The British Journal of General Practice

viewpoint

No user-fees for healthcare... We're British!

The new White Paper for the NHS has again reiterated that NHS services, including visiting family doctors, must remain "free at the point of use". No-one can be especially surprised, given the furore that ensued when Frank Dobson, the UK secretary of state for health, even hinted over the summer that charging patients to see GPs might become necessary.

But what about the poor parts of the world, especially Africa? Since the 1980s the sick have had to pay for visits to clinics, for drugs, for operations. "User-fees" for health and education are strongly espoused by the World Bank, and equally strongly rejected by non-government organizations working in poor countries. These charges are part of "structural adjustment programmes" agreed during loan negotiations in heavily indebted countries. When a country's economy is being "adjusted" it makes a promise to cut back on social spending, which means health and education. So, with strained health budgets, how else can poor countries finance health?

The theory behind charges is to raise revenue which can then support quality services, thereby producing a positive effect on utilization. The logic is backed by an experiment in Bamako, Mali, in 1988, where the local community using health centres agreed to pay modest charges for consultations and drugs. The revenue generated by these fees was retained in the health centre and managed by locally elected committees who re-invested it in improvements in drugs, wages of health workers and services. Like many "experiments" the initiative received considerable technical and financial assistance. And, surprise, it worked. People did use the health centres more and received better care. And everyone was happy. At least while the extra funding flowed.

So user-fees became the greatest thing since sliced bread (not that African have much of that). Throughout the 1980s, almost everyone in poor countries paid for health care; and the same is true today. But with no "pump-priming" from external sources, and because the money generated has not remained locally but been swallowed up into bottomless pits of Ministries of Finance, user charges have been a disaster for Africa's health. They are as much a cause of Africa's pitiful health record as the drain on health budgets for debt repayments.

The cost of treatment is very high in relation to the income of the poor: fees for just one consultation can amount to more than one day's wage for an agriculture worker. Health care has been priced beyond the means of many, and exemptions (such as there are) are bureaucratic to implement and do not adequately protect access for the poor. Preventive services, like antenatal care and family planning, are especially hard hit. In Zimbabwe, with the introduction of fees maternal mortality doubled between 1991 and 1992.

All this may have little to do with us, I hear you say. But, when the poor delay seeking treatment for their illnesses, under-dose or fail to complete drug regimes, when STDs go undiagnosed and AIDS spreads, when TB is inadequately treated, when patients default from follow-up and public health measures are hard hit, then, sooner or later, it will become our problem. You just need to climb into an aeroplane with someone with drug-resistant TB and that could be your, or your patient's, death knell.

And there is the question of justice. If we shrink from inflicting charges on the UK public, what right have we (and remember it is we tax payers who support the World Bank) to inflict charges on 300 million people, half Africa's population, who exist in grinding poverty? Shouldn't we be making much more protest at both the injustice and the short-sightedness of such policies?

Dorothy Logie

The Back Pages...

"... serious ideas seem to have to be expressed seriously in order to be taken seriously..."
or have they?
Willis, on page 948

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An evidence-based medicine journal club for general practitioners

Despite a growing interest amongst general practitioners in developing evidence-based practice, there are limited opportunities for us to acquire the skills needed to do this. David Sackett has described an EBM journal club which seemed to work well for clinicians in a hospital setting. We decided to try out Sackett's model with local GP colleagues.

Our journal club was advertised as a forum for GPs to share problems presented by patients seen in the surgery and to develop an evidence-based approach to solving them. We intended that GPs would acquire the skills necessary for critical appraisal of published research and hoped their enthusiasm would be stimulated to put research into practice.

Ten GPs from local practices signed up for the journal club, which was held at the London School of Hygiene and Tropical Medicine in Bloomsbury and met 13 times. We ran the meetings and acted as 'tutors' where necessary. We had secretarial help to track down journal articles and circulate papers. Funding from the LIZEI scheme covered our costs and also enabled the GPs to attend with no course fee and with locums paid for. PGEA approval was obtained.

We gave everyone a short questionnaire at the start which showed that participating GPs were currently spending about an hour and a half a week in reading related to clinical practice, with the 'free' magazines and the *BMJ* being about equally popular. Textbooks were consulted about a patient-related problem with a frequency varying from once a month to once a day. Journals were much less commonly used for this purpose, and literature searches were rarely performed. Six GPs used a patient-based computer system in the practice, and nine had a PC at home, six with a modem.

How the journal club worked

Introductory sessions introduced participants to the concepts of EBM and critical appraisal, literature searching using Medline, and basic statistics. Subsequent meetings fell into three parts:

1 We began by discussing patients seen recently with clinical management problems which EBM might help to solve. A couple of these clinical problems were then chosen, and the appropriate questions formulated for literature searches. GPs took it in turns to do the searches and bring abstracts to the next meeting. Searching was done on home or surgery systems via the Internet or the BMA dial-in Medline service , or the GPs came into the LSHTM where help with searching was available from a librarian, or, by arrangement, from one of us.

2 Next we discussed the abstracts generated from the searches on the previous meeting's questions. One or two journal articles on each topic were selected for critical appraisal at the next meeting.

3 Finally, the journal articles chosen last time were evaluated for their validity, relevance and potential to influence practice.

The clinical discussions covered a wide range of basic primary care problems and extended beyond individual patients seen to include topics that had aroused interest because of recent reports or attendance at other educational events. The problems chosen for a literature search are shown in Table 1. It was often difficult to formulate a suitable question to search on because many of the issues raised were not obviously amenable to investigation by randomized controlled trial in a primary care setting. This was confirmed by the paucity of published evidence found on some of our Medline searches.

How well did the journal club fulfil its aims?

As one would expect in this kind of forum, there was broad agreement amongst participating GPs on the general principles of management of the clinical problems we discussed, but a wide range of views about the specifics of treatment for individual patients. It was frustrating but also comforting to discover that evidence was often insufficient to resolve our differences. It seemed easier to

Enjoyable, educational and worth emulating...

Suggested reading

Sackett DL, Richardson WS, Rosenberg W, and Haynes RB. ***Evidence Based Medicine. How to Practice and Teach EBM***. London: Churchill Livingstone, 1997

Muir Gray JA. ***Evidence-based health care: how to make health policy and management decisions***. London: Churchill Livingstone, 1997

Greenhalgh T. ***How to read a paper : the basics of evidence based medicine*** London: BMJ Publishing Group, 1997

Jacobson LD , Edwards AGK, Granier SK, Butler C. Evidence-based medicine and general practice. *Br J Gen Pract* 1997; **47**: 449-452

Allery L, Owen P, Robling M. Why general practitioners and consultants change their clinical practice: a critical incident study. *BMJ* 1997; **314**: 870-4

identify relevant and accessible evidence when considering issues of clinical policy for a practice, such as drawing up protocols for the management of patients with common conditions like hypertension or sore throat. Perhaps this is the level of decision making at which EBM has most to contribute at the moment in primary care.

Although the GPs on our course enjoyed learning how to use Medline, most GPs will not be doing database searching often enough to attain and maintain competence. GPs would be best served by fast, easy access to good quality database searches, and a library service which can provide copies of journal articles quickly. Very few of us have this. The development of the Cochrane database may go some way to filling the gap.

Almost all the clinical problems we discussed were related to decisions about treatment. As a result, most articles selected for critical appraisal were reports of randomized controlled trials or systematic reviews of therapy. Ideally, participants in the journal club should have had more opportunity to develop skills in critical reading of articles on diagnostic procedures, qualitative research, audit, guidelines and economic analysis, as these are also very relevant to the work of general practice. It should be feasible to incorporate this within the journal club format.

Is it worth setting up EBM journal clubs for GPs?

We found the journal club format useful and popular, and it was well attended, although we are mindful that the generous funding provided made it an attractive educational proposition. All the GPs described themselves as feeling more positive about evidence-based medicine as a result of the journal club, and considered that their clinical behaviour had changed as a result of coming to the sessions.

To work successfully a journal club needs a convenient location, good administrative support and a significant input of time from at least one 'tutor' with EBM experience. Preliminary training in search and critical appraisal skills would be essential for most GPs. A large practice, or a group of smaller practices might be able to set up similar clubs in practice premises, but there are significant advantages in locating it in an academic institution where search and library facilities are on hand.

The journal club certainly stimulated enthusiasm for EBM and went some way towards providing GPs with the skills needed for a more evidence-based approach to practice. The format could be further developed to address the problems we identified. However, it is not to be expected that an educational initiative alone can overcome all the barriers to the integration of EBM into GPs' daily work. Whilst recognizing these limitations, we commend the EBM journal club as an educationally appropriate format to stimulate general practitioners to explore the possibilities of, and acquire the skills for, an evidence-based approach to clinical problems. We would be happy to give advice to any GPs, course organizers, registrars or postgraduate tutors who are interested in establishing a journal club in their area.

Berry Beaumont
Peter McCartney

Question	Conclusion
In post herpetic neuralgia, are there any effective treatments for prevention?	No Some
In a child under 2 with recurrent wheeze who is acutely ill, are inhaled steroids more effective than the oral route?	Uncertain
What are the risks and benefits of arthroscopy and wash out for osteoarthritis in the knee in a 60-year-old woman?	Uncertain
In a 27-year-old woman with a 24-hour history of Bell's palsy, do oral steroids prevent permanent paralysis?	Uncertain
Are Dianette and oral tetracyclines equally effective in the treatment of acne in young women?	Yes
In a child with fever, is the advice to give oral paracetamol based on any evidence that it is more effective than tepid sponging?	Yes
Should a patient over 74 with atrial fibrillation be on warfarin, aspirin or nothing?	Consider each patient on an individual basis
In a 25-year-old man with warts, is cryotherapy effective after one year?	Yes
Does regular exercise improve control in patients with diabetes aged 50 or under on insulin?	Yes
Does aciclovir have a role in an adult with chicken pox?	Yes, but what role?
In osteoporosis, are there effective drugs for prevention? and treatment?	Yes, in some people Yes, in the elderly?
What is the evidence for effectiveness of methylphenidate derivatives in Attention Deficit Disorder in adults and children?	Quite good

Table 1. Examples of clinical problems for which evidence is sought and discussed.

Evidence-based medicine: So is it useful? An example of cultural dissonance

It is a shame that Judy Chen's laudable aim of exploring EBM for her Turkish-Cypriot patient appear to have been almost entirely dismissed by Charlton and only mildly supported by Greenhalgh.[1] I think that a middle but not uncontroversial course is appropriate.

It is a greater shame that Chen did not make more of the "cultural and psychosocial background" of the patient, as a result of which the article was very doctor-oriented with little insight into how the patient was to be involved (surely the point of any decision-analysis?). Attempts to right this in the piece ("we take into account patients' own evidence and experience which are equally valid") appear hollow since no attempt is made to explore such key issues (not in the article anyway).

Charlton's view that a therapeutic alliance ought to be drawn up is a sound one; certainly the patient ought to be seen again – preferably with a better choice of interpreter – in order to try and find out more. It may well be that in subsequent consultations, the "apparently irrational decision" to forgo treatment will be clarified.

Helman's six questions that patients pose for themselves, often ignored in scenarios like this (presumably because they are not quantifiable), such as "why me", "why now", are very relevant here.[2] Of course, the various ethnic and cultural nuances of such questions, inevitably interpreted through the translator, mean this surely cannot be completed in the ten minutes normally allowed in general practice (but, then again, nor can the Medline search?). This case in its richness shows us that contemporary medical education must provide for a better understanding of "cultural aspects of health, illness and disease".[3]

The real problem here is that of *cultural dissonance* between a doctor's biomedical disease-oriented model and the patient's illness experience. While EBM applies to the former, it cannot apply equally to the latter. General practice is invariably where these worlds collide (disease *v* illness, doctor *v* patient, science *v* beliefs/perceptions). I am fascinated by the attempt to undertake the exercise, but did it help the patient? EBM may have landed at the door of general practice but will it remain unmodified by the rigours of primary care?

Surinder Singh

1. Chen J. Evidence Based Medicine: so is it useful?, and EBM - two commentaries, Br J of Gen Practice 1997; **47**: 762-765.
2. Helman CG. Culture, health and illness. Oxford, Butterworth-Heinemann, 1994.
3. Helman CG. The role of culture in medical education. Changing medical education and medical practice (WHO Journal, July 11) 1997 pp 24-25.

Resourcing Family Doctors — a global view

Delegates from 26 countries from all parts of the world met in Cambridge at the recent Physician Funding and Healthcare Conference, co-organized by the Royal College of General Practitioners, the World Health Organization (WHO) and The World Organization of Family Doctors (WONCA).

This meeting responds to part of a WHO/WONCA collaborative action plan. This plan arises from the influential meeting held in London, Canada in 1994 and reports on the relevance of medical education to patients' needs and the role of family doctors.

A clear recommendation from that report was the need to consider the appropriateness of family physician funding systems and how they can affect both the nature and the quality of services provided to patients.

In three sessions, primarily through small group discussion, three main topics were addressed in Cambridge:

- different socio-economic contexts, different remuneration systems
- boundaries — allocation/re-allocation of tasks among health professions at different levels of the health system
- payment systems and quality of care.

These issues were considered in relation to four contexts:

The RCGP's Scientific Foundation Board

The Scientific Foundation Board (SFB) is the nearest the College has to a research small-grants committee. Its principal activity is to administer the College's research endowments to support and promote research. Some of the available funds are earmarked for specific purposes (the Windebank fund, for example, can only be used to support research linked to patients with diabetes) but the larger part has no strings attached.

The available resource provides around £85,000 for projects each year. The SFB regularly reviews its policy for making awards, trying to ensure that support goes mainly to young or new researchers with interesting ideas. It is difficult to set absolute rules, but in general the SFB tries to support young general practitioners, working mainly in full-time service practice, and never having had financial support before. Grants average about £5,000 and can be held over a two-year period. The maximum for any single project is normally £10,000. As patterns of research training and funding change, so does the Board's policy on supporting research based in university departments and applications from social scientists or doctors from disciplines other than general practice. Decisions are taken on a case-by-case basis, mindful of the Board's general purpose, which is to support general practice research, and research by general practitioners and other members of the primary health care team.

The Board meets three times a year to review applications. Although the amounts of money available are not large, SFB support does not represent 'easy money'. Members of the SFB are all experienced researchers (which makes them particularly good at criticizing the ideas of others!) and they cover a wide range of expertise, including statistics. The main reasons support is not given (or is withheld pending re-application) are that research is unrealistic, questions are unanswerable, or vague, methods do not fit their purpose, or plans will give data that cannot be interpreted. It is because of the frequency of these problems that the SFB requires applicants to have sought proper advice before applying — and even then problems often still remain.

Part of the SFB's services to budding researchers is the availability of help at an early planning stage from the College's research advisor, presently Professor Freeling. Fenny Green is the point of contact for all SFB enquiries, and she will supply application forms and supporting notes for anyone interested.

Thinking of having a go? — once 'smitten' there's no turning back!

John Howie

- the managed care context
- the national health service context
- the transitional society context
- the developing society context.

One of the important outcomes of the conference is the publication of proceedings which will be made available to national governments and leading academic, political and medical organizations throughout the world. It will include the key conclusions from the meeting, recommendations concerning appropriate funding and resourcing of family physicians and suggestions for further research in this area.

One aspect of the WHO/WONCA collaboration is to encourage the involvement and influence of family doctors in the world-wide health care reform process. Both organizations see the role of the family doctor as essential to effective health care. The RCGP through its International Committee is pleased to be able to have facilitated such development with regard to physician funding.

This conference was made possible through the generous donation of educational grants from: Pharmacia & Upjohn, The World Organization of Family Doctors, The Scottish Council for Postgraduate Medical and Dental Education, and the Governments of Australia and The United States.

5 Good Reasons For Going To WONCA...

Number One

Craic is a word that defies definition. An experience, a feeling, a happening, an energetic mix of good company, conversation, music, and laughter. Never bought, sold, manufactured, or copied. Be there to feel it.

Audible, palpable, sensual, all-embracing. Choose your music from folk, traditional, jazz, pop, modern, or classical. Ballads to bodhrans, fiddles to flute, symphonies to sean-nós.

Perhaps the literary world is your interest. Your choice of century, style, subject or theme. Goldsmith, Swift, Sheridan, Shaw, Joyce, Wilde, and Synge. Perhaps theatre; the Abbey, the national theatre with its tradition of O'Casey, Maud Gonne, and Lady Gregory. The Peacock and the Project, the Gaiety and Gate. Modern, experimental, classical, cultural. See the legacy of the poets, of Yeats, Kavanagh, and AE. Artists new and old, Irish and European across the ages. Medical legends, Colles, Corrigan, Graves and Stokes. Trinity College, the Book of Kells, the Halfpenny bridge, Georgian squares.

Sink the black, or the golden malt. Quiet cafes, noisy pubs. Golf, sail, jog or swim. Walk mountains that only artists capture. See the Celtic tiger and the city, hustling, bustling, dancing, singing, every day a Ulysses.

All this and more at WONCA 98.
People and their family doctors — partners in care.
Dublin, June 14-18, 1998

Domhnall Mac Auley

First among equals... Dr Lotte Newman OBE FRCGP

Dr Lotte Newman completed her term as President of the Royal College of General Practitioners at the Annual General Meeting in November, concluding a distinguished career as a member of the College Council.

When she took up office three years ago, she set herself three major goals; to improve the College's contacts with its members, their families and their teams; to increase College membership; and to raise awareness of the College by the public and other academic bodies. Watched by her family, including her newly born grandchild, Lotte's inauguration set the tone of her presidency. She has actively welcomed members and their families to College events and worked tirelessly, visiting every Faculty, spreading the College ethos. Her innovative idea of a phone-in has made her accessible to all College members, encouraging feedback and ideas. She has welcomed and cherished members, guests and their families at numerous social occasions and she has represented our College with dignity.

Lotte had a distinguished career before taking up office as President. She had been a College examiner for nine years and a member of the College Council since 1980. She has been president of the Medical Women's Federation and she was the first woman to be elected president of SIMG (Societas Internationalis Medicinae Generalis). She is a member of a multitude of professional organizations, including the General Medical Council and has given numerous lectures to lay and medical audiences. Her Mackenzie Lecture in 1991, "Second Among Equals", highlighted her commitment to women in medicine. She has received many honours, including the Baron Dr Ver Heyden de Lancey Memorial Award for advancing the status of general practice. In 1991 she was awarded the OBE for services to general practice.

Lotte's natural warmth has created friendships throughout the world and she has been a most successful ambassador for our College and British general practice. She and her husband, Norman, are familiar figures throughout the international general practice community. She has been one of a small band of activists who have strengthened European general practice, raising the profile of our own College in Europe. At home Lotte has always taken the time and trouble to welcome new members of Council. I remember my first attendance at the Council, when she had her foot in plaster. Despite her own discomfort she made time to introduce herself to me.

Our past president can look back on her term of office with pride. The College Spring meeting is now better attended by the younger membership. Recognizing the balance of careers and families, these major College events now include crêche facilities. Many national and faculty College events include other members of the health care team, encouraging a multiprofessional approach to patient care. Dr Lotte Newman was the only president to be elected by ballot of the entire College membership. She is only the second woman to have held that office. It has been a memorable three years.

Jacky Hayden

Picture: Justin Grainge Photography

lotte

As president of WONCA Region Europe and the European Society of General Practice/Family Medicine, I want to send my warm greetings and thanks to Lotte Newman for her important contribution in working for the strong development of general practice in Europe. I am happy to report that her child, the ESGP/FM, is thriving.

Together with the Dutch general practitioner Fons Sips, Lotte must be given much of the credit for making this development possible. The RCGP is one of the leading colleges in this development, which will strengthen the position of general practice in many European countries, improve international sharing of information and inspiration, and improve networking between leading teachers and researchers in the field of general practice in Europe.

Lotte entered the European scene more than 10 years ago as the British representative in the former SIMG. Later she became president, then regional vice president of WONCA, while Fons Sips became president of SIMG. Together with members of leading colleges in Europe they realized that we could not continue with two strong competing GP organisations in Europe and three strong independent international scientific networks for research (EGPRW), education (EURACT) and quality development (EQuiP). Lotte Newman and Fons Sips were key members of the Group of Eight that made the amalgamation of SIMG and WONCA possible in Strasbourg in 1995. EGPRW, EURACT and EQuiP became strong working groups attached to the new society that among other activities chairs a big annual GP conference for family physicians in Europe. During the course of this development we have hugely benefited from Lotte's strong commitment and we are delighted to express our gratitude to her.

At the same time we are confident that, in Denis Pereira Gray, the RCGP has found another well-known, internationally committed president.

Thanks to Lotte Newman, welcome to Dennis Pereira Gray!

Frede Olesen

RCGP ACCOMMODATION CHARGES FROM 1 APRIL 1996

	Member Rate Single Occupancy	Member Rate Double Occupancy	Non-Member Rate Single Occupancy	Non-Member Rate Double Occupancy
Room 1 Double Room With Wash Basin	£41.00	£56.00	£56.00	£84.00
Room 2 Twin Room With Wash Basin	£41.00	£56.00	£56.00	£84.00
Room 3 Single Room With Wash Basin	£41.00	N/A	£56.00	N/A
Room 4 Twin Room With Wash Basin	£41.00	£56.00	£56.00	£84.00
Room 5 Twin Room With Wash Basin	£41.00	£56.00	£56.00	£84.00
Room 6 Single Room With Wash Basin	£41.00	N/A	£56.00	N/A
Room 7 Double Room With En-Suite	£51.50	£67.50	£73.50	£101.00
Room 8 Twin Room With En-Suite	£51.50	£67.50	£73.50	£101.00
Room 9 Twin Room With Adj Shower	£35.00	£50.00	£50.00	£78.00
Room 10 Twin Room With En-Suite	£51.50	£67.50	£73.50	£101.00
Graves Room Twin Room With Wash Basin	£41.00	£56.00	£56.00	£84.00

EXTRA BEDS - £17.50 per bed/per night
Room 2 - Can take 1 extra bed
Room 4 - Can take 1 extra bed
Graves Room - Can take 2 extra beds

CAR PORT CHARGES
Members £6 per day
Non-Members £14.00 per day

All bedroom accommodation charges include breakfast and V.A.T.

Breakfast Times
Mon - Fri 7.30am - 8.45am
Sat - Sun 8.00am - 8.45am
Breakfast is available to non residents during breakfast times at a cost of £6.00

For Accommodation bookings please phone 0171 581 3232 and ask for extension 269

funding for research

Advice on how to bid for centralized research funding under the new NHS arrangements for research and development was the theme of a seminar organized by the Royal College of General Practitioners and the Association of University Departments of General Practice on 28 November.

From 1 April this year, the diversity of funding arrangements through which the NHS has supported research in the past, has been replaced by a single budget.

"These new funding arrangements are a watershed in NHS research and development funding for primary health care. For the first time, research funding has been brought together, which should make it much easier for GPs and other primary health care professions to access funds. This is the first year of bidding for the Culyer funding, so it is a new experience for everyone. What the College aimed to do at the seminar was to facilitate the debate," said Professor Yvonne Carter, Chairman of Research at the Royal College of General Practitioners.

The 1994 Culyer report (by Professor Anthony Culyer) recommended the centralization of research and development funds and proposed that all research should be documented and costed. The report noted that much research in the NHS, especially that done outside teaching hospitals, was unrecognized and that costs were often subsumed in other budgets. It also recognised that, currently, the GP contract does not include any element of time dedicated to research activities. These are normally carried out in GPs' own time with the support of outside funding.

The White Paper *Primary Care: Delivering the Future* (1996), produced by the previous government, also identified research and development as priority issues and stressed the need to increase the 'research capacity' in general practice.

The seminar on 28 November was chaired by Professor Yvonne Carter. Speakers included Mr John Ennis, Head of the NHS Research and Development Strategy Branch and Professor David Mant, Chairman of the National Working Group on Research and Development in Primary Care, who both offered invaluable advice on how to submit bids for funding.

A total of 75 primary care led bids have been received for the first round of research grants. Those bidding for funding are advised to set clear goals, realistic targets and clear assessment strategies with quality indicators. They should also have established links with appropriate university departments which could be either departments of general practice or other relevant departments.

The timescale for the awarding of research grants is as follows:

Announcement of the winners of the first round of bids	*Dec 97*
Research funding begins	*Apr 98*
Second round of bids invited	*Early 98*

environment and health: opportunities in primary care

Being a good doctor is all about making connections. There is a link between a poor environment and ill health. Where people live, how people live, the air they breath and the food they eat are all inextricably bound up with their physical and mental well-being. Medicine is, inevitably, tied up with policies and politics.

These were some of the themes explored at a one-day conference held by the RCGP's inner city task force and the King's Fund urban primary care network on 20 November in London. Speakers spanned the social sciences, public health, food policy, transport and politics. It is no secret that if you happen to live in a small, damp, infested room in Stepney with poor heating you are more likely to suffer from coughs and colds, aches and pains, bronchial problems, stress and depression than someone living in relative comfort in the more salubrious areas of West London. Peter Ambrose, Director of the Centre for Urban and Regional Research at the University of Sussex, however, has come up with hard evidence to show that investment in better housing is cost-effective. In relatively affluent Paddington, residents experience less crime, make fewer visits to their GP and experience fewer fire incidents than residents in poorer Stepney. The implications are that investment in the infrastructure saves money and improves overall well-being.

One of the key messages was the need for proper strategic planning instead of short-term 'knee-jerk' reactions to problems. Peter Townsend, Emeritus Professor of Social Policy in the University of Bristol and one of the leading thinkers on social policy in the UK, highlighted some of the obstacles to progress. One of these is the tendency to "... make a hullabaloo about what are

really fragments of action" instead of looking at the whole picture. "There is a reluctance to provide or even accept the need for a proper explanation of the relationship between poverty and ill health. .....There is a need for big changes in the scope and mature of government planning." Townsend wants to see "a complex, national programme covering financial well-being, education, nutrition and housing."

Iona Heath, Chair of the RCGP's inner city task force, wants to see an 'agenda for change. "GPs have high public credibility; they should use their lobbying powers," she says. "The housing sector should be working in partnership with GPs to achieve change. It's all about making the right connections."

A short history of socialized medicine... 4

REFORMATION and RENAISSANCE
Social medicine in early modern times

As the reformation loomed, popular resentment of the clergy focused on taxation for their hospitals — even the great St Leonards at York lost its entitlement to tithes in 1469. The state-of-the-art hospital for a hundred 'poor needy people' completed at the Savoy Palace for Henry VII was lost on his son. "The great abbeys go down as fast as they may," wrote one of Henry VIII's ministers; by 1539, 110 hospitals had also been suppressed, leaving 23 counties without. Remaining London hospitals were eventually handed over to civic authorities. By the 1560s, London had lost five ancient hospitals (two new ones had also been acquired); survivors included St Bartholomew, St Katherine by the Tower, St Mary of Bethlehem, the Savoy and St Thomas Southwark — re-dedicated to the "sound" Apostle, severing allegiance to the rebellious martyr!

In 1557, infectious disease accounted for a third of burials at St Margaret's, Westminster, including 'bloody flux' (dysentery), 'pining sickness' (probably tuberculosis), and 'ague' (probably malaria). During 1517, Henry's court had been threatened by sweating sickness and plague; in response, Cardinal Wolsey and Thomas More introduced foreign models of quarantine, becoming the first to employ social medicine in policy. Influenced by Italian models and humanist physicians such as Thomas Linacre, Wolsey established the College of Physicians in 1518, which concentrated initially on excluding quacks rather than coordinating medical scholarship.

As medical science advanced, so pharmacy, anatomy and chemistry replaced the black arts of alchemy and astrology. Cecco d'Ascoi, a lecturer to medical students at the University of Bologna had perished at the stake in the 1300s for his interest in astrology! Frascatoro's theory of 'seeds of contaigion' explained infectious disease, previously considered due to putrefaction of the air itself. A London quack's claim of "A night with Venus — and a month with Mercury!" summarized the epidemiology and treatment of Syphilis, which probably travelled to Europe with Columbus' sailors.

Examination of the excreta was favoured for diagnosis: Thomas Brian in "The pissepot Prophet" claimed to diagnose pregnancy in this way. Although medical science was soon to lead to discovery of the circulation and the mechanics of childbirth, therapies remained empirical — herbs and spices supplemented by cupping and venesection. Surgery advanced more rapidly, driven by practitioners such as Ambroise Pare, whose experience as an army surgeon led him to use vascular ligatures, rather than cautery, to arrest haemorrhage, and to amputate through healthy tissues to promote healing.

By the 1600s the Royal College of Physicians had a monopoly of medical practice within seven miles of London. As Chief Justice Sir John Popham put it, "...a free man of London may lawfully be imprysoned by the Colledge." College Fellowship, however, was no protection against the feisty Queen Bess, whose physician, Dr Rodrigo Lopez, was hanged and quartered on suspicion of poisoning her!

Jim Ford

Sources

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Complementary Medicine
Tanvil Jamil
Butterworth Heinmann, 1997
PB 256pp £18.99 (0 7506 2881 2)

Complementary and Alternative Medicine
ed **Sarah Cant, Ursula Sharma**
Free Association Books, 1997
PB 220pp £15.95 (1 85343 352 7)

Complementary medicine is becoming increasingly popular, with reports suggesting that about one in four people in the UK have had some experience of it in the past year. Many GPs will have noticed some kind of "Alternative Health Centre" or "Natural Healing Clinic" opening up in their area. It is not an uncommon experience to have the possibility of a complementary medical approach dicussed or requested during a consultation. It seems as if almost every other book published these days covers some aspect of this phenomenon. These two are strikingly different and will appeal to very different readerships.

The Jamil book is a handy pocket guide to a wide range of complementary therapies; while Cant and Sharma provide a thought-provoking sociological analysis.

If you were to pick up a copy of *Complementary Medicine; a Practical Guide* in the bookshop and flick through it, you would be immediately impressed by the clean clear structure and layout. He covers over 70 different therapies and applies a consistent structure throughout the first section of the book. There are short notes (Background, Research, Mechanism of Action, and so on) for each therapy, together with addresses for referral, education and training.

In addition there are two highlighted boxes entitled "Which conditions are suitable/are not suitable for treatment by...", which on cursory inspection appears useful. Doubt, however, creeps in when some of the "facts" are found to be erroneous. For example, in the entry related to homoeopathy, Jamil states that it is not normally available on the NHS except that some doctors may refer to the Royal London Homoeopathic Hospital. In fact, homoeopathy is the only complementary therapy to have been included formally within the NHS; there are four NHS Homoeopathic Hospitals in the UK and several community-based clinics related to them.

About 20% of all GPs in Scotland have completed basic training in homoeopathy. He also states under Education that the Homoeopathic Hospitals train doctors only, when, in fact, any state registered health care professional can receive basic homoeopathic training there. He also fails to alert his readers to the fact that homoeopathy is practised by doctors and non-medically qualified practitioners and that this latter group are unregulated and do not submit to a single cohesive training and accreditation. In addition, the lists of conditions that "cannot be treated by ..." consistently contain "any condition that may be caused by serious underlying disease"; after the thirtieth time, this phrase becomes both unhelpful and irritating.

The second section of the book is intensely irritating for a GP and is clearly aimed at a lay readership. This confusion of target audiences causes the book to fall between two stools. Overall, a brave first attempt, but I look forward to a second edition, with the "facts" turned into real "facts" and the second section either dropped or re-written.

Cant and Sharma's book is completely different. The best feature is a capacity to make you stop and think. The worst feature is a capacity to make you stop and try to figure out what on earth that word means. From a GP's point of view, both strengths and weaknesses derive from the fact that it is written by sociologists. As in all professions, they have invented their own language to communicate. At worst this is irritating jargon, but at best you can learn new words with which to baffle and impress your friends. Take "performativity" for example, an assessment of the value and effect of a therapeutic intervention — apparently. Another thought-provoking theme is the sociological description of medical knowledge and how it gains its authority. I was struck by the consideration of the doctor–patient relationship as the sharing of "generic knowledge" and "local knowledge", i.e. the practitioner brings "generic" knowledge in the form of knowledge of pathology, epidemiology etc, and the patients brings their "local" knowledge — a knowledge of their symptoms, their feelings, their experience. Healing begins through an exchange of these two "knowledges". I like the challenge to the disease-focused approach in medicine offered by the consideration of the significance of individuality — not only of the patient, but also of the therapist — and how this leads to a unique therapeutic understanding in every case.

This is the kind of book within the field of complementary medicine that stimulates the reader to consider more objec-

tively not only complementary medicine but also "orthodox" medicine and so become a more thoughtful practitioner.

Bob Leckridge

CyberMedicine: How Computing Empowers Doctors and Patients for Better Healthcare
W V Slack
Jossey-Bass, 1997
£15.95 (0 7879 0343 4)

Computing in medicine is finally approaching lift-off. After thirty years of effort we are perhaps close to that point on the graph where the line, instead of inscribing a slow ascent of the foothills, suddenly begins to point to the sky. However, if you expect *Cybermedicine* to be about the possibilities of this take-off, you would be mistaken, for its reference point is the past rather than the future. Furthermore it is not about primary care and does not cover anything outside the USA. So unless you are seriously interested in the history of computing in big American hospitals, don't buy this book.

Instead use the time to wander through the webpages quoted in the *BMJ*'s Netline section, look up the *Electronic Journal of Informatics in Primary Care* (www.ncl.ac.uk/~nphcare/PHCSG/Journal/index.html) or try the National Clinical Audit Centre new site (www.ncca.org.uk).

Or if you can't do any of this because you are not yet on-line, then take the plunge and get your act together.

Paul Hodgkin

The Quick and the Dead; Artists and Anatomy
A national touring exhibition organized by the Hayward Gallery, London, for the Arts Council of England.
Showing at the Royal College of Art, London (until Nov 24); Mead Gallery, Warwick Arts Centre, Coventry (Jan 10-Mar 14); Leeds City Art Gallery, Leeds (Mar 28- May 24)
Catalogue - 1 85332 172 9

There is much of ourselves here, taking us back to that first contact with the body — old, stiff, pickled, somehow unsexed and no longer human; for some, that may have been the first contact with death, rendered prosaic by pressure of work and dissecting room camaraderie.

The body has been explored in western art, by artists as artists, by artists as scientists, by artists who became, in effect, anatomists — and recently by artists using the technology of scans and scopes and X-rays to boldly go where no artist has ever gone before. The *Quick and the Dead* traces this evolution from the purely topographical with its preoccupation with symmetry and physical beauty, to the stripping of skin — there to disclose and anatomize bone and muscle. Simple beauty of form is replaced by structure, and then by relating structure to function. How different their subjects to ours; theirs always in the prime of life — erect and firm-fleshed, and well-muscled, always posed in the heroic attitudes of convention, of Ancient Greek and Biblical heroes. Such convention leads on to the disturbing thought, at which the exhibition hints, that the conventional, the ideal, of physical form can be perverted into a model of racial purity.

Highlights include the stunning draftsmanship of Leonardo da Vinci and Michelangelo, and the partially anatomized equine studies of Stubbs. The library of Glasgow University contributes the gorgeous *Fabrica* of Vesalius. Two dimensions give way to three, with the marvellous anatomical models in wax and papier mâché, and a rare opportunity to see the old Edinburgh Stereoscopic Atlas of Midwifery.

As we go through the exhibition, the image of the body becomes less that of the Artist, and more of the Explorer, perhaps even the Voyeur. Technology takes over via orifices and channels; the unease of sexuality is explored in imagery that is frankly ugly and mechanistic, and which speaks to the darker corners of the mind. Such imagery drives one of us, at least, back in gratitude to those who hymned the body as well as exploring it so long ago, and whose technical limitations (as well as those imposed by taste, tradition and religion) allowed such exploration to preserve beauty and form.

Michael Lasserson

Orthopaedics in Primary Care
eds **Andrew Carr, AnthonyHarnden**
Butterworth Heinemann, 1997
PB 230pp £25 (0 7506 2219 9)

Amongst all the surgical specialities, orthopaedic surgery is probably the source of greatest frustration to both patient and practitioner alike. The combination of long referral times and uncertainty over the need for intervention is a classic recipe to ensure that a potentially resolvable situation becomes a chronic problem.

This publication has evolved after prolonged discussion between GPs, orthopaedic surgeons, rheumatologists and physiotherapists, and is a beautifully balanced text reflecting orthopaedic problems found in general practice. Despite this collaborative input, the messages on best management are not 'fudged' , but are clearly set out in a very practical form.

Each chapter, based on a specific joint, starts with an excellent functional anatomical description and an ordered method of annotating the clinical findings which, when included in the referral letter, can allow the second examiner the luxury of comparing clinical findings. The anatomical line drawings are clearly presented, and the tables detailing the specific joint differential diagnoses in different age groups would be very useful as a quick point of reference.

The emphasis each contributor places on good and ordered history-taking should help the examining doctor establish the need for urgent orthopaedic referral, for example eliciting a history of nocturnal pain, the relationship of pain to activity, and preceding traumatic episode.

Almost every GP surgery session will have at least one presentation of back pain, either acute of chronic. The consequences of this workload are well set out in the chapter on lumbar spine problems. The utilization of the management guidelines for acute back pain, published in 1994, is a useful means of defining priorities in the assessment of back problems.

The clinical case histories cover many of the patterns of presentation of lumbar spine problems, and would be an excellent teaching tool.

The specific advice that x-rays are of limited value in spinal problems, could be 'highlighted' and shown to those patients who believe in the therapeutic value of back x-rays.

The clear management methods set out in this text on orthopaedic problems in childhood, joint injection techniques and rehabilitation exercises will be a source of comfort and sound advice to GPs previously unschooled in such subjects. This publication wll also serve as a useful review text for more experienced GPs who wish to review their skills in assessing and treating orthopaedic problems in general practice.

Gerry Haggerty

annual general meeting

This year's AGM of the College on 21 November saw the appointment of a new President, Professor Denis Pereira Gray OBE FRCGP, who will lead the College into the new millennium. Professor Pereira Gray has had a long and distinguished career as a general practitioner, academic, writer and editor. He has played a prominent role in the College, holding positions which include nine years as Honorary Editor of the *Journal of the Royal College of General Practitioners*, 25 years as Honorary Editor of RCGP Publications, Chairman of Council (from 1987 to 1990) and Chairman of the Joint Committee on Postgraduate Training for General Practice.

Professor Pereira Gray is the 18th President of the College. He succeeds Dr Lotte Newman. Dr Newman has been a popular President, the first to have been elected after a national ballot. She has brought to the role a particular interest in women's issues, international primary health care, and in supporting College Members and their families. During the past three years she has travelled extensively throughout the world promoting the College and British general practice and has hosted many international gatherings both at the College and abroad. Dr Newman is a former Vice Chairman of Council and a member of the College's International Committee. She is a former President of the Medical Women's Federation and was the first woman President of SIMG (the International Society of General Practice).

This year's AGM featured a new award — the Bill Styles Memorial Award — which was established in memory of former Chairman of the College, Dr Bill Styles, who died in 1996. The award is intended to encourage younger members or associates of the College (aged 35 and under) to further their education either within the UK or abroad. The first recipient of the award is Dr Eunice Laleye, MRCGP, who will be travelling to South Africa in January to spend six months with a primary care training and education programme in Soweto.

The James Mackenzie Lecture on "The Place of the Humanities in the Education of a Doctor" was given by Dr Brendan Sweeney, FRCGP, Chairman of the College's Committee on Medical Ethics. His marvellous address was accorded a standing ovation, and the text will appear in a spring issue of the *BJGP*.

One hundred and ten fellows attended the 1997 Meeting to receive the award of fellowship. Nominations for fellowships for 1998 are invited. Nomination forms are available from the Clerk to the Committee on Fellowship on 0171 581 3232 x233. Please note that enquiries about Fellowship by Assessment should be made to Janet Bailey, Vale of Trent Faculty, Department of General Practice, Queen's Medical School, Nottingham, Notts NG23 2UH, 01602 9709391.

New members/observers on the new College Council

David Holton
SE Scotland
Ursula Hutchinson
NW England
Ann Orme-Smith
SW Thames
Jim Repper
NE Scotland
John Sanfey
Vale of Trent
Peter Stevens
Sheffield
Sunil Bhanot
Wessex

Alec Logan
DepEd, BJGP
Brian Goss
2nd GMSC Observer
David Lewis
GP Registrar Observer
Surendra Kumar-
GP member of the Overseas Doctors' Association

Ruth Chambers
Shaun O'Connell
Lesley Southgate
by National Ballot

november council (22 november)

Tobacco advertising — The College has written to the Secretary of State for Health and produced a statement expressing concern at the recent government decision to exempt Formula One racing from the proposed ban on tobacco advertising. The evidence that smoking causes premature deaths is clear and the College supports the banning of all tobacco advertising.

Health inequalities — A College working group is being set up (subject to securing funding) to examine issues relating to health inequalities and to assist in forming College policy in these areas. Chaired by Iona Heath, it will have a broad membership, covering both inner city and rural interests and will link with the inter-collegiate forum on poverty and health.

Disability and rehabilitation — Services and care for people with disabilities and unstable and progressive conditions were discussed at Council. A report from Charles Sears of the Wessex Faculty outlined some of the issues. The College's inequality forum will look at the related political and resource issues and a further report will be brought to January Council.

Assessment network — Discussions are in progress about the establishment of an assessment network to coordinate the diverse work on assessment being carried out by the College in areas such as the Examination, fellowship by assessment and membership by assessment.

Next Meeting of Council
Friday 30 January 1998.

diary

Forthcoming RCGP Events

14/15 January
Assertiveness Skills Course

22/23 January
Minor Surgery Course

10-14 February
MRCGP Course

24 March
Conference -
Medical Negligence

31 March
Conference on A&E Medicine

17/18 April
Spring Symposium (Exeter)
Further information: please telephone 01395 567 808 or 01392 403 031

11-15 May
International Course on Developing Teaching Skills-Module II

21 May
Research Symposium -
Regent's College

4 June
Study Day -
Counselling in General Practice

11-14 June
WONCA (Dublin)
For further details please contact the Irish College of GP
Telephone + 353 1 673 3706
or Fax: + 353 1 676 5850

8-12 September
MRCGP Course

Unless otherwise stated, all the above events take place at the RCGP in London.
For further details please contact:

RCGP Courses & Conference Unit,
14 Princes Gate,
London SW7 1PU.
Tel: 0171 823 9703
Fax: 0171 225 3047
Email: courses@rcgp.org.uk

Tina Ambury

A Nightmare Scenario...

Every GP has nightmare scenarios involving heartsink, violent or misdiagnosed patients. Waking at 2 a.m. in a cold sweat, questioning their patient-management decisions, is familiar to many. My nightmare happened, and I am trying to come to terms with it.

My elderly mother has been house-bound by her respiratory disability for several years. She has been cared for by my equally elderly father, with most of the work being done by my nearby sister. Mum's exacerbations are getting more frequent and longer-lasting, becoming a strain on the whole family. We had not realized just how much of a strain it had been for Dad.

Mum's often dramatic hospital admissions attract most of the family's attention. During a visit, on the way to a much-anticipated holiday, Dad mentioned he had been 'off-colour'. Dad's health needs have always been relegated to possible attention-seeking behaviour, so I didn't pay much notice. On the return journey he did not look well, but as he had been seen by two GPs and a hospital team whilst we were away, I felt things were under control. Though the diagnosis of constipation fitted, his abdominal pain was getting no better. I reassured him that things would be fine and that he should stop grumbling.

That was the last time I saw him alive. Within a week he had undergone an emergency laparoscopy for sub-acute bowel obstruction, at which a carcinoma of the transverse colon was resected. His surgeon was upbeat about the prognosis and felt the tumour had been cleared.

Dad had other thoughts. Cancer terrified him. He had lost his own father and three uncles to cancer — all within a space of six months — long before I was born. Within a day his body began to fail. Five days after the surgery, everything possible had been done (to no avail), and life-support was withdrawn. He died twenty minutes later.

To my shame, even after the surgery I felt things would improve. Work commitments meant it was difficult for me to get home, and I chose not to. As a result, I was the only one of his four children not to say goodbye before he died.

The emotions aroused by these events are complex and I constantly put off dealing with them. My relationship with my father was not a good one and I have been surprised by the strength of the feeling his sudden death has provoked. I admit to feeling guilty about not taking his symptoms seriously. I regret not having been able to say goodbye.

Most of all, I feel uncomfortable that on both a personal and professional level, I trivialized his final illness.

Every GP worries about missing a fatal diagnosis that might have saved a patient's life. The fact that Dad's carcinoma proved to be too advanced for this does not make my failure as a doctor or as a daughter, any easier to bear.

My father died on 3 September 1997. He was joined by my mother – his wife of 50 years – on 8 December 1997.

web site of the month

Doctor BJ
Seasonal greetings Bob and Trish. Found some xmas presies on the Web for...
The first one is the Medical Matrix. Huge amount of medical links split into categories using the national Library of Medicine MESH thingy. Sites are given *stars* (none to five) for usefulness, content and presentation by expert reviewers from AMIA. Try it at **http://www.medmatrix.org/info/about.html.** It's even get its own free medline access and mailing list that you can join to ask questions and develop ideas.
If you want a UK equivalent check out OMNI - Organizing Medically Networked Information **http://www.omni.ac.uk/.** Same sort of crack as the Matrix but with a UK bias instead of a US one. Really good CME events on-line database (1200 entries and brill article evaluating different internet Free Medline services so yhou know which one you should pick). My advice is pick the 'worst' one because there's a good chance no-one's using it and it will be quicker.
Check it out
Rob Wilson, Sowerby Centre for Health Informatics - http://www.schin.ncl.ac.uk/

our contributors...

Dorothy Logie is Principal Primary Care Adviser to Borders Health Board. Her magisterial Personal Paper (with Solomon Benatar), "Africa in the 21st century: can despair be turned to hope", was a highlight of the *BMJ*'s recent Humanitarian issue (**315**: 1444-1446)

Berry Beaumont edited "Care of Drug Users in General Practice" (reviewed in the December BJGP) and is a general practitioner in London

Peter McCartney is also a GP in London and a lecturer at the Health Promotion Research Unit, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine

John Howie is the only professor of general practice who has run the line at an international rugby match. He is chairman of the RCGP's Scientific Foundation Board

Surinder Singh is yet another London GP

Domhnall Mac Auley is a GP, in West Belfast. He edits the *British Journal of Sports Medicine* and is Chairman of the Communications and Publications Committee, WONCA 1998, which presumably is worth a few free pints of Guinness

Jacky Hayden is not averse to the odd pint of Guinness herself. She is the Dean of Postgraduate Medical Studies at Manchester

Frede Olesen is professor of general practice in Aarhus, Denmark, and Research Director and President of the European Society of General Practice (ESGP)

Bob Leckidge is a doctor at the Glasgow Homoeopathic Hospital

Gerry Haggerty is a GP in Ardrossan, Ayrshire, and has an interest in Sports Medicine. He tended to the recent Australian rugby tourists, doing his own nation no good at all

Tina 'Biggles' Ambury was formerly a medical officer in that unglamorous branch of the military, the Royal Air Force. She has been described, by herself, as a 'Freelance Medical Journalist' and seeks gainful principalship

Andrew Trevett is that exotic new beast, the Higher Professional Training Fellow in general practice. He is learning, near Inverness, how to write feisty academic papers whilst holding his cutlery correctly.

All our contributors can be contacted through the Journal office

James Willis

A grain or two of truth

I once had a patient whose glass eye fell out when she laughed. This had a terrible effect on her sense of humour. She used to tell me, with a carefully straight face, that she had once enjoyed a joke as much as anybody, but that it would now be a kindness if I were to conduct consultations in funereal solemnity to keep the thing in place. This I tried to do, biting back jokes and suppressing chuckles, but conscious all the time of being deprived of what is called 'the best medicine'.

In compensation for this sad experience I now realize what a priceless preparation it was for writing a column in a learned journal. It may be thought that few readers will share my patient's sad affliction and that most can risk a belly-laugh or two without losing anything more from their persons than an occasional button or denture. But the fact is that serious ideas seem to have to be expressed seriously in order to be taken seriously. They have to be written in a kind of gloomy dialect calculated to stop the most precariously-seated eyeball prosthesis from pinging unbidden across the page. Introduce a bit of levity, squeeze in a jolly story between the tables of data, go, if you absolutely have to, for the 'Full Monty' by making the whole thing easy to read, and you find yourself flung from the chamber of serious discourse and languishing on the pavement outside.

Yet I'm not sure. I think one of the things that worries us most about, say, evidence-based medicine is that it isn't funny. I can't remember a single occasion it raised so much as a smile. This journal's pages, first the front, now the back and sometimes both at once, are filled with discussions about why we distrust EBM so much when it seems to be such an eminently good idea. This is my explanation: it takes itself far too seriously. It thinks it has the answer to everything but at the same time it can't make, still less understand, the simplest joke. And that makes us suspicious that it hasn't got all that much to do with life.

While life isn't always funny, far from it, we know from our experience that even the most desperate situations have a capacity for humour. Even dying patients can be, should be, cheered up with a joke. On the right occasion that is. Even my patient with the glass eye really saw the joke of her situation. Which, as you can probably imagine, led to some fairly complex scenes. But humour is a very special part of communication and if we exclude it from the mainstream of thought we lose touch with a great deal of the meaning of life.

"Winnow all my folly, folly, folly," said Gilbert's jester, Jack Point, in *The Yeomen of the Guard*, "and you'll find a grain or two of truth amongst the chaff." Seriously.

Andrew Trevett

Back To Frontism

I opened up the *BJGP* today and, have to admit, I started at the back page. This is a habit I usually restrict to my daily newspaper, not to find out the football results — I've already wasted a couple of hours listening to the blow by blow account on the radio — but, even more sadly, to look for some crumb of comfort in the description of another team's heavy defeat. Perhaps the reporter will have spotted that the intricate short passing game that my team played offers hopes of a brighter future, or that the fourth goal was a fluky deflection past a stranded goalkeeper. I suppose with a habit like that for the past 25 years, it's unlikely that I'm going to become a front to backer and my daily mood will still be influenced more by last night's results than by the latest spat on European Monetary Union.

Back to frontism offered rich rewards today, revealing two articles by friends of mine, challenging, provoking and thinking about what we do in general practice. It's all too easy to become bogged down by the minutiae of our daily work, embroiled by paperwork and irritations, by tiredness and frustration. Sometimes we need to step back and enjoy the joys, explore them, develop them, appreciate the sheer privilege our job gives us to share peoples lives. We can get joy from our patients' joys; we might allay their fears or help them with their difficulties; sometimes we can lessen their sorrows. Everyone we see will teach us something if we are open and receptive enough to see it. Things that go well give us an opportunity to rejoice, things that don't, an opportunity to learn. Back to frontism gives us the chance to keep perspective, to look beyond the minutiae, to realise that the bottle is, after all, still half full. Every job has its bad bits, ours has more good bits than most if you make time to notice them. Enjoy them!

Mind you! Losing 4-3 after being 3-0 up, it's going to be tough today! Maybe it shouldn't have been a penalty? I'll just see what the bloke in the *Independent* had to say. I tell you, it's tough being a football fan!