

The Back Pages

viewpoint

Why 'advanced access' is a retrograde step

Is 'advanced access' (AA) the solution to the perennial and growing problem of demand outstripping supply in NHS primary care? It has been seized upon with enthusiasm by our political masters who are insisting on its inclusion in the new GP contract. And with good reason (for them): adopting AA means that we will absorb an unlimited workload for limited remuneration.

The whole concept of AA, as taught by the National Primary Care Development Team and adapted from a USA business model, is built upon a number of logical fallacies.¹

First, the main reason given to justify its blanket introduction is that 'surveys show' that patients want rapid access. We all know that we want isn't necessarily good for us, but before I am accused of paternalism (heaven forbid that doctors should know best how to run their practices), ask yourself this: in how many of these surveys were patients asked whether, in return for rapid access for any problem, however trivial, they were prepared to pay the prices of (a) lack of choice of doctor, (b) being triaged away from the doctor, (c) telephone advice as a substitute for a face-to-face consultation and (d) lack of follow-up care and continuity? Practices and their patients are discovering that these are the consequences of prioritising rapid access, as complaints about lack of appointments are replaced by complaints about lack of choice and continuity. There is no such thing as a free lunch. The change of focus from long-term therapeutic relationships (whose benefits are intangible and difficult to measure) to short-term interventions may have unforeseen consequences for the future health of our patients, and for our own levels of job satisfaction (and thus recruitment and retention). Only time will tell.

Secondly, a central tenet is that 'once patients realise they can be seen any time, they stop booking just-in-case appointments'. I have yet to see any evidence for this assumption. It appears to be an article of faith. Did significant numbers of patients book 'just-in-case' appointments before AA? The simple truth is that we don't know, but I would guess not.

Thirdly, 'demand actually falls!'. Well, this is certainly **not** the experience in many practices, as our own experiences and the letters pages of the medical newspapers show. Of course, zealots normally counter that 'you are not doing it right'. It is thus impossible to disprove the tenets of AA, which accords them the scientific status of Freud's theories.

Fourthly, 'it's all about working smarter and not harder'. Really? Why, then, are we told to employ more locums to cover our absences? And at extra cost to ourselves, note. The measly incentive payments on offer cover a tiny fraction of these costs only. But there is a shortage of locums, so what do we do then? 'Get the nurse to do more triage'. And who is doing the doctors' and nurses' usual jobs while they're doing telephone triage (or 'blocking', as it is more accurately termed in the NHS)? What about evidence that telephone consultations are an inefficient use of time?² And assuming we can get a locum, are they willing to do open-ended surgeries?

Some practices do report benefits from the introduction of AA, and they get much one-sided coverage in the NHS-funded press. However, many do not benefit. The attempted universal imposition of AA, inadequately evaluated and uncritically accepted, is yet more evidence of clumsy over-interference from the political centre which is leading increasing numbers to question the future position of general practice within the NHS.

AA can, at best, help some practices with some aspects of their workload. But it does not justify the evangelical zeal of some of its proponents, for whom it seems to have almost religious status. If included in the future GP contract then it will hasten the development of primary care independent of the NHS, as increasing numbers of patients seek the quality personal care which AA threatens to devalue and erode.

Anthony Lamb

References

1. <http://www.npdt.org/AccessstoPrimaryCare/advancedaccess.pdf> (Accessed 24 September 2002.)
2. McKinstry B, Walker J, Campbell C, *et al.* Telephone consultations to manage requests for same-day appointments: a randomised controlled trial in two practices. *Br J Gen Pract* 2002; **52**: 306-310.

"I got bored with general practice; I missed the smell of ether ... that's why I went back in to the hospital service ..."

Paisley doc Patrick McC, on why he has 'outside interests', page 1039.

"... I am in a country that has become one of the poorest on earth. When I buy a beautiful, handmade chess set for £2, I realise that someone has spent over a week on it and that the shop makes a profit."

Gilles de Wildt on Moldova, page 1041.

"I write in order not to forget who I am."

Martin Winckler, a new translation by Iain Bamforth, page 1052.

contents

1036	news Poverty reduction and health, Logie Medical Humanities, Meakin Plus – <i>Flora Medica</i>
1038	paisley docs 7 Outside Interests, Graham Smith
1040	miscellany Community participation with Latin style! Cawston, Ordonez Moldova, de Wildt
1042	essay The stupidity of Elizabeth Fry, Miles, Huntsman
1044	digest and reflection Gillies on the end of modern medicine, Cameron on ethical research, Horder on anthroposophic medicine. Plus – poetry by Bolton and neighbour <i>Behind the Lines</i>
1048	matters arising RCGP AGM
1049	diary and goodman on boxes
1051	a feast of Winckler Bamforth on Dr Sachs Excerpts from <i>En soignant, en écrivain</i> , by Martin Winckler
1056	our contributors and willis on Winckler

Poverty reduction and health

IMAGINE that you have AIDS-related diarrhoea, live in Nairobi's hellish Kibera township with one million others crammed into 110 hectares of land, and are without sanitation because, officially, this township doesn't exist. It costs you 2p a go to use the 'private' pit toilet shared by 50 others. Your total income is less than 50p per day. What do you do? You use a polythene bag then throw it and the excreta on the streets. In a health situation that is truly appalling, Kariba is famous for its 'flying toilets'. The township contains no government health facilities but, without access to clean water or sanitation, how do you deliver good health care anyway?

PRSPs

The World Bank and IMF think they know. They have developed new conditions for debt relief, soft loans, and aid to poor countries, called poverty-reduction strategy papers (PRSPs) which should contain 'pro-poor health plans' and ensure an increase in the flow of resources to health. But in fact the policies are the same old structural adjustment programmes with a new label. The new bits are an increased commitment to 'country-led' health planning (instead of Washington-dictated) and a demand that the government consults 'civil society'. But the people of Kariba won't have much say. Sadly, neither will the Kenyan Minister of Health or even local doctors who know the true picture. The PRSPs are still mainly controlled by the economists and all the hallmarks of neoliberal economic thinking remain: liberalisation of the economy, privatisation of utilities like water, a cap on social spending at very low levels, and an all-out effort to export basic commodities like tea and coffee with little regard for local nutritional needs or the famine currently raging in southern Africa.

The World Health Organization estimates that a \$60 per capita annual health spend is needed if the main diseases, such as AIDS, malaria, and tuberculosis, are to be contained. Currently the average health budget in the poorest countries is under \$10 per capita. Economic crisis and austerity programmes slashed health budgets during the 1980s and it is going to be very difficult to regain the lost ground, especially with an

AIDS pandemic of massive proportions. Many are hoping that PRSPs will facilitate a new dialogue between governments and users of the health services that will allow resources to be targeted at the poor more efficiently, and that government control of the health sector will improve, but, simultaneously, plans for increased privatisation of health care are sweeping Africa.

The need to address the broader health determinants

One of the main problems with the delivery of health to poor countries is that health care is seen inside a box, while the wider determinants of health, such as access to sanitation, clean water, and food, are considered in different boxes. Health is all too often equated with the provision of health services — and not health outcomes. A full understanding of the links between health and its determinants at different levels is still missing. For example, the poor are more exposed to environmental hazards and natural disasters than the rich. Also missing from PRSPs is how poverty-reduction programmes fit into other programmes, such as the Global Fund for AIDS, Malaria and TB; WTO and GATS policies; and health sector reforms.

Governments need to be held responsible to their citizens and especially to vulnerable groups. Health must be seen as a human right and not as a means to economic growth, which is the way in which the international financial institutions tend to think of it. Commitments should be linked to realistic budgets and the implementation of policies should be monitored closely. Unfortunately, many feel that PRSPs have little chance of achieving any of this.

The reaction to the PRSPs comes in two forms: the optimists say it may be a window for improved dialogue with the poor in formulating a country's health policies, while the pessimists say it is no more than window dressing or rearranging the chairs on the Titanic, as Africa's health slides further into the icy sea of chaos.

Dorothy Logie

Further reading

Marseille E. HIV prevention before HAART in sub-Saharan Africa. *Lancet* 2002; **359**: 1851.

de Cock K. Shadow on the continent: public health and HIV/AIDS in Africa in the 21st Century. *Lancet* 2002; **360**: 67.

Stover J. Can we reverse the HIV/AIDS pandemic? *Lancet* 2002; **360**: 73.

Verheul E. *Poverty-Reduction Strategy papers: what is at stake for health?* London: Wemos, 2001. (Available in the UK from Medact, 601 Holloway Road, London N19 4DJ; tel: 0207 272 2020.)

Logie D. Breaking the silence. *Br J Gen Pract* 2000; **50**: 763.

ARE you interested in the relationship between the arts and humanities and medicine?

In February 2002 the Association for Medical Humanities was formed at a meeting of individuals interested in medical humanities held at the University of Birmingham.

Medical humanities is an interdisciplinary approach to education, health care, and research, which includes exploring health and illness through literature, fine art, the performing arts, history, philosophy, and medical ethics. We believe it can broaden the education of health professionals and deepen our understanding of the experience of health and illness.

The Association aims to promote the medical humanities in education, health care, and research within the UK and the Republic of Ireland by providing a forum in which those interested in the field can exchange ideas, develop academic and educational rigour, and find support from colleagues. The Association is linked to the journal *Medical Humanities* (an edition of the *Journal of Medical Ethics*), which is published twice a year. The first annual conference and AGM will take place at the University of Durham in July 2003 and we plan to publish a newsletter providing regular information on initiatives, degree programmes, research results and much else.

If the Association is to be successful it will need a broad and representative membership. There are three categories of member: individual, institutional, and student. The annual subscription rates are: individual — £15, institutional — £40, student — £5. If you are interested in joining you can obtain further information and an application form from Mr Robert Arnott, The Secretary, The Association for Medical Humanities, Centre for the History of Medicine, The Medical School, University of Birmingham, Birmingham B15 2TT (e-mail: R.G.Arnott@bham.ac.uk) or contact Dr Richard Meakin, The President, The Association for Medical Humanities, Royal Free and University College Medical School, Archway Campus, 4th Floor, Holborn Union Building, Highgate Hill, London N19 3UA (e-mail: r.meakin@pcps.ucl.ac.uk).

Richard Meakin

From the journals, October 2002 ...

N Engl J Med Vol 347

1151 Why do people with eczema get so many skin infections, whereas in psoriasis they are rare? It's all to do with endogenous antimicrobial peptides, a newly discovered but very ancient system of protection for body surfaces, found in 400 million-year-old hagfish as well as higher animals.

1169 Antibiotics for otitis media? Here's a useful review suggesting we use them only if there's a fever and a bulging drum.

1227 The final vindication of the idea put forward by Geoffrey Keynes in 1922 — that lumpectomy and radiotherapy should replace mastectomy in the treatment of breast cancer.

1318 Subtotal hysterectomy is a bit simpler to perform than total, and the results are good: in fact for both kinds of hysterectomy, bladder, bowel and sexual function are normal at 12 months in this follow-up series.

1397 More about heart failure from Framingham: a declining incidence in women but not in men. Dilemmas of heart failure epidemiology are discussed in the editorial on page 1442.

1403 Physicians in the USA have been reluctant to give up digoxin in heart failure without atrial fibrillation, and the DIG study in 1997 seemed to show a small reduction in hospital admissions. But this analysis of the effect by gender shows increased mortality in women.

Lancet Vol 360

1037 Non-steroidal anti-inflammatory drugs worsen heart failure and antagonise the effect of ACE inhibitors: could the same be true of low dose aspirin? No, says this systematic review.

1071 And in the general population, NSAIDs are not associated with adverse cardiac events — this study looks at rofecoxib.

1155 Just call me CYP — the cytochrome P450 system gets abbreviated. Which is just as well, as it's so important in drug metabolism, as this complex review explains.

1203 If anyone doubted that particulate air pollution from motor traffic causes morbidity and mortality, here is a study from The Netherlands, plus one from Dublin on page 1210 and a comprehensive review on page 1233.

JAMA Vol 288

1622 A review of the benefits of exercise in type 2 diabetes and hypertension.

1723 The obesity epidemic in the USA is described in three papers.

1867 Low blood folate is associated with increased risk of miscarriage.

1889 Bone densitometry is a big issue here and in the USA — here is a useful guide on how best to deploy it.

1994 Bad news for sedentary reviewers: exercise reduces coronary disease in men in a dose-related manner.

2015 A meta-analysis of the much-debated link between homocysteine and vascular disease. It seems to be mediated largely through increased systolic blood pressure.

Other journals

Arch Intern Med Vol 162: lowering blood pressure prevents dementia (page 2046). Heavy analgesic use is associated with a two-fold risk of hypertension in women (page 2204). A three-year study confirms an earlier six-month study in the *Lancet*: glucosamine reduces the symptoms and progression of osteoarthritis (page 2113). Men with hip fractures are usually osteoporotic but often get no treatment (page 2217).

Ann Intern Med Vol 137: get ready to pronounce ximelagatran — it may replace warfarin as it needs no monitoring and prevents deep vein thrombosis after knee replacement (page 137). What and where is consciousness? With positron emission tomography you can actually watch the brain waking up (*Brain* 125: 2308). Headache has its own journals, such as *Cephalgia*, which reports on a trial of topiramate to prevent migraine (22: 659) — it works, and tends to cause weight loss too. The Scandinavians have at last found a use for acupuncture — it seems to work for labour pains (*Acta Obs et Gyn Scand* 81: 943).

It's a bit worrying to discover a 'common' condition one has never heard of: common variable immune deficiency 'is prone to underdiagnosis' says the *QJM* 95: 655 where a case series is described, mostly presenting with recurrent chest infections. *Thorax* 57: 880 provides welcome evidence that giving children with asthma long-term inhaled steroid treatment markedly reduces hospital admission. And *Spine* (27: 2291) contains yet more evidence that lumbar spine X-rays do not affect clinical outcomes in low back pain, though they increase patient satisfaction. For a (non-systematic) review of this topic, see *Ann Intern Med* 137: 586.

Plant of the Month: *Arbutus* 'Marina'

A hybrid strawberry tree, probably the same cross as *Andrachnoides*, and very beautiful in form, bark and evergreen leaf. The drooping clusters of tiny waxy pink flowers are replaced by the orange-red fruits throughout winter.



Audio extracts from the interviews can be listened to as sound files on the SchARR website:

<http://www.shef.ac.uk/~scharr/hpm/IGS/>

References

1. The Wellcome Trust's History of Medicine Programme funded the oral history project.
2. More details about REMS can be found at <http://www.abi66.dial.pipex.com/data/REMS.htm> and Have a Heart Paisley at <http://www.show.scot.nhs.uk/demonstrationprojects/haveaheart.htm>
3. As noted earlier College membership in the town has been important. See Smith G, Nicolson M, Watt GCM. An oral history of everyday general practice 1: speaking for a change. *Br J Gen Pract* 2002; **52**: 516-517.
4. Smith G. An oral history of everyday general practice 6: beyond the practice — the changing relationship with secondary care. *Br J Gen Pract* 2002; **52**: 956-957.
5. GPP 09.
6. GPP 18.
7. GPP 03.
8. GPP 10.
9. GPP 07.
10. GPP 09.
11. GPP 30. For a history of St Mirren FC see <http://www.paisley.org/paisley1/history/saints.php>
12. Smith G. An oral history of everyday general practice 11: teaching, training and the transmission of medical knowledge *Br J Gen Pract* (forthcoming).
13. GPP 16.
14. GPP 07.
15. GPP 08.
16. GPP 04.
17. GPP 09.
18. GPP 08.
19. GPP 25.

An oral history of general practice 7: Outside interests

EXTRA-CONTRACTUAL work, or 'outside interests' as some practitioners put it, has excited little interest among historians of general practice in Britain. And yet such activities have remained a constant feature in the working lives of the three generations of Paisley doctors that I interviewed.¹ At the time of the interviews, partners in at least nine of the town's 13 practices were participating in either medico-political activities, education and training, or in some type of paid non-GMS provision. And the doctors frequently described all this as adding variety to everyday working lives in general practice, as well as providing an important connection with developments in medicine and in the delivery of medical services.

For over 60 years GPs have provided the local professional football team with a doctor, the town with police surgeons, social care agencies with medical services, and private nursing homes with medical cover. From the 1960s onwards, new posts became available within a growing range of hospital specialisms while some opportunities have declined, including medical posts with industrial companies. More recently the number of medico-political positions have grown and family doctors not only continue to represent colleagues on the Local Medical Council (LMC), but have also become increasingly involved in a range of new organisations.

The organisations that have emerged in the past decade include Renfrewshire Emergency Medical Services (REMS, the out-of-hours co-operative), the Local Health Care Co-operative (LHCC), and a number of community-based health initiatives, including Have a Heart Paisley — a project funded by the Scottish Executive.² As a result of their involvement in such activities, GPs know more about each other's partnerships than they would have in the past and there is evidence of an increase in inter-practice co-operation in the town. In addition, new opportunities are developing for the doctors involved in these structures. One of the key organisers of REMS, for example, has left practice to take up a post with NHS 24 (the Scottish equivalent of NHS Direct).

Such initiatives build on an earlier history of activism that involved smaller numbers of GPs and a smaller range of organisations, including the LMC and the Royal College of General Practitioners.³ The oral testimonies suggest that there has been little rivalry between the leading activists of the RCGP and the LMC in the town. Instead, a spirit of close collaboration, mutual respect, and a common goal of improving general practice mark recollections.

While the range of 'outside interests' has

been important, the paid medical posts in both the private and public sectors have also shaped the development of general practice in Paisley. Of these, it is the hospital appointments that have proved especially significant, according to the GPs. The earlier removal of family doctors from hospital posts in the years immediately following the formation of the NHS could have led to a complete division in British medicine.⁴ However, as GPs with hospital appointments have argued, sessional posts have allowed for positive relationships to develop with hospital doctors and for GPs to remain in touch with hospital medicine. It is also worth noting that many of these posts belonged to the areas of medicine that have traditionally been viewed by hospital doctors as having a relatively low status (including geriatric care, dermatology, and mental health care).

Particular activities, including hospital posts, have often become associated with particular partnerships in the town and younger GPs have found themselves inheriting positions from older partners. While there are breaks in continuity, as a practice decides to give up a commitment and another takes it up, there are clear patterns of activity over time. There continue to be continuities in practices' involvement in particular outside interests. This development has contributed towards an informal specialisation of general practice. Some practitioners, for example, talk about either attracting particular patients or have patients with certain conditions referred to them by their partners, because they deal with such conditions or patients in their hospital posts.

There is also unease, with the GPs often describing outside interests in negative terms. Some younger partners engaged in the less lucrative organisational developments have found themselves in conflict with older partners who are engaged in paid work. One GP who found himself in this position characterised his practice as 'money-minded'. Another practitioner recalled a former colleague and GP trainer, who left general practice in the 1980s as a result of the pressure he felt from his partners. In part, such anxieties contribute to a shared concern that care needs to be exercised regarding the amount of time and energy expended on organisational activities, or as one GP noted, it is necessary to 'keep life manageable'.⁵ Similarly, among some of those engaged in paid posts there are worries that outside interests could detract from their NHS duties. It is interesting to note that there is a recurring emphasis on the ways in which finances from external work are used to pay for initiatives aimed to help NHS patients. Working in such a mixed economy seems to produce stress and strain for the profession.

The oral evidence

There were only a few practices with partners who were not engaged in non-GMS activities.

Linda F: 'We don't have any outside interests in the practice ... I think in a bigger partnership it's much easier to have outside interests. ... Probably going to look at that in the next six to nine months... I think it is very good to have outside interests. We all see the place for it.'⁶

Patrick McC had been one of the town's GPs whose services in the local hospital had been dispensed with in 1950 (see article 6, previous issue). Some 20 years later he was back working in a hospital setting after successfully training in anaesthetics:

Patrick McC: 'I got bored with general practice; I missed the smell of ether ... that's why I went back in to the hospital service ... And then I gave anaesthetics at Southern General Hospital [in Glasgow, from 1973 to 1977]. I did four-elevenths of a full-time job there, combined that with general practice. So I was if you like seeing Annie Muggers with a blister on her toe and an hour later I was anaesthetising somebody in a major car accident.'⁷

His younger brother, and practice partner, also returned to study.

Charles McC: 'I did a year ... half-time in paediatrics... My retentive ability was terrible. But, then ... I had my physiology book on tape, reading it and putting the emphasis, as I wanted it ... A whole book was on 24 hour-long tapes, and I used to go through them every fortnight, a tape on physiology and a tape on paediatrics and I [when he was around 47 years old] just plagued my brain ...'⁸

Partnerships developed particular interests.

Robert E: 'The geriatric unit at that time consisted of an assessment unit and ... long-stay units. And the assessment unit had one full-time junior hospital doctor, and ... four of us [GPs] looked after the ... long-stay units ... The hospital weren't very interested in where the general practitioners came from. They would have been quite happy for somebody from each practice. But the new consultant geriatrician, who is there just now, was very keen to have people from the same practice to get the out-of-hours cover taken care of.'⁹

David D works in the same practice that Robert E retired from.

David D: '... There'd been a kind of, almost cartel of geriatric jobs, clinical assistant jobs, that had existed when I came here ... it does add a dimension to what we're doing

here, and means also that we probably are better at keeping up to date in terms of modern medical practice ... than we might do if we were isolated in general practice alone ...'¹⁰

The sheer variety of posts is only matched by the enthusiasm that GPs often expressed about the work they undertook.

Stewart McC: 'I've been the club doctor for St Mirren for longer than I care to remember, since 1978 ... Fortunately the assistant manager at that time was also the physiotherapist ... [and] he had spent a long time in football ... Then we had other physiotherapists who were all very good. I have enjoyed it; it's good fun ...'¹¹

Education has been particularly important for College members in Paisley since the 1960s.¹²

Douglas H: 'I went into practice in Paisley in 1954 and I joined the College in 1957, but that was all I did initially ... The College had started student attachment schemes and I became Chairman of the Faculty in Education after a couple of years as secretary. Bobby E [1969 to 1972] ... his track went more medical-political, but I couldn't see myself wearing two hats, I had to just wear one and I avoided the medical-political side altogether. There were a few [GPs] that stood out as caring and wishing to improve quality.'¹³

And then there was the LMC.

Robert E: 'I think it was 1953 or 1954 before I joined ... The 1966 business ... a lot of turmoil and various different questions being raised ... [Then] when they proposed to have a health centre in Paisley with 40-odd doctors. The proposals were ... to have one huge health centre and there were certainly a lot of objections to that idea and then it was decided to split it and have two health centres ...'¹⁴

In the face of opposition the health centres were never built in Paisley. Other issues, including resource allocation, continued to face politically active GPs in the 1990s.

Carol S: 'The managers don't have the resources ... So that was the reason I went on to the GP-Sub and LMC ... frustration at things not being done. And it's also quite good to work on the inside to know what's happening.'¹⁵

New organisations have emerged.

Graham D: 'We had a few meetings that had been organised by the LMC, went along to that initially and had volunteered that I would be very keen to get involved ... I think we weren't REMS then, it was REDS,

Renfrewshire Emergency Doctor Service, but that was dropped because of the eventual connotation of REDS under beds and all this kind of stuff; it was like some kind of paramilitary Trotsky organisation...

'We drew up the ... protocols, trained up the nurses, sold it to the GPs ... We had said, "Join and join at the start ... this is a co-op". ... And we did it on a sort of collegiate vote system ...'¹⁶

David D: 'I also have become very much involved in the Local Health Care Co-operative since its inception just over 18 months ago. In terms of the time that I'm involved in that now it is absolutely enormous. In terms of the income that accrues from that it's not very enormous, but I still see it as quite important work ...

'I've got a long list of projects and committees that I seem to be tagged onto at the moment with varying degrees of workload attached to that. I'm reasonably comfortable with that, because it's been new and different and it's something which I would immodestly say I was quite good at and it's been quite a discovery for me ... So, I've really very much enjoyed that and been very loathe to let that go, although at times it's just about as much as I can cope with because I'm still doing all my GMS work here ... and we are very busy here. It's a big practice and we have big lists and there's no mechanism for reducing the commitment...'¹⁷

In contrast, paid posts can provide an important source of additional income.

Carol S: 'We look after the hospital for mentally handicapped and there's a lot of physical illness there ... it's emergency cover ... And we get paid so many sessions for that — that's what I was saying, the jam on the gingerbread. It lets us for example pay the girls [clerical staff] more money than we're being reimbursed ... you were able to perhaps do a little more for your NHS patients doing that work ... It seems a bit daft...'¹⁸

But outside interests can add to existing difficulties within partnerships.

Andrew K: 'He [a senior partner who retired around 1980] did outside work. He worked ... doing war pensions, industrial injuries and really he regarded that as equivalent to another thousand patients ... He brought that money into the practice. Yeah. ... There are two things that ... break up practices, workload and money.'¹⁹

Graham Smith

Community participation with Latin style: Eighth International Primary Care Conference 'the 20th century: challenges of the 21st century'. Havana, Cuba 17-21 October 2002

Acknowledgement

Attendance at the conference by Peter Cawston was jointly funded by Greater Glasgow Primary Care NHS Trust and Glasgow University.

Reference

1. Craig M. Viva Cuba! *Br J Gen Pract* 1999; **49**: 1020-1021.

A longer version of this article can be accessed on <http://www.gla.ac.uk/departments/generalpractice/index.html>

CUBA'S long experience in giving consistent political priority to primary health care provides many lessons for primary care in other countries.¹ It is appropriate, therefore, that Havana should have played host recently to an international primary care conference, sponsored by the World Health Organization and attended by delegates from 33 countries on four continents.

The past 40 years have seen dramatic health gains for the Cuban people. Despite a profound economic crisis, health indicators, such as infant and maternal mortality, have equalled those of First World countries during the 1990s. This is attributed to concentrated investment in training family doctors, eradicating infectious diseases, and integrating health promotion and low cost traditional medicines into health care. It is estimated that 40 million US citizens remain without financial access to adequate health care, despite having a gross national product 30 times that of neighbouring Cuba. By contrast, 99.1% of Cubans now have access to free medical care in the communities where they live.

Community participation in primary care

Community participation in health is a practical application of the theory that 'social capital' is required for a healthy society. Primary health care can contribute to this by developing the capacity of communities to take collective decisions about the issues that influence their health.

Family doctors are essential to this process in Cuba. It is the norm (although not universal) for the doctor to live in the neighbourhood where they work, in many cases above the *consultorio*. In attending the

doctor's consulting room, patients are not only expected to consult for advice but to be consulted in return about their needs and health concerns. Small patient lists and strong personal relationships are the foundations for effectively involving the community in health.

Family doctors work closely with a community nurse, often seeing patients

together. Around half of their time is designated to proactive activities, such as home visiting, health education, and needs assessment. They must provide an annual report, described as a community health diagnosis. They are also required to regularly attend neighbourhood meetings, such as those of the popular councils.

Popular councils are neighbourhood fora for discussion and decision-making. Council participants include neighbourhood associations ('committees for the defence of the revolution'), local members of 'mass movements' (such as the Cuban Women's Front), and representatives of various *grupos de ayuda* (support groups). The latter are set up to provide social interaction and support for vulnerable members of the community. They include, for example, 'grandparent circles', set up to provide social and exercise-based activities for older people.

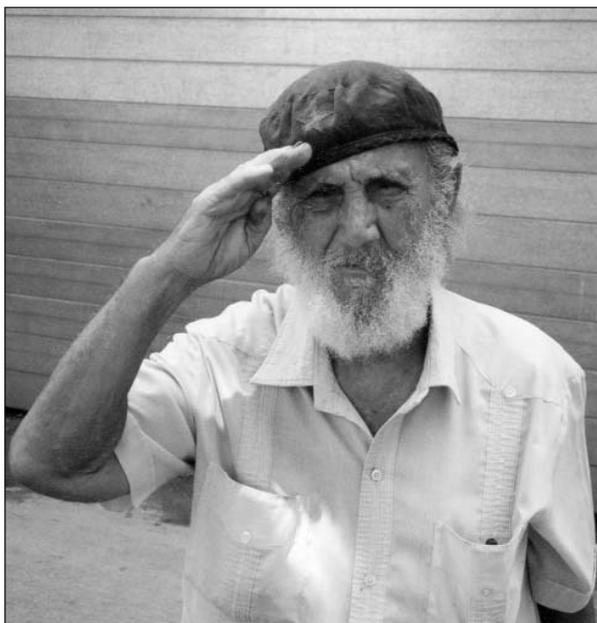
A recent campaign against a resurgence of the once endemic dengue fever depended for its success on this close working between communities and health services. Family doctors were given a pivotal role so as to capitalise on their relationship with popular councils and mobilise community networks. The epidemic was eradicated within a remarkably short period of time.

Above neighbourhood level, the organisation of primary care is planned so as to provide synchronicity between health areas and local authority municipalities. Family doctors are involved at each level of this hierarchical structure, and may serve as municipal health directors. Each municipality relates specifically to one medical school, which is responsible for undergraduate and postgraduate training as well as overseeing the inspection of practices.

In the absence of this close structural relationship between health workers and communities, other Latin American countries have experimented with 'health and peace-promoting municipalities'. Common characteristics include community assemblies, health-promoting schools and making use of a wider diversity of talent in health. Lay health promoters, traditional healers, and workers drawn from anthropological and sociological disciplines, have all been effective when integrated into the primary health care team. In particular, they have helped to provide means for using community health beliefs creatively and developing culturally appropriate responses to perceived health needs, in many cases without resorting to medical technology or drugs.

Challenges to UK general practice

British general practice is perceived in Cuba to have provided an important historical



context for the emergence of a biopsychosocial theory of health. Both systems share much in common, not least a national health service, free at the point of need, accessed through a registered family doctor. Cuban family medicine is evolving, however, in a direction that diverges considerably from recent historical developments in the UK.

Clearly, the political, cultural, and societal demands differ greatly. While there are far more GPs to go around in Cuba, their income is astonishingly small compared with that of British GPs. The challenge of responding to the relentless marketing that drives rising consumption of medical technology is largely absent in Cuba. The Cuban experience, however, raises many valid challenges for UK general practice.

Home visiting and needs assessment by GPs in Cuba are seen as the basis for responding to the lived experience of communities in setting the priorities for primary care locally. This contrasts with strategies promoted in the UK to manage 'patient demand', such as telephone consultations, nurse triage, and avoidance of home visits. Can we respond adequately to needs as perceived by our patients when we increasingly meet with them on our own territory and on our own terms?

Active participation in neighbourhood organisations is seen as a core element of quality medical practice in Cuba and not a pastime for the devoted few. Can 'methods' for community consultation by Primary Care Groups in the UK ever become part of a practitioner's core concerns without such a network of personal relationships with key community members?

Cuban GPs are local residents in the areas where they practice, sharing the same neighbours, shops, schools, and amenities. While this is true in many affluent neighbourhoods in the UK, the same cannot be said for most deprived communities. Do we unwittingly contribute to the Inverse Care Law when the future of our own children does not depend on the advancement of the community in which our patient's children are being raised?

The Cuban model represents GPs as actively responding not only to medical needs, but to the social, housing, and environmental concerns of their patients. The bureaucracy surrounding such concerns in the UK is perceived to be a major and unnecessary burden on GPs. In disengaging ourselves from this so as to focus on defined medical services, are we also attempting to abdicate our responsibility to work with patients and communities in making healthier lives possible?

**Peter Cawston
Cosme Ordonez**

Moldova

MOLDOVA'S capital is Chisinau. Its centre is pleasant and leafy. During early morning jogging I see sweepers who keep the parks immaculately clean. Traffic is orderly and the lights are working, and most people are dressed much more elegantly than at home.

Still, I am in a country that has become one of the poorest on earth. When I buy a beautiful, handmade chess set for £2, I realise that someone has spent over a week on it and that the shop makes a profit. I give the equivalent of 20p to an old woman begging outside a bank and she sinks on her knees. She has some change in her hands perhaps not worth more than one penny altogether — I have just given her a fortune. Almost half a million of Moldova's inhabitants are working elsewhere, mostly illegally, in Russia, Italy, Portugal, Spain. Their remittances keep their families afloat.

Moldova is a particularly sad example of the over-hurried transition from the Soviet command-and-shortage economy to one based on private profits. Regard for governance or justice fell by the wayside. It has opened up its markets but stands no chance in the new world — which is not so free trading after all. Moldova is fertile but the USA has just announced that it will raise its farm subsidies to near the levels of the European Union. The profitable sectors — weapons production and drug running — are in a part of Moldova that remains outside government control. The gap between rich and poor widened more than in most other ex-communist countries. Interestingly, countries such as Poland and the Czech Republic, where inequality rose less, are faring much better.

I am representing the RCGP, together with Kevork Hopyan, at a conference on family medicine in the former Soviet and Eastern European communist countries. It is fascinating to hear what the delegates have to say. Some countries appear to have got their acts together. Bulgaria is developing a social insurance-based health care system. To reverse a trend, it pays its general practitioners considerably more than hospital doctors. Kazakhstan has oil money to spend and is moving forward, as are Latvia and Lithuania, which are looking to Scandinavian countries for help and inspiration. Many countries have based their family practice organisation and training on European Union models.

Health care in most other countries is in a bad state. In communist countries, the status and pay of doctors is very low, compared with other professions. This has not improved in the post-communist era. We are told that in some parts of Russia, half of GP vacancies are unfilled and half of the working GPs are pensioners who will quit as soon as pensions rise. Most Russians appear to deeply mistrust the state, which had already become an instrument for privilege and favouritism in the communist years and has worsened ever since. Salvation is expected from privatisation. We are met with utter disbelief when we explain that the railways in Britain are being renationalised after the private sector made a mess of it, and that it is often preferable to be in an NHS hospital, rather than a private one, when you are acutely and desperately ill.

What did RCGP representatives do here? We gave presentations about different systems of primary care and evaluation of services, about health aid, postgraduate training, and education. But most participants knew more about the ways things are done in the UK, other European countries, and North America than in neighbouring countries.

Perhaps our roles were to be relative outsiders, helping to facilitate and to reflect. We felt appreciated and we learned much about ourselves. It struck me that in many countries the battle for ideas has been won in favour of equity-oriented social insurance or taxation-based health care systems. This has happened in spite of massive lobbying for private for-profit health care. Continuity and personal doctoring are seen as central values. It is amazing then, that we in Britain appear to be at risk of losing this in the new GP contract.

It was striking, too, to realise that being a doctor, a GP, can give that instant sense of professional brotherhood and sisterhood. It may well be a politically incorrect thing to talk about brothers and sisters in our post-Hippocratic GMC days — but dealing with life, illness, and the trust of patients remains a special and precious vocation.

Most countries without mineral wealth will continue to depend on foreign aid to pay for their health systems. Many participants appeared keen on maintaining international contacts to exchange information and to learn from experiences. There may be a role for the RCGP and it could be a truly two-way process.

Gilles de Wildt

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With thanks to Kevork Hopyan

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The stupidity of Elizabeth Fry — was it dyslexia?

'I was thought and called very stupid and obstinate.'

Elizabeth Fry
Journals, 23 August 1828

DYSLEXIA is a debilitating disorder which affects about 3% of children (which means approximately one in each classroom). It is a syndrome which, despite variation, displays a recognisable pattern.¹ It is independent of social class,² it tends to run in families,³ and has a ratio of males to females of about four to one.⁴ Some dyslexics may have special talents.⁵

Post mortem examination and, more recently, brain scan techniques,^{6,7} have shown that the brains of dyslexic individuals are differently organised, having abnormalities in the language areas of the cortex. There is possibly some malfunctioning of the cerebellum,⁸ which would explain why some dyslexics are clumsy or have poor handwriting.

Elizabeth Fry (1780–1845)

Among the historical figures who overcame the problems of dyslexia was Elizabeth Fry. Her major contribution to society is commemorated today by the recent selection of her portrait to appear on our £5 notes.

Elizabeth Fry, who was a Quaker, was the child of a Norfolk banking family.^{9,10} She began her prison work in 1813 when she entered Newgate prison in London. There she faced 300 fighting, gambling, half-naked and often drunk women, all imprisoned in a space of 190 square yards. She possessed remarkable speaking skills and organisational ability, encouraging others to help her to establish a school for children who accompanied their mothers to prison. Order replaced chaos and her success became the talk of London. She travelled throughout Europe advising on penal reform and establishing committees of local ladies to visit and inspect their prisons.

Elizabeth Fry became involved in other philanthropic activities, establishing libraries for the coastguard and navy and forming 'Friendly Societies', which encouraged the poor to save. Through her formation in 1840 of the 'Institution of Nursing Sisters' she made a major contribution to nursing reform, which is at last receiving recognition.¹¹

Dyslexia: importance of early diagnosis

If dyslexia is recognised early (say, by the age of seven or eight years), its negative effects can largely be prevented. If diagnosis and aftercare are denied, however, the price can be very high. The undiagnosed dyslexic may be accused of laziness or of 'not trying' and may be subject to all kinds of stresses.¹² In extreme cases the result may even be a custodial sentence. This tragic result is often owing to the necessary intervention falling between four stools; representing parents,

teachers, general practitioners, and educational psychologists.

Despite the gap of two hundred years, the evidence as to whether Elizabeth Fry was dyslexic will be presented as a reconstruction of her likely responses to questions or simple tests put to her in a doctor's consulting room today.

The consultation

When informed that the patient is a poor speller the doctor should immediately consider the possibility of dyslexia. Lack of intelligence and/or educational opportunity must be excluded. This can certainly be done in Elizabeth Fry's case: her education, thanks to her caring Quaker parents, exceeded that offered in many schools today.

Sometimes there is comorbidity with dyspraxia, with attention deficit hyperactivity disorder (ADHD) or with Asperger's syndrome.

As part of the diagnostic procedure the doctor may wish to use the Bangor Dyslexia Test.¹³ This test is suitable for use with both children and adults, and, apart from its diagnostic function, it can serve as a way of helping dyslexic individuals to talk about and come to terms with the things that have put them under stress. We lack information on how Elizabeth Fry might have responded to many of the items in this test; we do not know, for instance, whether she would have shown any uncertainty over 'left' and 'right' or whether she would have had difficulty in repeating tongue-twisting polysyllabic words, such as 'preliminary' or 'statistical'. However, the present-day doctor may well find the patient's responses to such questions interesting and informative.

What is your problem?

The commonest early manifestations of dyslexia are lateness in learning to read and difficulty with learning to spell. These, however, need to be related to other signs, and a diagnosis needs to be made on the basis of the total picture.

Response: there is no evidence as to whether Elizabeth Fry was late in learning to read. With regard to her spelling, however, her private unedited journals of approximately 500 000 words¹⁴ give overwhelming evidence that she was a poor speller (Figure 1 gives an example of her writing at age 17). Examples of the many spelling errors in her journals include 'impreshon' for impression, 'intomit' for intimate, 'peepole' for people, 'drayhths' for draughts, and 'whent' for went.

Her journals are in total contrast to the standardised literary style in contemporary publications, where both grammar and spelling are identical to what is found today. *Conclusion:* Diagnosis of dyslexia is

supported.

Apart from the spelling, what is your writing like?

Some dyslexic children have very untidy handwriting, and some have considerable difficulty in learning grammar and punctuation.

Response: An examination of Figure 1 shows that punctuation consists of an occasional dash, the sentences rambling on. This example of her handwriting was specially selected — in much of the journal it is barely legible. Even in middle age, she admitted to being 'a poor scribe'. (Untidy handwriting on its own is, of course, not an indicator of dyslexia; it has been suggested that, if it were, a disproportionate number of medical doctors might be diagnosed as dyslexic!).

Conclusion: Diagnosis of dyslexia is supported.

Are you slow at getting things done?

Slowness (e.g. at completing homework) is a feature of many dyslexic children.

Response: Elizabeth Fry writes 'I have observed today how slow I am doing things ... I have so much slowness in my composition'. In another passage she comments on how slow she is in comparison with her sister, Richenda.

Conclusion: Diagnosis of dyslexia is supported.

Do you have any problems remembering things?

Many dyslexic children tend to forget instructions — for instance, they may not remember what homework has been set. Immediate memory can be tested by asking them to repeat random digits — both forwards and in reverse order. They also may find difficulty saying the months of the year, particularly if they have to say them backwards.

Response: Elizabeth Fry writes 'I am so forgetful ... I receive an idea quickly but it soon vanishes'.

Conclusion: Diagnosis of dyslexia is supported.

Is there a similar problem in the family?

In about 50% of cases of dyslexia there may be affected relatives.

Response: Letters at Friends' House, London, handwritten by Elizabeth Fry's father and brothers show virtually impeccable handwriting and spelling.

Conclusion: There is no evidence of a family history of dyslexia.

Have your parents been helpful?

Caring parents can do a great deal to minimise the adverse effects of dyslexia.

Response: A comment by Elizabeth Fry is as

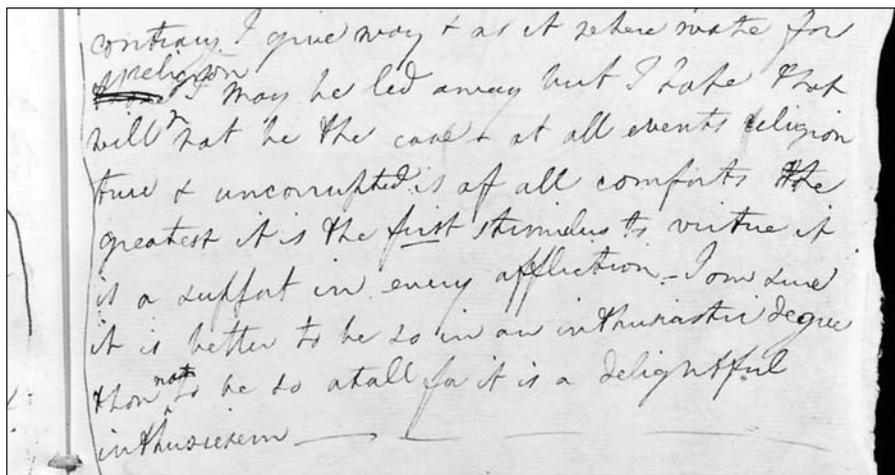


Figure 1. A sample of Elizabeth Fry's handwriting.

relevant today as when it was written some two hundred years ago. 'I know not what would have been the consequence [sic] had I had any other than a most careful and wise mother and judicious nurses, if I had been alarmed as too many are by false [sic] threats of what might happen to me if I did wrong I know not what the consequence [sic] might have been to me'.

The repetition or near repetition of parts of a sentence — in this case 'I know not what would have been the consequence' — is not uncommon among dyslexics and illustrates how they may 'lose track' of what they have already written.

Conclusion: Elizabeth Fry had full support in the home.

Is there anything you are especially good at?

Many dyslexic children are especially gifted at art, and some may even become poets or writers.

Response: Two of Elizabeth Fry's daughters note that 'she certainly always possessed more genius and ready quick comprehension, than application or argument'.

Conclusion: Her life confirmed unusual ability.

Summary of diagnostic findings

The case for saying that Elizabeth Fry was dyslexic rests not on any one sign on its own but on the different signs taken in conjunction. Particularly relevant are her poor spelling, her sometimes indecipherable handwriting, the absence of punctuation, her self-reported slowness and forgetfulness, and the 'genius and ready quick comprehension' mentioned by her daughters. The repetition of words in the sentence just quoted is also a tell-tale sign.

Critchley and Critchley¹⁵ specifically mention a variant of dyslexia that 'may present itself in the guise of atrocious, barely legible handwriting, coupled with a

mild degree of spelling disability and unorthodox punctuation'. These words precisely describe Elizabeth Fry's literacy problems.

Management of the dyslexic child

Dyslexic children need plenty of encouragement, as in many cases their self-esteem is likely to be low. Being set to memorise spellings, dates, etc. is difficult for them and unrewarding. This is what Elizabeth Fry wrote at the age of 48: 'What great care is needful ... not to force children to learn too much as it not only injures them but gives a great distaste for intellectual pursuits [sic] — the instruction should be adapted to their condition and communicated in an easy and agreeable way'.

In some cases dyslexic children may feel encouraged if they are told of dyslexics who achieved lasting fame, for instance, Hans Christian Anderson, Thomas Alva Edison, Michael Faraday, and William Butler Yeats. Among contemporary eminent dyslexics are the actress, Susan Hampshire, and the racing driver, Sir Jackie Stewart.

Parents should be encouraged to tolerate such irritations as forgotten messages, missed appointments and school books left at home. Dealing with these problems is a matter of common sense. A word processor with a spellchecker, and a calculator may prove invaluable.

Contacting the school is the desired course of action, with subsequent referral to an educational psychologist being sometimes indicated. The address of the British Dyslexia Association is: 98 London Road, Reading RG1 5AU. Special techniques are now available for helping dyslexics with their literacy problems, and parents should press that persons brought in to help their children are suitably qualified.

T R Miles
Richard Huntsman

The end of modern medicine: biomedical science under a microscope**Laurence Foss**

State University of New York Press, 2002

PB, 327pp, £16.44, 0 79145130 5

THIS book is part of a series from the State University of New York on 'constructive postmodern thought.' I have a very limited understanding of postmodernism, but what I did know suggested to me that 'constructive post modern thought' was, in essence, an oxymoron. Not so, states the introduction by the series editor, who distinguishes this constructive (or reconstructive) approach from deconstructive or eliminative postmodernism. I counted ten different words ending in '-ism' in the introduction alone, which lets you know what you're in for. There is a striking plurality of -isms. I was therefore very grateful for Ian McWhinney's brief and lucid foreword, which summarises both the intentions behind the book and its main arguments and conclusions.

Modern medicine has been on shaky philosophical ground for some time now. Founded on Cartesian dualism and the rationality of the Enlightenment, it has achieved a huge amount for mankind over the past century. Le Fanu, in *The Rise and Fall of Modern Medicine*, describes these achievements in fascinating detail, but concludes by attacking the 'intellectual falsehoods of the Social Theory and the intellectual pretensions of the new genetics' (page 405). The undermining of clinical judgement by evidence-based medicine, and the hubristic greed of the pharmaceutical industry, he suggests, is turning us all into patients, or at least consumers of drugs. In the process, public and private health systems are being bankrupted.

Illich, writing in 1976 about social iatrogenesis and the invention and elimination of disease, predicted it all. In trying to eliminate suffering, we doctors inevitably create more, as we have engendered in our culture the deeply rooted misapprehension that all suffering is avoidable. This is a profoundly unhealthy belief.

Furthermore, while we in the West become

medicalised, the health problems of developing countries, victims of the global market, are sidelined by modern medicine. As Solomon Benatar tell us, 87% of international healthcare expenditure is spent on 16% of the world's population. Ninety per cent of research expenditure is spent on diseases causing 10% of the global burden of disease.

So, if these are just some of the problems, does this book offer some solutions? Foss starts with a detailed discussion of the limitations of the reductionist mechanistic view of medicine. The views that the mind is only matter, that all complex processes are reducible to a large number of simple processes, and are ultimately explicable in terms of 'physiology gone astray' are attacked on scientific and philosophical fronts, and found wanting. His 'successor model' rests on two premises. One is that the human body, or mind-body, is a self-organising system rather than a mechanism. The other is that, within this organism, energy flows are separated from information flows. Energy transfers effect predictable, long-recognised physiological or pathological processes. Information transfers affect many parts of the organism simultaneously, releasing the potential within the organism — body and mind. Because we are reflective, self-referential beings, able by the exercise of will to affect our own physiology and pathology, these effects are complex, unpredictable, and contingent on the unique characteristics of the individual organism, and on the social milieu within which that organism lives. Information is transferred by 'memes', self-replicating psychosocial information units passing from mind to mind. Thus instead of immunology, we have psychoneuro-immunology; instead of pathophysiology, we have pathopsychophysiology, and so on. Neurolinguistic programming techniques seem to employ these information flows in a carefully calculating way.

In the development of the theory, there is an acceptance that, as Bernard Williams says, the Enlightenment is intellectually

irreversible. This seems to be what separates the constructive from the deconstructive postmodernists.

This model, says Foss, is 'infomedicine', the successor to biomedicine. Perhaps it should be infobiomedicine? It will come as no surprise to family doctors, who have been quietly working with this model, expressed through intuition and judgement rather than in academic language, for decades. Foss acknowledges his debt to McWhinney, whose Pickles lecture of 1996, 'The importance of being different', still represents the best summary that I know of the essence of general practice. He also quotes Kuhn's remark that paradigm shifts come from the edges of a discipline, not the centre. It's hard to imagine such a profound shift coming from an interventional cardiologist. Recent analyses of medicine in terms of chaos and complexity and post-normal science can be subsumed within the infomedicine model, as can Dixon and Sweeney's study of the human effect in medicine.

Will this approach help to address the issues of hubris, medicalisation and injustice discussed above? Probably yes, if the concepts move beyond academia, where they currently rest, and are incorporated into the delivery of health care, based on an expanded ethic incorporating interpersonal ethics, public health ethics, and the ethics of international relationships; the model suggested by Solomon Benatar. This perhaps, should be the basis for the postmodern global order discussed in the foreword.

Is infomedicine really a science? I can't think of a test of falsifiability that might answer that question, but there may well be one. It's intriguing, however, to read about a scientific theory purporting to explain How Things Really Are (apologies to Richard Rorty), which also claims to be postmodern. Perhaps the Truth is still Out There.

John Gillies

'Here be angels'¹

not the kind with guilt
dinner plates on their heads
stuck with vicious looking knives
shooting ray-gun fire

no, the kind who wears
a purple angora cardie
while crocheting blankets
from cloud

who wraps you in wings
as big as a hug

until you forget
what colour knickers you possess
never mind are wearing

the kind who winks,
eyes crinkling laughter
at the corners, until you laugh
at yourself too, for being pompous;

the kind who teaches you
how to lean into the bend
when you ride pillion

¹Heather Hawkins/voyaging

'The angels' share'

They roll around drunk in the aisles
of the distillery cellar
after everyone's gone to bed,
legless (or wingless?) on whisky
sniffed through the wood,
straight into their blood,
or whatever pumps through their hearts —
'quintessence' I suppose —
probably mostly whisky.

Another Use for Clouds

For David

Our toes touch
as we sit crocheting cloud
into fields and snowflakes
each as big as a blanket;
patchworked together,
they mound over our laps
and cuddle our backs.

Through the gap
created by our unravelling
of the cumulus
which pillows our feet
I can see
the world we have woven —
and all is well
all is well
all manner of things are well.

It takes two to tango

For the Lindsays

I'd like to dance with you, angel:
one firm hand in the small of my back,
one pair of wings arched over us,
and a halo, soft as lamplight,
to guide the way;

we don't know the steps
(perhaps there is no choreography
to the music of the spheres)
but your naked feet
touch my feet.

I'd be afraid if you were a seraph,
so awesome and yet so bashful:
two wings to cover his face,
and two to cover his genitals
and two more to fly¹ —

A cherub wouldn't do either —
only going on wheels in straight lines,
with all those faces, and all over eyes²
we'd never know which way to go.

Now I want to sleep, angel
in spoons —
me breathing into golden hair
cushioned by one wing, the other
draped over;
dreaming I'm in heaven.

¹Isiah 6, 1-2,

²Ezekial 10, 8-22

Gillie Bolton

Medicine and the Arts, Department of
English, King's College, London WC2R 2LS.
g.bolton@sheffield.ac.uk

A model of integrated primary care: anthroposophic medicine

Jane Ritchie, Jane Wilkinson, Madeleine Gantley, Gene Feder, Yvonne Carter, Juliet Formby

Department of General Practice and Primary Care
St Bartholomew's and the Royal London School of Medicine and Dentistry
Queen Mary College, University of London (published 2001)
(Available from the Department, tel 020 7882 7907)

THIS review is about a systematic effort to evaluate the work of a group of primary care practices that employ anthroposophic medicine and show some unusual features. The research addressed three questions: What is anthroposophic medicine, as interpreted by doctors and others working in general practice? How is it organised and delivered within primary care settings in the United Kingdom? What impact does it have on patients, both in terms of clinical outcomes and patient responses?

Six general practices and primary care teams and a 16-bed residential unit were evaluated. They share a common source of inspiration in principles proposed by Rudolph Steiner and use clinical methods and treatments derived from both conventional and complementary medicine. Their patients are registered under the National Health Service, but most of the practices have developed charitable resources, which pay for additional staff and structures or special forms of treatment.

Anthroposophic medicine is an extension of conventional medicine. It is based on the beliefs that each individual is unique; that scientific, artistic and spiritual insights may need to be applied together to restore health; that life has a meaning and purpose; that the loss of this sense may lead to a deterioration in health; and that illness may provide opportunities for positive change and a new balance in a life.

It aims to provide a means by which people can develop their own latent capacities. It involves a variety of therapies including, for example, art and music therapy, eurhythm, massage, and counselling as well as anthroposophic medicines. It offers opportunities for work and for social rehabilitation. Its study must be based in a multifactorial and multilevel view of human health and illness — a huge challenge to scientific method.

Answers to the three research questions were provided mainly through a descriptive, qualitative approach. No comparison with the work of other practice teams was attempted. That would have been too ambitious, requiring the research group to surmount a cluster of barriers to achieve valid comparisons. Some of these barriers could not even have been foreseen without the sort of exploratory study that has now been carried out. Nevertheless, it might be expected from work done elsewhere¹ that patients in a practice where, for example, they are generally seen by one GP throughout the whole treatment programme

and have received an initial consultation of at least 45 minutes, would report positively on their care and that they might prove to be more 'empowered' (the criterion of quality proposed and elaborated by Howie²).

Although mainly descriptive, this study does pilot three before-and-after comparisons of the effects of treatment: first, a qualitative assessment of physical, psychological and behavioural outcomes, through interviews in which patients were asked about effects they had felt or observed; secondly, two separate questionnaires completed by patients about their health (both currently used in primary care research). These research methods were chosen because they most closely represent patient priorities for their lives and health care, addressing their own concerns rather than imposing standard questions which may not be relevant to them. The three types of assessment gave consistent results in terms of physical and, to lesser degree, psychological outcomes. There was evidence of benefit to patients with chronic conditions, but it was not possible to disentangle the effects of anthroposophic treatments from other influences, such as the supportive relationship and the amount of time offered. The number of patients was small and there was no control group. As the authors point out, the study demonstrates only that it is feasible to use these tools for this group of patients and practices.

This detailed and thoughtful report of 150 pages focuses on anthroposophic medicine, but this particular problem can be seen as representative of other multidimensional or complex problems in primary care. Indeed the evaluation of primary care overall, particularly the central role of the clinician-patient relationship, faces similar methodological challenges. Is it realistic to single out the care of one illness when so many patients have more than one at the same time? Or one form of treatment when more than one at the same time is common practice? Does the intentional neglect of other influences on a patient than the one selected for study lead to misleading conclusions and inappropriate practice? Such problems of research method — and the choice of ways forward — are faced and discussed by the authors. One conclusion stands out — that quantitative evaluation is cogent, but inadequate. Combined with qualitative and descriptive work, it gains both meaning and usefulness.

I hope that this difficult task will not be abandoned at this point.

John Horder

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On quality and quantity

THERE is no single issue more important to the improved health of the nation than the drive for quality, to whose mast the RCGP has firmly Blu-tacked its colours. Top quality clinical medicine is — or should be — within the intellectual reach of every doctor. And a steady narrowing of the gap between aspiration and reality is — or should be — the experience of every voting tax-paying patient. We know pretty much how it is to be done. Non-threatening incentives to promulgate best practice. A ratcheting-up of the present 'minimal competence' level of summative assessment. Replacing the culture of blame with a culture of cooperation and common sense. Vocational training based in general practice. And so on. Investment, time, resources. The long haul, the big picture, the non-partisan vision. Pursue the drive for quality, and the nation's blood pressure will soon be impeccable, its cholesterol level beyond reproach. Patients in their droves will scarcely have time to scribble a 'thank you' note to their GPs before they're up on the operating table having their veins done.

On the other hand, there is no single issue more important to the improved health of the nation than the drive for quantity, to whose mast the Department of Health has firmly nailed its colours. Nailed? Would that it were anything so flimsy. Riveted, welded, superglued. The logic is at first sight irresistible — more care for patients requires more appointments and more time, and hence more doctors. More doctors means more recruits, faster training, fewer failures, fewer dropouts. But since we apparently need about another 6000 GPs by a week on Tuesday, they are not going to be delivered by what we've come to regard as the normal channels.

So the chicanery has already started. The press gangs have set to work recruiting GPs from Spain and Austria, wooing them with fables of that healthcare paradise which is the UK. The (so far) very few who have been seduced will have their expectations quickly downsized to British levels and will be fast-tracked into practice in the most disadvantaged areas. Deaneries are already under pressure from the DoH to lower their selection and training standards, and one at least has been told that the answer 'no' is unacceptable. The embryonic Postgraduate Medical Education and Training Board (from whose title the word 'Standards' has interestingly been quietly dropped) will have most of its 25 members appointed by the Secretary of State, to whom alone it will be accountable.

For some reason I find myself remembering a little scene I saw being played out at my local garden centre this morning. Judging by the scrum around the wallflowers, you'd think they were giving away a crate of Beaujolais nouveau with every half-box. The adults were tight-lipped and ruthless, elbows flying, trolleys cutting swathes through the competition like the war chariots of Boadicea. But the under-fives were having a whale of a time. The centre has rather a nice take on the shopping trolley; some of them, for the use of parents with imaginative children, are got up as toy cars. While the grown-up pushes towards whatever it is the grown-up wants, Junior is seated behind a red plastic steering wheel. The wheel, of course, is connected to nothing at all. Nevertheless, 'Brrmm brrrrmm!' goes the kiddy, engrossed in a private fantasy of power and control, steering vigorously to the left in the direction of the preserves and biscuits. And the other shoppers smile indulgently. But today the wallflowers were over there, to the right.

Quality and quantity agendas, as currently formulated, are irreconcilable. 'Better equals fewer' and 'more equals worse' are simultaneous equations with no solution. Unless — brainwave! — the College, which continues to cherish the hope that MRCGP will become the entrance standard to unsupervised practice, can increase the exam's pass rate to 185%. That should do it. But otherwise the College's policy of 'promoting excellence in family medicine' may make us the enemies of the Department, whose imperative is to do a quick paint job on the NHS in time for the next election. Diplomacy, persuasiveness, and an unblinking gaze are required of our leaders, and we should pray for them now as never before. In the short to medium term, our quality agenda puts us potentially in the same relationship to government as a hedgehog to a truck.

We can console ourselves that hedgehogs, as a species, multiply and survive, while trucks ultimately turn to rust. Meanwhile, though, it would be sad if the last that was heard of us for a bit was a happy 'Brrmm brrrrmm!' dying away on the indifferent air.

Merry Christmas and a ...

How the RCGP works: Number 1 in an occasional series...

11. College Constitution

The Honorary Secretary presented the proposals to introduce new constitutional documents for the College and formally moved the two resolutions on the agenda, which were seconded by Dr John Toby.

Concern was raised by Sir Denis Pereira Gray that the wording of Article 14 of the Supplemental Charter, which set out the rights of honorary fellows, was inappropriate as it did not confer a right on such fellows to attend College general meetings. Although this provision had not been changed from the existing Charter and Ordinances, following further debate, the Honorary Secretary proposed an amendment to the wording of the Article, which was seconded by Dr Philip Evans and agreed by the meeting. The amended Article read as follows:

'14. An honorary fellow is entitled to attend general meetings and to receive all general notices sent out by the College to its members and to participate in the activities of the College as decided by the Council, but shall not as such rank as a member of the College. Persons previously elected as fellows ad eundem are deemed to be honorary fellows for the purposes of this Article.'

The substantive resolutions were then put to the meeting separately. The President asked the meeting to vote on each and on a show of hands the first resolution was passed *nem con* thus fulfilling the requirement for support by two-thirds of those present and voting. The second resolution was then approved *nem con*.

It was resolved:

(1) that a Humble Petition be presented to Her Majesty The Queen in Council, in the form of the draft set out in Annex A to the Notice praying for the grant of a Supplemental Charter as amended (with new Ordinances to be scheduled to the Supplemental Charter) to the College in the form of the draft scheduled to the proposed Petition, subject to such amendments as Her Majesty in Council may require; and

(2) that the Bye-Laws made by the Council on 14th September 2002, as set out in Annex B to the Notice, be confirmed, contingent upon the grant by Her Majesty The Queen in Council of the proposed Supplemental Charter referred to in Resolution (1) above.

RCGP AGM, November 2002

The President, Professor Dame Lesley Southgate was in the Chair. More than 25 members were present in person and therefore a quorum was present.

Notice of the meeting had been circulated on 16th October 2002.

1. Welcome

The President welcomed everyone to the meeting and referred to the Mace Procession which customarily opened the meeting and which on this occasion had been led in by the College piper, Dr Ronnie Seiler.

2. Appointment of Honorary Fellows

Dr Sheila Adam, Professor Sir Ian Kennedy, Professor Bengt Linder, Professor Roger Strasser, and Mrs Sarah Thewlis were appointed to Honorary Fellowship and presented with their Fellowships by the President.

3. Presentation of Awards, Medals, Prizes and Scholarships.

The President presented and announced Awards and Scholarships as set out in the booklet Awards and Fellowships 2002, tabled at the meeting.

4. The Rose Prize

The President announced the Rose Prize, a new award jointly supported by the Worshipful Society of Apothecaries and the RCGP for a project on the history of medicine. The award would be presented once every two years and the first such occasion would be in 2004.

5. Appointment to and Presentation of Fellowships

The meeting appointed to Fellowship those members whose names appeared in the booklet Awards and Fellowships 2002, tabled at the meeting.

6. James Mackenzie Lecture

Professor Mike Pringle, University of Nottingham, presented the James Mackenzie Lecture 2002, entitled 'A Dog's Life'.

Routine Business

7. Annual Report of Council 2001–2002

The Chairman of Council, Professor David Haslam, presented the Annual Report of Council for the year 2001–2002 and highlighted major events. The report was adopted *nem con*.

8. Accounts for the Year 2001–2002 and Auditors' Report

The Honorary Treasurer, Dr Tony Mathie, presented the Accounts for the year ended 31 March 2002. He also presented the report from the College's Auditors. The Accounts were adopted *nem con*.

9. Auditors

Messrs Buzzacott were proposed and appointed as Auditors until the 2003 General Meeting. The meeting also authorised

Council to agree arrangements for fixing the remuneration of the Auditors.

Special Business

10. Annual Membership Subscription — reduced subscriptions — Amendment of Bye-Law

The Honorary Treasurer introduced an amendment to Bye-Laws 2.(A), the effect of which was to delete the words 'and has been a medical practitioner with full registration from the General Medical Council for less than 10 years' in the first sentence. This wording had proved to be confusing and had offered no benefits to any significant number of members.

It was resolved that Bye-Law 2.(A) be amended to read as follows.

'One-half of the Full Subscription

Except as provided for in sub-sections (v), (vi) and (vii) hereunder, any Fellow, Member or Associate who on 1 April of any subscription year has a gross income from all professional services of £20 000 or over per annum, and has, on that date, been a Member or Associate of the College for less than five subscription years, shall pay one-half of the full annual subscription. Gross annual income will be based on the previous year to 31 March. The five-year period will commence from the date of completion of vocational training or the first date of College entry, whichever is the later.'

11. See margin.

Routine Business

12. Council 2002–2003

The Honorary Secretary of Council, Dr Maureen Baker, announced the Faculty representatives appointed to serve on Council for 2002–2003 and the other members who would continue to serve on Council in 2002–2003. Following their success in the elections earlier in the year, the following were newly-elected or re-elected members of Council to serve from 2002 to 2005: Dr Graham Archard, Dr Tony Downes, Professor Jacky Hayden, Dr Brian Keighley, Dr Mayur Lakhani, and Dr John Toby.

13. Spring Symposium 2003

The Spring Symposium 2003 will be held in Bristol.

14. Date and Time of 2003 Annual General Meeting

The Honorary Secretary announced that the 2003 Annual General Meeting would be held on Friday, 14 November 2003, commencing at 2.00pm.

15. Concluding Remarks

The President thanked everyone for attending the AGM and reminded the meeting of some of the very many successful events that had been held during the College's 50th anniversary year which was concluding that day.

Boxes

THESE are 22 consultants in our department. All of us received a cardboard box through the post. It measured 18.5 x 13.5 x 5.5 cm. Inside was another box, a marvel of paper engineered with complex tucks and flaps, and inside that were just two pieces of paper. One was a prepaid postcard, the other a gatefolded picture of some anaesthetic equipment. Some of us opened the box, but most of us, forewarned, threw it in the bin.

So a mailshot of our department took up 0.03 cubic metres of space, first in the post office, which presumably gained something from the 44 pence it cost to deliver each box, but then in our post room, which can ill afford to have to deliver a pile of completely unnecessary and unsolicited rubbish. There are 2500 consultant anaesthetists in this country. Storz, the company responsible, took up 3.5 cubic metres of NHS space. I hope the advertising genius who thought up the idea is downsized.

I throw all advertising arriving on my hospital desk unopened into the bin. In our department, one of us sits on the equipment committee and another on the drugs and therapeutics committee. If they think we need something, they read about it, or see it, and ask the rest of us. We are generally happy to take their advice, and I don't intend buying my own private anaesthetic machine, nor my own drugs. I'm sure this is true for my colleagues, and for almost all other consultant anaesthetists. As clinicians we are threatened with all sorts of guidelines for best practice. Some of these are consensus statements, thrashed out with much dissent and argument. There is nothing wrong with dissent. Medicine, despite what some people would like to think, is often an uncertain discipline. But there is much wrong with imposing consensus. Whether we wish to argue with NICE that best practice demands ultrasound for the insertion of elective central venous lines (and I am only too happy to use ultrasound if my trust will buy the equipment and train me), only an idiot would think it was best practice to waste trees, energy, and the precious time of NHS staff by posting empty boxes around the country.

In the wake of the consultants' rejection of the gravely flawed contract, Alan Milburn is busy slagging us off as greedy. He is threatening to appoint 'junior consultants' so that he can continue his 'modernisation'. What happened to the insistence that we must be properly trained? His bullying and lack of logical thinking about health care are more obvious by the day. He needs the consultants. Why doesn't he take out his aggression on the people who waste our time posting us empty boxes?

Nev.W.Goodman@bris.ac.uk

THE VERY EXTRAORDINARY CASE OF DR SACHS...

BACK in 1998, the year I closed my practice in Strasbourg after several years of trying to remake myself as a French doctor, a remarkable novel appeared on the stalls: it gave vent to my own mood of frustration, sorrow, and disbelief that Europe's *grande nation* could expect its GPs to work under such economically straitened and socially isolated conditions. What was that old chestnut about the British being a nation of shopkeepers? — It was the French who seemed unable to conceive of social relations in terms other than those imposed by the market.

More remarkably, *La Maladie de Sachs*, Martin Winckler's second novel, found a huge public. Awarded the Prix de France-Inter (by a radio jury) that year, it went on to become a bestseller and has since sold more than 600 000 copies. A sober film adaptation was made the following year by Michel Deville, and the novel has appeared in an excellent American translation by Linda Asher as *The Case of Doctor Sachs*. Martin Winckler (born into a medical family in Algiers in 1955 as Marc Zaffran) has seized the opportunity offered him to speak up on behalf of his public: his radio slot, *Odyssée*, can be heard every morning on France Inter. His latest book — *C'est grave, Docteur?* — is a tour of the body in lay language. He is a man with a mission, and he makes no bones about his dislike of the French medical establishment: 'doctors', he roundly declares, 'are cowards'.

Winckler's defence of the patient's point of view may initially seem surprising in a country such as France, where patients are free to shop around for a doctor — any kind of doctor. The morality is the market's: patients demand, doctors oblige — when Sachs refuses to prescribe a lipid-lowering drug to one crusading client the rebuke is rapid: 'Who does he think he is? After all I know better than he does what I need. Who's the patient anyway?' In many respects, France remains a conservative, rigid, and even mistrustful country, and its old scholastic habits have survived perhaps most comprehensively in its disease palaces — the hospitals. At the bottom of this medical hierarchy are purblind GPs. Forty years ago, they might have been small-town notables; now they're lucky if they find a rung standing in for the priest-confessor of earlier times. Other habits die hard. France was one of the last countries in Europe to allow patients access to their hospital dossiers (in 2000), and even today doctors are chary about giving patients bad news, especially of cancer. Morphine, too, remains underused (see why in the 'Little Medical Afflictionary' below), while the consumption of antibiotics and psychoactive drugs remains sky-high.

Martin Winckler is an engagingly open writer. He has translated and written about American TV series and *polars* (detective novels), and their influence is discernible in the pace and framing of his book. His fictive 'conscripts' in *La Maladie de Sachs* include Mesdames Queneau (the nurse), Borgès (the cleaner) and Matiouze — all fetish writers of his, the last presumably a long-lost relative of the American expatriate Harry Mathews. Sachs' name nods to Oliver Sacks, the well-known American neurologist. Even the pen-name Winckler is a tribute: to the eight-year-old deaf-mute in Georges Perec's *W or Memory of Childhood*. One of France's greatest recent writers, Perec (1936–1982) was a tireless compiler of lists and inventories, and his interest in what he called the 'infraordinary' — routine actions and quotidian events — is carried over profitably into Winckler's work.

At the heart of his novel is that odd, ambivalent, involuntary thing called the doctor–patient relationship, although under French conditions it sometimes feels like a heart cut out. Some doctors might talk down to their patients, but Sachs' patients address him in the second person singular. This is a clever narrative strategy: it puts Sachs under scrutiny, and lends an oddly objective touch of intimacy to his dealings with them (voice-offs are used in the film). Sachs comes across as intelligent and caring (no over-prescriber), a bit stiff in his decency perhaps; he often fails to see how much the treatment he doles out is mutual. Interestingly, the ideal doctor he aspires to be comes from Balint's *The Doctor, the Patient, and the Illness*, the 1950s study that helped establish British general practice as a discipline uniquely positioned to surmount the mind–body divide. That was a generation ago, of course: it is doubly ironic that market liberalism is making British medicine more 'French' by the day.

Though *La Maladie de Sachs* seems to want to escape the adversarial politics that have characterised France since the war, it actually continues a 20th century French genre, the medically-inspired study in alienation. Where else are doctors perceived as outsiders in their own society? And what a transformation from the saviours of society who put a better foot forward in Zola and Balzac! For that reason alone it will be interesting to see what Winckler does next — whether his humanism is robust enough to develop in the land of many -isms or whether it succumbs to the politics of the person, which is no politics at all.

Iain Bamforth

Marc Zaffran, Martin Winckler

Selected publication list:

La Vacation (Editions P.O.L.), 1989.
La Maladie de Sachs (Editions P.O.L.), 1998.
En soignant, en écrivant (Indigène), 2000.
Contractions mode d'emploi (Au Diable Vauvert).
Légendes (Editions P.O.L.), 2001
C'est grave, docteur? (Editions de la Martinière), 2002
The Case of Doctor Sachs (trans. Linda Asher), Seven Stories Press [www.sevenstories.com], 2000.



MARC ZAFFRAN ON MARTIN WINCKLER

I've always loathed books by doctors. And despite that, I believe medicine and writing go hand in hand. In order to preserve the record of what they know, of what they do, doctors have to keep written signs. Words fly off. Or, worse, undergo a sea-change in people's memories. Writings remain. They've always been a fixed point for me. All the more so since I often forget what I've written. But I've come to understand, with the passing years, that each text, even if just a sketch, contains in embryo a further text.

This is particularly true of the texts in this collection. Not only are they a repository for my own anger and arguments against the medical establishment, but they also preserve the outlines of characters, dialogues and forms I've made use of later when writing my books.

In my eyes, all writing is a part of a whole, not a succession of literary pieces whose genre dictates their value. Whether medical translations or novels, essays about television series or autobiographical jottings, all texts count. I don't draw up a hierarchy. It's not my job to do that. But I have my preferences, based for the most part on what I feel when I read. I believe in the value of intuition in literature, just as I believe in the value of intuition in medicine. In that, I feel myself to be closer to English-speaking doctors, who accord great importance to proven facts but never stifle their own sensitivity or that of the people they care for. Paradoxically, it's because they take account of pain 'objectively' — by considering it as an aspect of disease in its own right — that they have no difficulty in relieving it.

French medicine, on the other hand, prides itself on being 'neutral and benevolent' although a doctor is neither. A doctor is not a robot, but the double of the person he is treating. That's the main source of my anger as a writer. By prohibiting caregivers in training from voicing — indeed from feeling — their most disturbed emotions and making them believe that they constitute an elite distinct from the rest of the population, by turning a deaf ear to what their patients say or filtering it through their diagnostic grids, by elevating lying by omission into an ethical rule and treating patients as incompetent majors, French medicine is responsible for the extraordinary gulf which has been dug between it and the population.

One of the principal signs of this gulf is the overspecialisation of a majority of practitioners, and their disdain for general medicine. Not so much for GPs themselves, but for the conditions under which they practise, the type of relations they establish with their patients, their daily struggle against social, political and bureaucratic factors which have nothing to do with the diseases described in manuals but everything to do with the sufferings of those who consult them.

I've always loved variety — in literature as in medicine. I've never taken the attitude

HOW TO LOOK AFTER YOUR DOCTOR

[Comment Soigner son Médecin]

A doctor isn't necessarily someone who's always patient.

Sometimes he's fed up to the back teeth with repeating the same old thing about the pill, coughs and colds, vaccinations, coughs and colds, 18-month checks, coughs and colds, bronchites, coughs and colds, back pain, coughs and colds, cancers-which-aren't-but-which-are-far-more-common-than-cancers-which-are-really-cancers (but you know how it is with everything that you see!), coughs and colds, fitness certificates for sports, coughs and colds, sore throats, sore ears, purulent noses, recurrent sore throats and corns on the feet.

A doctor isn't someone who works for the happiness of mankind, but because being a doctor is a job. A doctor isn't someone who likes people to be ill, he's someone who'd like to treat only people in good health. A doctor isn't someone who likes handing out medications; if he does it's because the laying on of hands doesn't do any good. A doctor is someone who wants to strangle parents when they threaten to give their kids jabs if they don't behave themselves. Because a doctor is someone who feels sympathy for some of his patients, and dislikes others.

In short, if you didn't know (and if you'd forgotten, it's not a bad idea to remind you of it) a doctor is an individual like any other. He has a car that doesn't start, problems with the tax man (yes, I know, there are problems with the tax man we'd all like to have...), an inflammation of the

NO TO THE HOSPITAL AS CONCENTRATION CAMP [Contre l'hôpital]

In *The Case of Doctor Sachs (La Maladie de Sachs)*, a GP recalls the period when, as a student, he rebelled against the faculty and the hospital. He finds a leaflet from his student days which bears the words: 'We are all Nazi doctors'. Sickened by the totalitarian ideology of the world of the university teaching hospital, and after having come up with a few over-the-top examples, Bruno Sachs drove the point home a few pages on by declaring: 'And while GPs are just little kapos, hospital chiefs — with a few exceptions — are real big Mengeles.'

When I wrote those words, it occurred to me that should that phrase and the pages which follow it ever be read by colleagues, I would receive scores of threatening letters. The violence and rebelliousness expressed in this part of the novel were not

that some literary genres are inherently noble, and others not. Writing is a tool. It can be used to represent the world or to question it any of many ways. Some — and I'm one of them — believe that the completion of a text, its range, are intimately bound up with its form as well as its content. Formalism doesn't make a text. Empty ideas remain empty whatever the vocabulary or the syntax. But, the most potent ideas are futile if the spectator isn't caught up by the text. If the text hasn't been worked on in order, reciprocally, to make the reader work.

I've been writing for ages, but I've never really had a 'big' literary project. I was writing, that's all. Text after text. But the same is true of writing as of any artisanal activity, of any practice. When you're not afraid of experimenting, you learn a lot. First and foremost, how to master your instrument. To play it without having to think about it.

I've been very lucky, and this collection shows it: in meeting after meeting, experience after experience, I've tried lots of things in the 20 years I've been writing. Different themes, different forms, different publics. In doing so, I've attempted to get as close as I could to the writers I most admired — those who had no prejudices when it came to writing. But the purpose of this permanent experimentation, subconscious no doubt, was to acquaint myself with all the describable and indescribable feelings my profession of physician might stir up in me.

As some readers will observe, many of the texts reprinted in this collection announce, sometimes years in advance, some of the characters or central themes of *La Maladie de Sachs*. The most astonishing thing was that before rereading them, I couldn't remember having invented 'Madame Renard' when I worked on the review *Prescrire*, and I couldn't recall having previously written a text presenting Balint groups. No more, as it happens, than I remembered having written, in my diary, that 'one day, I would have to learn how to do TOPs', ten years before writing up this same experience in a novel called *La Vacation*. Things like that happens because I forget what I write.

The whole point of a collection of texts is not to show retrospectively what a prolific or inspired writer you've been all these years. As far as I'm concerned it's a way of reminding yourself of the person (writer, physician, citizen) you've been and continue to be. A tree sheds its bark but its layers persist. Under the skin of the forty-year-old there's still the rebellious boy, the untried physician, the apprentice-writer. I know they're there, but I sometimes have the need to find them again, to look them in the face.

I write in order not to forget who I am.

I concentrationnaire]

exaggerated: the stories which gave rise to it are part of my own experience, even though I haven't lived all the stories I cite in my role as doctor. Two years have slipped by, and despite the huge number of letters, signings and meetings which have followed on from the publication of my book, the hard landing I'd expected hasn't come to pass. If the book had stayed *samizdat*, it would have been easy to imagine that, lacking the time to read it, doctors would have remained unaware of its existence and contents. However, the book has sold more than 400 000 copies, most of my mail comes from caregivers of all types, it is now recommended reading in medical schools, and I'm invited to talk at postgraduate medical meetings, nursing conferences and to students in their lecture rooms. The number of readers who've asked me to sign the book for a parent, friend or acquaintance who happens to be

LITTLE MEDICAL AFFLICTIONARY

[Petit afflictionnaire medical]

Antibiotics [Antibiotiques]: medications for lowering fever. Always a source of tiredness, they should never be taken with milk (makes your stomach turn). Very common cause of allergy.

Cholesterol [Cholestérol]: modern equivalent of the ancient gods. When it climbs, sacrifices have to be made (no more butter, meat, sugar); when it falls, one indulges (no more medication).

Diagnosis 1 [Diagnostic 1]: complex mental process at the end of which: (a) the doctor names the disease or (b) the patient dies without anyone understanding why. (These two propositions are not incompatible.)

The intellectual process is the product and conjunction of knowledge, intuition, hunches and sometimes amazing revelations, and may be compared with the resolution of a crossword puzzle in which symptoms are the horizontal definitions and signs the vertical definitions. The doctor is able to call upon three diagnostic tools: blood tests, appeals to specialists, and hospitalisation.

Diagnosis 2 [Diagnostic 2]: (by extension) capacity possessed by a physician to resolve crossword puzzles more or less reliably, i.e. to provide an explanation for everything including an inexplicable death (Example: 'He has a good nose for diagnosis:').

Family [Famille]: universal pathogenic medium, resistant to antibiotics, vaccinations and to all therapeutic methods invented in the last six thousand years (see Family Doctor).

Fever [Fèvre]: symptom which justifies:
1. wrapping babies in three pullovers and twin covers (to avoid them catching cold);
2. calling the doctor at night (in order to be sure of finding him at home);
3. prescribing antibiotics (in order to avoid a complication);
4. issuing a sick note for the mother (in order to ensure that baby doesn't develop an allergy to antibiotics).

Illness [Maladie]: the sum total of unpleasant phenomena that brutalise the body and mind of a patient, and whose cause, development and nature is codified, described and indexed in all good medical treatises. An illness is often a hydra with several heads. Whether it affects the body (physical diseases), psyche (psychiatric diseases), both (a real mess) or neither (psychosomatic diseases), its origin is either external (measles, dysentery, malaria, chemical pollution, radioactivity, family conflict), internal (resentment, guilt, frustration, cancer) or mixed (that's life...).

Family doctor [Médecin de famille]: species currently in the process of disappearing. After rapid mutation in the last 50 years, the supposed focus of the family doctor's attentions has acquired a

knee that prevents him from doing his ten kilometres three times a week (but not his home visits) a forehead that's losing its hair, a brother-in-law who had a bout of renal colic last night, friends who come to tell him their life story when they're worried about their health or their relationship, children who say that they've got tummy pains when they come home in the evening, relatives dying in hospitals where they don't know a soul. In short, compelled to be a doctor all the time, a doctor sometimes feels like doing something else.

So, when you think about it, he has just as many problems as you, this man. A few more perhaps. For you, the crick in the neck that came on this morning on getting up is almost a godsend, you won't have to go to work today, and then it'll go, in three days the last twinge of it will be gone. Whereas he'll still be a doctor once your neck is cured and you've forgotten his existence and thrown away his prescription. Because being a doctor is incurable!

Now a doctor is someone who gets worn out if treated badly. For a doctor to be useful, operational, well-performing, and if he's to last a long time too, he needs to be handled gently. Are you going to consult him? Are you quite sure you've nothing serious? Well, make a little effort! Smile at him when you come in for the consultation, that will cheer him up. Ask him for explanations by making it clear to him that it's just to inform yourself, and not to annoy him: that will set him at ease. Tell him that you don't necessarily need treatment if it's not necessary: he'll have the illusion that you've been cured simply by seeing him. Advise him to take holidays (without saying that he looks tired, that will annoy him). In three words: look after him.

He'll be eternally grateful to you and, with everything that you see, you never know when you might need a doctor...



a doctor, or even for their own doctor, is considerable. Not only is *The Case of Doctor Sachs* the highest-selling novel in 1998 (and one of the highest-selling in 1999), it is probably the medical novel most read by doctors since André Soubiran's *Les Hommes en blanc (Men in White Coats)*.

Although most of the expressions of sympathy have come from GPs, many of whom recognise themselves in the dialogue and experiences recounted in the novel, I've also received many letters, and not a few warm handshakes, from specialists or hospital doctors met during my tours. And not once have I experienced any sign of hostility or the least reproach about Bruno Sachs' wild utterances.

This silence doesn't catch me unawares. Hospitals might have been terrible places 50 years ago (have a look at Soubiran's novels), but that was no longer quite the case 25 years ago and the situation has surely changed since then. For the better, it is to be hoped. And despite that, not a single indignant letter, no outraged reaction, no complaining letter to the Regional Medical Council (it is well known that doctors complain about their colleagues at the drop of a hat, which is precisely why they're afraid their patients might one day do the same...).

On the other hand, I received an astounding letter from a 70-year-old historian and philosopher, a specialist in concentration camp history who had shortly before undergone an operation for a cancer of the oesophagus: he described his stay in hospital as being something like a concentration camp. 'With one exception', he added, 'there I could have thrown myself against the barbed wire and have ended my misery in a salvo of machine-gun fire.'

The reason for the silence of the caregivers is not, I believe, because they're indifferent to what I've said. When their reputation is on the line, hospital doctors are too touchy to overlook what's said about them in a work with a large circulation. What takes the wind out of the sail of any commentary, I believe, is that hospital doctors are well placed to know that, here and there, hospitals are indeed more a source of suffering than of care. Having become specialists by inclination or necessity, they're aware of not having all the skills needed to respond to the entire gamut of symptoms expressed by the patients in their bed. Caught between the burden of administrative duties, the chronic lack of medical staff, the falling number of house officers and budgetary restrictions, they are perfectly aware of the fact that they are unable to shoulder completely their triple mission as caregivers, teachers, and researchers. For some, care comes after the clinical trials. For others, teaching is sacrificed for an efficiently running department. Furthermore, some hospital doctors lack, and lack by a mile, the proper attitude to the persons they are supposed to be looking after. Their blank spots have nothing to do with their degree of competence, but are part and parcel of in their general attitude to patients. Not everybody likes those he or she has to treat: this is as true of hospital doctors as of other health care personnel. But why are they doing the job then? And not only that, but on what grounds do we allow them to do the job? Why do we allow colleagues to behave abjectly without saying a word? Why do we let alcoholic surgeons operate without so much as lifting a finger? Why do doctors hesitate to blow the whistle on colleagues guilty of behaviour which is at least questionable, if not criminal?

Let it not be thought that this is just a matter of challenging other doctors or drawing attention to exceptional situations. Awkward personal questions are something each one of us should be asking.

Those of you reading this article, medical colleagues — have you read the hospital patient's charter? All of it? Have you had your patients read it? Have you discussed it with them? Have you set up analgesic protocols that can be administered night or day by the nursing staff? Do you accept to be called outside your on-call period or your contracted time in order to talk about a patient you usually look after? How many times have you sat down at a patient's bed this week? How many times have you taken their hand? Do you set time aside in the day for meeting families? Is it your practice to talk frankly to your patients or do you lie to them as a matter of principle 'so that they don't abandon hope'? Do you find yourself saying things to the family that you wouldn't say to the patient? And inversely? Do you always explain the different diagnostic or therapeutic options to your patients before setting them in

motion? What would you say to a patient who asks you to let him die in peace? Do you take the quality of life of your patients into account when you decide about treatments? Have you ever said things to a patient that you regretted? Have you ever felt the need to offer an apology to a patient? Have you done it? Have you ever asked whether one of your patients has died because of something you did? Have you talked about it to a colleague, to someone close, to your mother or father? Do you ever ask the auxiliary nurse about the welfare of the patient whose tray she has just picked up?

Have you set time aside, in your department roster, for a discussion group that would allow all the members of the health team to express their views? Are you or have you ever been part of a Balint group? Do you know what a Balint group is? Have you already undergone a course of psychotherapy yourself to help you cope with the difficulties of the job? Do you ever weep when carrying out your tasks? When you get home? Do you ever get the urge to pack it all in? Do you have a hobby outside medicine? Does your professional life spill over into your private life?

I could continue this list indefinitely. I don't believe there are 'good' or 'bad' responses to these questions. I don't believe either that they all have to be answered. But I do think that the surest bulwark against the development of the hospital as a concentration camp, against the subconscious sadism we are all capable of, against the confusion between patients and study subjects, between health care and trial protocols, lies in asking ourselves every day some of these questions, or indeed any questions which come to mind and shake our certainties.

The surest bulwark against the violence of medicine, this violence we are all capable of showing through fatigue, obscurantism or mere oversight, is not just our awareness, but more especially keeping open our doubts and methodically questioning the way we act.

All the proof I need is this anecdote, which was told to me by a hospital doctor a year ago during a postgraduate meeting. One of the doctors present asserted loud and clear that the treatment of pain was properly provided in every French hospital department. One of his colleagues raised his hand and said:

'That's not true, and you know it. I underwent arthroscopy a few weeks ago. I received a regional block and everything went well. But three hours after having been wheeled out of the theatre, it started to hurt like hell. I asked the sister to give me some painkillers but she replied that the anaesthetist had gone without leaving any instructions, that there was no question of disturbing the duty doctor for a thing like that, and that all I had to do was go to sleep and it would pass. I was in agony until the following morning.'

And he added in a disillusioned tone: 'I must have deserved it.'

I asked him why he'd said that. He replied: 'I'm a gastroenterologist. I carried out colonoscopies for ten years without anaesthesia or neuroleptic sedation. For ten years, there were two of us there suffering. The patient and me. At the end of ten years, I said to myself: "It should be possible to put patients to sleep ..." and I started to do colonoscopies under general anaesthesia. And since then nobody has suffered.'

'How on earth did it take you ten years to think of doing that?'

'Because I'd been taught to do them that way.'

When doctors are satisfied with slavishly reproducing what they've been taught, the risk of becoming Nazi doctors is high. In order to avoid becoming kapos or Mengeles, it seems to me absolutely essential that we question, on a permanent basis, what we think and what we do while first asking ourselves if it is possible to do more for the comfort and dignity of the persons who entrust themselves to us. The ethics of a doctor are essentially measured by the place which that person — the other — occupies in his or her everyday concerns.

heightened resistance which makes it sometimes insensitive to this category of care provider. Today, it is not uncommon for a family to require multiple therapy involving GP + specialist + psychoanalyst + homeopathic doctor, which at least stabilises the general condition. Some authentic family doctors still subsist in remote regions, but it would seem that urbanisation and the spread of parabolic antennae will soon have put paid to these last pockets of susceptibility (see also Family).

Medication [Médicament]:

1. object of profit.
2. instrument of power.
3. source of allergies. (Example: 'I'm allergic to all drugs but especially to antibiotics.')

Morphine [Morphine]: illegal drug consumed solely by hopelessly dependent junkies and patients in terminal phase. Morphine is the doctor's worst enemy since, by depriving the patient's sense of how painful reality is, it makes him less dependent on the therapist.

Reimbursement [Remboursement]:

complex system for racketeering, laundering and recycling money between a producer (pharmaceutical laboratory), wholesaler (pharmacist), dealer (physician) and drug consumer (the insured person) under the supervision of two nationwide criminal organisations (the French State and pharmaceutical industry).

Sexuality [Sexualité]:

1. taboo subject (in consultation).
2. conversational topic (on TV).
3. main nutritive element of the pathogenic family milieu.

Specialist [Spécialiste]: Doctor who doesn't do home visits, and who looks after only a bit of the anatomy (eyes OR breasts OR haemorrhoids, but never all three at once).

Blood pressure (measurement of)

[Tension (prise de la)]: objective reflection of the doctor-patient relationship (Example: 'He didn't even take my blood pressure!') but differently assessed depending on the observer:

1. for the physician, 'normal' blood pressure is greater than 155 — the figure above which the occasional patient becomes a 'patient on permanent treatment' — or less than 80 — the figure below which hospitalisation becomes a must. Between these two values, French doctors say that the patient has no 'tension' (i.e. blood pressure).
2. for the patient, the blood pressure is 'normal' if, and only if, the figures obtained are strictly identical to those previously measured, even if the reading was three years beforehand. (Example: 'How can that be, 120 on 80? Last year, I measured 130 on 90. It's not normal!')

These selected extracts from Petit Afflictionnaire Médical are translated by Iain Bamforth with the kind permission of the author and can be found in En Soignant, en écrivain, 2000.

'We write because we forget what we write. I write in order not to forget who I am.'

Marc Zaffran

our contributors

Iain Bamforth has secured a two-book deal with Verso in 2003. Next year's Christmas presents for the discerning reader...

Gillie Bolton, *La Grande Dame* of Therapeutic Writing, has moved from Sheffield to London, to King's College.

Morvern Callar is a film worth seeing

John Gillies is a GP in Selkirk. He drove *Medicine and Society*, a joint RCGP and RCPE working group, that reminds us that there is rather more to medicine and life than National Service Frameworks.

John Horder, with five others, wrote *The Future General Practitioner*. Enough said.

Richard J Huntsman is recently retired to Norfolk, where Elizabeth Fry and Horatio Nelson are the county heroine and hero.

Anthony Lamb practises in Stafford.

Dorothy Logie would commend the *Lancet's* ongoing series on Medicines, Society and Industry (I-III, 360; 1590).

Richard Meakin is an elegant King's College medical humanist, and amanuensis for Gillie Bolton.

Tim Miles edits *Dyslexia — the Journal of the British Dyslexia Association*. He is Professor Emeritus in the Department of Psychology, University of Wales, in Bangor.
pss044@bangor.ac.uk

Roger Neighbour spends almost as much time in France as Martin Winckler. His next book, *Consultation Skills for Shepherds*, in contemporary Lowland Scottish, will be published during 2003, and will revel in ostentatious Scotticisms.

Glasgow twinned itself, in November 2002, with Havana, Cuba, so it is appropriate to publish in this issue an article co-written from both cities.

Cosme Ordóñez is Director and Professor of Epidemiology, Division of Community Based Sciences, Policlinic 'Plaza de la Revolución', Hermita y San Pedro, Plaza de la Revolución de la Habana, Cuba, and **Peter Cawston** is a clinical lecturer at the Department of General Practice and Primary Care, University of Glasgow. Cosme remains more rhythmic.
P.G.Cawston@clinmed.gla.ac.uk

Gilles de Wildt complains a lot less about British trains and the NHS since transport and health care went pear-sheeped in his native Holland.

James Willis samples commercial genomics in the January 2003 issue of the *BJGP*, available at all good newsagents.

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

IAIN Bamforth has done a superb job of translating a new collection of Dr Marc Zaffran's writing for this issue. But Zaffran the man needed no translation; to an audience of British doctors this Frenchman obviously speaks our language. It is a comfort and strength to all of us that his plain, uncompromising words — going straight to the subtle, contradictory, intensely human heart of our job — have proved so popular with 600 000 miscellaneous Frenchmen. The highest selling novel of 1998 no less, and nearly that in 1999.

And this is not hi-tech, whiz-bang, saving-lives-with-both-hands, Emergency Room stuff. Rather the reverse; rural French general practice is revealed in *The Case of Doctor Sachs* to be surprisingly low-tech, not a computer in sight; surprisingly passive; surprisingly vulnerable. Nor is this another old-fashioned Casebook — the sophistication and intricacy of this tale (just try to work out why some of the pages are grey, for a start, never mind the extraordinary, dare I say unique, crossed searchlight-beams of the second person narrative style) is one of the things which makes its success so remarkable.

What this book is, is a story of people meeting and of people not meeting, of people looking into one another's eyes, souls, hearts, and of people carefully (or carelessly) not looking into those places. It is a good new story of a good new journey through the good new vicissitudes and the good new joys. It is a record, chiselled into the stonework of our age, and it reminds us who we are, lest in all the spin and all the calculus we forget.

One of the nicest occasions I can remember was being invited to St Malo to meet Marc Zaffran and to talk about his book. Dougal Jeffries had spotted its significance on reading it in the original French (not in general practice is Renaissance Man extinct!) and the fact that it bore similarities to my book, *The Paradox of Progress*. Dougal had been eagerly waiting for a translation to appear so that he could recommend it to colleagues. Now that the English (or rather the excellent American) version was out, he had arranged a double-bill cross-over session for his trainer's group annual study weekend. Marc Zaffran was to talk about my book and I was to talk about his. It was unfortunately necessary for him to read my book in its original English — one of the obvious differences between them — and in recompense the entire British contingent embarked for France to join him in the privations associated with his land. As I say, a happy memory.

Marc Zaffran paints a picture of French general practice which is a revelation because it is so like the picture we see here. I don't mean the picture which is officially broadcast but the one that represents our experience behind the closed surgery door. He is a passionate advocate of generalism, even more beleaguered in France than it is here, and just like us, he is conscious of the absurdity of the specialists' assumption that the narrow view is inherently more valid than the broad and the long. Just like us he is angry about the 'subconscious sadism' and 'violence' that doctors can do by, for example, 'filtering what patients say through their diagnostic grids'.

We can't all write a number one best-seller. So in a mysterious way Zaffran is writing for us all. Because we respond to what he has written and see that it is true he is chiselling that record on behalf of us all. And when the world outside sees the chiselling and understands and values it too, that is something for us all to celebrate. That may change the world a little on all of our behalves. If he expresses an anger which many of us share, and if he manages to make things a little better, then we are all the richer for it.

And, in future we will all know where to look when we want to remember who we are.