** or Kathleen Dyer at RCGP Princes Gate,

The full report from UK Council, for those of you who like that sort of thing, is available from the RCGP website at **www.rcgp.org.uk**

UK Council, June 2002

Child protection
High profile cases such as the Victoria Climbié inquiry and the Lauren Wright Independent Health Review require an RCGP response, and support for GPs in child protection issues. Yvonne Carter will work with other similarly experienced members to supply guidance.

New General Medical Services (GMS) GP Contract Framework
The College has prepared comments on the framework for the new GMS contract. A draft commentary came to Council. We were fortunate to have with us John Chisholm, Chairman of the GPC, who was able to hear Council's views first hand. Trenchant discussion ensued.

The College confined its comments to areas of legitimate interest, such as quality, patient-centredness, academic basis of and evidence for the contract, and the workforce and career issues.

Education curriculum
Council continues to scrutinise the GP education curriculum with a current focus on where College assessments will sit within it. This is in anticipation of the publication of the report on Postgraduate Medical Education and Training Board (formerly called the Medical Education Standards Board), and the Senior House Officer Review. These will be seminal documents, with opportunities for the College. There are also risks. Unless we move quickly and positively, those opportunities might be lost. We must ensure, in particular, that the MRCGP is fit for purpose, and also the appropriate assessment at the right point in new structures. Developments on this will come forward rapidly over the next few months.

Modernising the NHS
We received reports from the four UK countries on how modernisation is, or is not, progressing.

The GP Workforce is now a huge issue in delivery under the modernisation plans. We have discussed extensively with our colleagues on GPC about how we can work together to offer our expertise to making the now fragmented workforce planning structures work better. There are significant problems across the UK following the demise of the Medical Practices Committee and specific issues in England. We have not had effective interface with these new structures and Council noted that our Chairman, David Haslam, is to write jointly with the Chairman of GPC, John Chisholm, to the NHS Chief Executive, England, to express our concerns.

Council was also clear that it is important to inform the public about the real problems that there are in the GP workforce, without this being portrayed as scaremongering. We will look to ways in which we can draw these issues to the attention of the public in a measured and informative way.

College interface with government
David Haslam drew to our attention difficulties which had arisen in recent weeks, where he had been asked, together with other medical leaders, to sign documents produced by government. Signing easily equates with endorsement. Governments have used such tactics in a number of instances in the past few years. When the *NHS Plan* for England was issued, the College drew up rules of engagement with government and others to ensure that we remained an independent and objective commentator. Those rules are now to be revised and renamed *Framework for Involvement*, not just with government, but where the College is asked, quite properly, for a view by other parties.

Reform of the GMC
The Department of Health has issued for consultation, a document which brings together various aspects of reform of the GMC, including the necessary changes to introduce revalidation, changes to registration, introduction of a licence to practise and changes to the governance of the GMC itself. Essentially, this brings together changes that we have been aware of, commented on over the last two years but we are asking for any further comments in order that we can put forward a comprehensive response.

Appraisal and revalidation
This is proceeding around the four constituent parts of the UK with varying degrees of urgency. Adequate resourcing of appraisal remains a key issue. On revalidation itself, GMC is moving towards implementation, and we will look at how best to support the process for College members. We proceed to finalise the document prepared many months ago under Mike Pringle's Chairmanship — *Criteria, Standards and Evidence for Revalidation*, helpful as a practical guide for members.

College Constitution Update Project
There has been a surprisingly large response to the constitution consultation and one with exception, the eight questions which were subject to consultation with members

Key vacancies

The Honorary Treasurer, Dr Tony Mathie, has indicated his intention to retire from office at the conclusion of the Council year 2002–2003. It is necessary, therefore, to identify his successor.

The custom is to appoint an Assistant Honorary Treasurer from this November who will, subject to approval by Council, succeed the Honorary Treasurer in November 2003. Nominations are now invited with a closing date of **noon on Friday, 30th August 2002**, to be submitted to the Returning Officer at the College. This is also displayed in the classified advertising section of the *British Journal of General Practice*.

Each candidate can submit a CV and a statement not exceeding 100 words. These will be circulated to all Council members in advance of the September Council meeting. Candidates will be invited to make an oral presentation at the September meeting after which voting will take place and an appointment made. Nomination forms can be obtained by emailing **corpaffairs@rcgp.org.uk**

If you would like any further information on the matters discussed above or any other issues we covered at Council then please do not hesitate to contact me. E-mail: honsec@rcgp.org.uk.

Maureen Baker

received a favourable response. The exception was the proposal to take powers to establish a connection with the College for UK health professionals where opinion was very much more divided. That is not to go forward. Council agreed that all the other proposals should go forward although there may need to be some small refinements. Council also agreed that International Fellowship (FRCGP Int), which was introduced by earlier changes to our Ordinances, should be equivalent to domestic fellowships.

Detailed drafting can now go forward and will come to Council in September for approval, and thence to the AGM in November.

GPs with a special interest
A joint document has been issued by the Department of Health and the College on implementing a scheme for GPs with a special interest. The College may be invited by the Department to develop frameworks for a number of areas of clinical interest. The College is happy to do this provided that the principles we have set for GPs with special interest can be maintained. We believe that such doctors are generalists, first and foremost GPs, and will normally work in a community setting. GPs with a special interest will be independent practitioners within a framework of accountability and clinical governance. We see the frameworks as emphasising a supportive educational role. In some instances this might include some form of qualification. However, qualifications, such as diplomas are likely to be the exception, at least in the short to medium term. It is also important that work by the College is fully funded and is seen as being of genuine support and relevance to members.

Further input will be forthcoming from the RCGP Education Network, with support from the Clinical and Special Projects Network, as well as analysis in the October issue of the *BJGP*)

Farewell
Council formally said farewell to Sarah Thewlis, our General Manager for the last eight years, and thanked her warmly for all the work she had done for the College. Sarah is moving on to become Chief Executive of the Nursing and Midwifery Council.

Maureen Baker
Honorary Secretary

neville goodman

Private crimes
They say 1 in a 100 people is dishonest. Social stratum is irrelevant; in general, there is a bad 1%. What differs between strata is the crimes they commit. Bad doctors evade taxes, or perhaps link up with dishonest solicitor friends for more serious financial scams; bad brickies steal VCRs or tell their friends where the VCRs are.

You'd have to nick a lot of videos to get your hands on $338 million, which is what Bernie Ebbers, chairman of WorldCom, took from his company as a 'loan'. WorldCom was the second largest telecommunications company in the USA. It crashed spectacularly after it was discovered that they had invented a trick even better than erecting beds in casualty departments to reduce the number of patients counted as trolley waits. They counted expenses as profits. Spent money was called earned money. Much of WorldCom's spent money was spent taking over and downsizing smaller companies. The salary rises of company directors being inversely linked to the relative number of lesser mortals remaining on the payroll, WorldCom's directors did spectacularly well. Salary rises in big business are obscenely large; they averaged over 15% in the UK in the last year. (Council workers have just been offered 3.3%, and are intending to go on strike.) But the salaries are peanuts. It's the share options that really fatten up the wallet. At WorldCom, as at Enron a few weeks before, the directors thought up an excellent wheeze. Realising that someone was catching on to the translocated profits and losses, they sold off their share options at the fraudulently inflated price, simultaneously preventing the workforce from selling any of theirs.

There are no general lessons to draw from this, except that some people are unimaginably greedy: what do you do with $338 million? Private or public, it's one in a hundred, but dishonesty has greater scope in the private sector. In the long run, the safest money is government money, which is our money. Stripped of the detail, this is why Professor Allyson Pollock, mentioned in this column in November last year, opposes PFI. The House of Commons Select Committee on Health criticised Pollock and her team, usurping parliamentary privilege with unwarranted slurs, said many academics on both sides of the Atlantic. It's about time Alan Milburn and Tony Blair accepted Pollock's sound economic evidence, abandoned PFI, and apologised for it. Home Secretary David Blunkett reflected, and abandoned widespread official access to e-mails, and that was only on weight of opinion, not evidence as such. If this government wants to lay claim to evidence-based policy it must act similarly.

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our contributors

Iain Bamforth only paid twice for the privilege of attending WONCA, London, where he presented memorably, despite food poisoning. He works and writes in France

John Frey is American, more specifically a professor of general practice from Wisconsin. He is the very antithesis of Henry Kissinger

Anne Hendry is a Stoke Physician, so-called, but is far too good to define herself so narrowly. She works in Lanarkshire

Saul Miller provides the *BJGP*'s monthly sheep joke, though on this occasion we're too tired to try. Will he escape from NSFs?

Doreen Montag is an anthropologist from Heidelburg, in Germany

Richard Neal is a senior lecturer in primary care oncology and a GP in Leeds. Once upon a time he won a BMA News Review Caption competition and a letter in the Guardian. He has since won 'photograph of the week' in GP. He is in training for a triathlon. **r.d.neal@leeds.ac.uk**

Roger Neighbour still awaits his Moet

Catherine Panter-Brick revels in the most exotic surname published in the *BJGP* for some time now. Inevitably, she too is an anthropologist, from Durham

Andrew Russell also anthropologises at Durham. More importantly, he's (just) a new dad, and everyone at the *BJGP* is all wobbly at the knees, and cheering. Our very best wishes!

Graham Smith is an oral historian at the School of Health and Related Research, University of Sheffield

Peter Toon is a non-principal GP and, since 1992, the RCGP's St Petersburg Fellow

Wendy-Jane Walton is a GP at the Marden Medical Practice in Shrewsbury, Shropshire

All of our contributors can be contacted via the Journal office at journal@rcgp.org.uk

saul miller

Out to lunch?

THE thing that really sold general practice to me was siesta time. That long lunchtime to sit out in the garden and admire the sweet scent of summer, the swooping of the swallows, the warm feel of the sun viewed through closed eyelids. I have never gone the whole hog and opened a bottle of wine but there really was that feel of Mediterranean time about the middle of the general practice day. Going back to the surgery to work on until early evening never seemed so bad after a good siesta. I am sure it is fairly obvious already why I am describing this in the past tense.

Admittedly, being a registrar is nothing like the same as being a principal: I was never so naïve as to expect anything else. Nevertheless, there is a limit. Not only has siesta time long gone but even so the day is not long enough. I am sure I am not alone in questioning the prevailing drift — getting home after dark is all very well in winter but not in summer. Let this not get gloomy though. I have a plan.

Once upon a time, it was believed that doctors had a sense of vocation, that they really cared about what they did for a living. That anyone who interfered with them as they went about their daily lives was a scoundrel and to be apprehended. Still, everyone knew that there were bad characters in the profession, but where there was any doubt, doctors got the benefit of it.

Nowadays the emphasis has shifted somewhat. Doctors no longer get the benefit of the doubt and the general perception is that most of them are scoundrels. All of which I might be prepared, grudgingly, to accept as true on behalf of my colleagues but certainly not if it also includes me.

Fewer and fewer GPs do old-fashioned on-calls now. In relation to this there is a general trend towards living outside one's practice area. The benefit of this seems to be the ability to keep a low profile, to present oneself as a manager or a lawyer to the neighbours and generally to avoid being linked to one's job. This idea of going to work, doing the job and escaping home again contrasts hugely with the idea of medicine as a vocation, as a way of life.

Curiously enough, just as medicine seems to be in the process of becoming just another job, a process strengthened no end by all of the energy-sapping initiatives that soak up siesta time, there are some countercurrents starting up. Think of the interest in medical ethics (ever heard of plumbing ethics?), and interest in the character-refining properties of the humanities. Even the *BJGP* has become less boring!

These highly influential currents all lead one way: to the idea that medicine is not just another job. You may not have to be an extraordinary person but you do have to care, not just about what you do but how you do it. In truth, you have to be, despite the existence of a few inevitable exceptions, a certain sort of character.

That's enough of theory, what of my plan? Good people work best in an environment where there is time to think about what they are doing. Flooding them with guidance, rules, and initiatives does not necessarily get the best results. On the other hand, a siesta does the trick nicely.

Jubilee Competition News ...

Jubilee compers were somewhat restricted by being given the wrong e-mail address. So full marks to Alan Shirley: for managing to submit an entry, for getting 11 titles, and, most magnificently of all, for getting three titles that I wasn't aware of. He deserves to know that the three he missed were 'How Long Will It Take' by the Plimsolls, 'Into the future' by The Vibrators, and 'Moving Targets', which was an LP by Penetration. The full list (my 11 plus his three) is available to anyone who mails me at **Nev.W.Goodman@bris.ac.uk**. And does anyone have a copy of 'Hotrod Lincoln', by Jane Bond and the Undercover Men?

Nev G