The British Journal of General Practice

viewpoint(s)

Fair play for disabled doctors

It is no doubt true that we disabled doctors are not actively discriminated against, but sometimes it certainly feels that way. I should like GP tutors, when organizing post-graduate tuition, to understand that disabled doctors are as interested as their able-bodied colleagues in pursuing their education.

Disabled doctors are a disparate group varying from those disabled by MS or an RTA, to those suffering from arthritis or myocardial ischaemia. Under the terms of the Disability Discrimination Act 1995 (DDA), disability is defined as a condition which makes it substantially difficult for the person to carry out normal day-to-day activities. One problem, though, is common to all these groups — unless some care is taken by the GP tutor when choosing the venue, then none of these doctors will be able to attend. Care must be taken to ensure such facilities are available as adequate car parking for disabled drivers, ease of access to the conference centre, with slopes not stairs, and lifts to upper floors. I have been told that it is not always possible to choose a conference centre with such care. If not, I ask, why not?

The debate about the provision of educational resources to the disabled is a wide one. The DDA 1995 (the educational provisions of which came into force on 31 July 1996) is permissive and rarely mandatory. It instructs institutions that receive public funds to produce regular statements detailing the provisions for the disabled. It does not demand the actual provision of such facilities. It is in effect toothless, offering very little help to the disabled seeking continuing or higher education.

There is, I am sure, a fund of good will amongst GP educators towards disabled doctors; however, this goodwill must not be squandered in emollient platitudes, but channelled into constructive action. It is not known how large the problem is, nor how many GPs throughout the country are physically restricted in some way.

This caring profession must learn to care for its disabled members who, as well as many weaknesses, have many hidden strengths.

Richard Hayward

Further Reading
Hayward R *Disability Care* RCGP Members' Reference Book, 1997
The Disability Discrimination Act 1995, from RADAR, 12 City Forum, 250 City Road, London EC1V 8AF

Another Introduction to the Back Pages, and not the last...

Many thanks to the large number of readers who submitted sample columns to the *BJGP*, in response to our invitation in October. I have always felt that general practice seethes with untold tales, and the response to our competition has borne this out. One problem, however, is that excellent copy outstrips the space available for publishing it, and, in the finest traditions of the National Health Service, rationing has become inevitable.

So, four columnists, three columns each throughout 1998, and the successful contenders are.... **James Willis**, **Liam Farrell**, **Alan Munro** and **Bruce Charlton**. Naturally, performance will be carefully audited, and they'll be sacked at the first sign of droopiness in their citation indices. Apologies for the fact that they're all chaps, but at least no beards! We shall be able to print at least one other column of writing for the sake of writing in each issue, and feel free to submit copy.

Alec Logan

The Back Pages...

Dr Phobius spoke softly with that air of carefully constructed non-possessive warmth that makes doctors so terminally annoying...

... introducing Gallstone Grove, page 1033

contents

1016 news and debate
parachuting gently into practice

1018 international
teaching in the community, and more WONCAs

1020 guidelines
shiny enthusiasts from the city of steel, *v* more dour Scotch professors... More fun than EBM!!!

1024 Miscellany plus **Socialized Medicine**
and the Birth of General Practice

1028 Homage to Kilgore Trout
How One Man and His Main Frame Computer Bring Health and Happiness to the Citizens of Newcastle

1030 Digest
Speaking Proper with McKinstry, like; Sore Elbows with Ballard; plus Isaiah Berlin, Clifford Kay

1033 Gallstone Grove
The post-modern medical soap that *Index Medicus* has been waiting for... Stand by for Phobius!!

1035 Diary, RCGP News plus **Walker**

1036 Our Contributors, plus **Duncan**

Filling the void (or providing the parachute): a model for higher professional training

A young doctor speeds, free fall, towards the ground, with parachute as yet unopened, a hypodermic syringe in one hand and a stethoscope in the other. This was the image chosen to grace the cover of the First Annual Report, in November 1993, of North West region's Associate Physician Scheme. Since then, the initiative has been popularly known as the Parachuting GPs Scheme. It is not an inappropriate metaphor: as one associate described joining the Scheme, "It was like Star Trek with a guarantee of neither a safe landing nor a friendly reception."

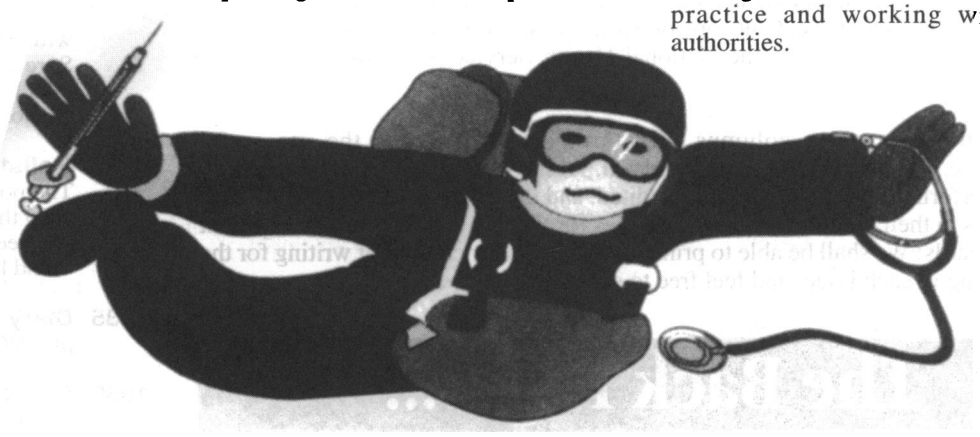
So why did sixteen high-quality young doctors decide to put themselves through all this? Perhaps partly because the alternative — becoming a GP principal — itself has no guarantees of a soft landing. In the words of Dr Rosalind Bonsor and colleagues, whose article 'Listening to voices from a void' was published recently in the Journal, "training often ends in uncertainties for GP registrars, who may feel as if they have landed in a void." The article argues that the transition from registrar to principal is "less of a step, and more of a quantum leap", often leaving doctors "struggling to recognize and develop the skills required to perform successfully in today's primary care".

Dr Bonsor's points are disturbing, particularly in light of the endemic low morale in the medical profession as a whole, and the reduction in the numbers of full-time principals, GP registrars and principals under the age of thirty-five.[1] The problem is even more acute in inner-city areas, in which there are particular problems in recruiting GPs.[2] As a result, deprived areas are often served by a large number of small practices with big list sizes and a high workload, operating from substandard premises.[3]

"Buy me some GPs!" was the Regional Health Authority Chairman's matter-of-fact instruction to his counterpart at Liverpool FHSA, when faced with a specific example of this general problem in Merseyside in 1993. There were twelve vacancies for GPs in the Liverpool district, with some practices struggling to achieve targets and to provide a range of services and structured chronic disease management. Recruitment attempts had borne little fruit, and the situation was causing increasing difficulties for patients, GPs and the FHSA. To do nothing was not an option.

It was decided to set up the Associate Physician Scheme. Advertisements would be put out for recently vocationally trained doctors to work with practices in inner-city and deprived areas across the North West on three-year contracts, with funding for higher professional training and arrangements for mentorship and personal support. It was hoped that a proportion of them would continue to work in deprived areas after the completion of their contracts. The scheme aimed to improve the quality of primary medical care and to deliver *Health of the Nation* objectives in areas of current sub-optimum provision.

The cynics insisted that they would "only attract doctors who can't find jobs anywhere else". Prospective applicants, meanwhile, were often warned by others that becoming an associate would be a bad career move, jeopardizing their future through taking a career step that was not tried and tested. Despite these views, the demand for the jobs was high. The sixteen associates selected were committed to general practice, and were attracted by the combined opportunities of peer group support, needs-based learning, study for a higher degree, "testing the waters" of inner-city general practice and working with health authorities.



Sources
1 British Medical Association. *Medical Workforce Task Group Report*. February 1996
2 Donald AG. Retreat from general practice. *BMJ* 1990; **301**:1060
3 Bolden KS. Inner Cities: Occasional Paper 19, London: RCGP. 1981
4 Fleming D. A Comparison of the practice activities of Trainees and Principals. *Br J Gen Pract* 1986; 36: 212-216
5 Information supplied by NHS Executive.

Further Reading
May C, Dowrick C, Richardson M. *Primary Care Initiative 1994-1997: Final Report of the Evaluation Team*. 1997

Woodward R *et al.* *Supporting Doctors in General Practice: Lessons learned from the Associate Physician Scheme*. September 1997

Van Zwanenberg T, Harrison J. *GP Tomorrow - Living with Uncertainty*. Radcliffe Press (in publication)

Many of the associates frankly admit that they would not have lasted longer than three or four months without the support provided, which, in the words of one young doctor, "practically guaranteed the success of the initiative". This support was provided largely by the management team of three part-time GPs, and took the form of one-to-one discussions and small group sessions.

The supportive environment of the small group sessions, which became particularly important to the associates, was a far cry from the void often experienced by new GPs; the positive atmosphere contrasts with that of many young principals' groups, where, it seems to us, despondency often prevails. These sessions became a vehicle for discussing misgivings the associates had about general practice following vocational training; talking through problems and issues in their practice; defining strategies to bring about change; developing ways of maintaining change after the scheme had finished; and discussing learning needs identified in their daily work.

Hypnotherapy, medical informatics and management were amongst the diverse range of higher degree courses selected for study during the second and third years. We believe that all doctors entering practice require protected time for professional development, to examine more closely the skills that are now required to work in modern primary care, and to define and meet their learning needs.

Being able to "test the waters" of work in socio-economically deprived areas is also important to young doctors - the option of salaried posts that demand neither an initial long-term commitment nor a large financial outlay is one way of doing this. The scheme has undoubtedly been successful in retaining doctors in inner-city or other deprived areas, with six of the nine "graduates" now working as principals in such places.

"I now have the ability to see the potential in a practice, not just what is already there and in place," was the comment of one associate, reflecting the wider tendency of the young doctors to gain a more positive view of inner-city practice. This is an important skill, particularly given that the typical training practice is well organized and provides a wide range of services. As a result, vocational training rarely gives the opportunity to be directly involved in setting up services, reviewing in detail those already in place, or improving these where necessary.[4]

Making up just 23 per cent of all practices,[5] training practices are not representative of general practice as a whole, as young principals often find out to their dismay. The scheme prepared the associate doctors for this reality, so that the move into partnership was less likely to bring nasty surprises — and if it did, the young doctors at least had the skills to cope with these. "I thought that the practices we were assigned to were in the minority; after becoming a partner, I have quickly realized they are the majority...The good thing now is that...I am able to tackle these problems," said one associate.

Improving the quality of primary medical care was originally the main aim of the scheme. This it did, as has been borne out by an independent evaluation conducted by Liverpool University's Department of Primary Care. The North West's Parachuting GPs Scheme has, however, brought far more than this: it has provided an important model for the provision of higher professional training for newly vocationally trained doctors. One associate, reflecting the views of many others, stated that the scheme "should definitely be a compulsory extension of vocational training".

We must listen to those voices from the void - and we must act on what they are telling us. Whilst the prospect of being at the helm of a primary care-led NHS brings more opportunities for aspiring GPs than perhaps ever before, it necessitates too the acquisition of new and broader skills. Life is not going to be a bed of roses for any young doctor within general practice - we owe it to our successors to prepare them as well as we can. The vocational training schemes do not currently do this.

Which would you prefer - to be hurtling towards the ground with a parachute or into a void without one?

Roy Woodward
Rosalind Bonsor
Sarah Carr

Community-based education: a perspective from Mexico City, October 1997

The Network of Community-Orientated Educational Institutions for Health Sciences spans all countries of the developed and developing world, comprising institutions involved in educating doctors, nurses, and other health professionals. More than 260 medical schools are represented in the organization, which is dedicated to the objective of making education relevant to the health needs of the populations served by its graduates. There is an active student body.

As a participant in the twentieth Network conference, I was struck by the similarities in problems faced by educators in attempting to base more of their curriculum in the community. I was presenting a poster on a pilot project involving third-year medical students at the University of Leeds, who spent four days of that year learning and practising taking histories from patients in a general practice setting. The impetus for increasing the amount of community-based undergraduate medical education in the UK has been driven by the General Medical Council's 1993 document *Tomorrow's Doctors*. The GMC has recommended widespread changes to make the education of medical students more relevant to the needs of the next century. Given that many doctors will eventually practise in the community and that most health promotion, disease prevention and sickness occurs outside hospitals, it seems logical that students should spend a greater proportion of their time in the community than they do at present.

Teaching undergraduate medicine in a tertiary centre is like teaching forestry in a lumber yard...

British medical schools have risen to this challenge in various ways, as described in detail in the publications listed below. But the shift towards community-based education is not only seen in UK, nor in medical schools. Nor is the reluctance of some hospital-based teachers to accept the change an isolated British phenomenon, as I found out in Mexico.

British medical schools have risen to this challenge in various ways...

During one workshop a multi-professional group of delegates was asked to define the steps needed to help institutions implement a community-based programme. We were given two case scenarios from the USA and Sudan which highlighted the fact that many doctors are inadequately trained to work outside the hospitals in which they receive most of their education. The same applies to other health professionals.

We began to define educational objectives for a community-based programme to meet some of the needs of students who would become doctors such as these. There was little disagreement on these objectives but we felt that the main stumbling block to providing more relevant community-based education was the feeling of many hospital-based clinicians and teachers that the real work of health workers takes place in hospital. Secondary and tertiary care centres are seen to be the location of 'proper medicine'. Yet, as one Canadian doctor quoted a colleague: "Teaching undergraduate medicine in a tertiary centre is like teaching forestry in a lumber yard."

In the UK the perception of 'proper medicine' is fostered by television programmes such as *ER*. There is an exciting backdrop of saving lives, putting up drips and communication in a language far removed from that of the sixth form and suburbia. And that is one of the problems of hospital-based, doctor-centred and disease-centred education. Patients do tend to be very ill and are less likely to suffer several raw undergraduates taking their histories. Hospital clinicians, who have been the principal educators of medical students for many decades, are reluctant to devolve any teaching sessions to their community colleagues. There may be financial implications as well as a reluctance to change, while the view is also expressed that students only learn general practice *per se* in primary care settings and not generic clinical skills.

Community-based education involves more than students learning from patients in a community setting. There is an assumption that students will return something to the community, that they will benefit the patients in some way. Students may have a therapeutic role. Sending them to talk to patients in their homes, asking them to explore concerns and expectations, may uncover facts

about our patients that we have never realized.

In a recent paper in the *British Medical Journal*,[1] commented on in an editorial,[2] the authors make the point that patients' rights must be respected when medical students are taught in general practice. Community-based teaching must go beyond learning in general practice, where the teaching is predominantly by general practitioners. Students need to understand patients within their communities, and how people access health care in different ways.

An example of how a community-orientated curriculum may run was described in an address by Dr Wasylenki of the University of Toronto. From 1992 this hitherto traditional medical school has set aside one half day per week throughout the first and second year of the undergraduate course for students to become involved in community projects. In the second year the students are attached to an agency for the weekly session to study in depth a health problem related to a social issue, e.g. alcoholism and homelessness. Each student devises an individual learning plan with the help a field supervisor and faculty tutor. At the end of the year the students produce and present a report which may form the basis for change in social services policy.

How relevant is this to a future doctor's needs? The Toronto students score higher than other Canadian students in national community and public health final examinations. They rate the course highly as demonstrating the importance of a patient's social history. For the educator, community-based teaching and projects need to be evaluated both quantitatively and qualitatively to see if they fulfil their aims and make a significant difference to a student's knowledge, skills and particularly attitudes.

The Network conference in 1998 will take place in New Mexico. The organizers hope that submissions for presentation will concentrate on the research agenda for community-based education.

Jill E Thistlethwaite

References

1 O'Flynn N, Spencer J, Jones R. Consent and confidentiality in teaching general practice: survey of patients' views on presence of students. *BMJ*, 1997; **315**: 1142

2 Williamson C, Wilkie P. Teaching medical students in the community. *BMJ* 1997; **315**: 1108-1109

Further reading

GMC. *Tomorrow's Doctors*. London, 1993.

Seabrook M, Booton P, Evans T (eds.) Whitehouse C, Roland M, Campion P (eds.). *Teaching in the community*. OUP, Oxford, 1997.

6 More Good Reasons to attend WONCA '98 Number Two

● Your partner in life is soccer mad. Attended WONCA '98 and holidaying in Ireland for two weeks after the conference should ensure that the temperature of World Cup fever is reduced and France '98 avoided.

● You are single and unattached — in a social rather than professional context. Preliminary booking figures indicate a very high attendance of good-looking, unattached doctors with ulterior motives for attending WONCA '98 .....

● You are an academic GP. Research has shown the predictive value to obtaining a professorship within one year of attending a World conference is very high.

● You are a recently appointed principal in a large practice. All the good holiday dates for July and August have been pre-booked by your senior colleagues. Cash flow is tight and the baby will be only nine months old. And it is only three hours by car ferry from the U.K ...

● You are a keen golfer who has never experienced the magic of links golf. There are half a dozen links courses within 25 miles of the conference centre. Free standing papers in the morning, 18 holes in the afternoon?

● You have seen Springtime in Paris, had autumn breaks in Rome, been in the coffee houses of Amsterdam, but never seen Dublin in the 'rare oul times'. What's keeping you?

Finally a message for Gaelic speakers:

"Bí linn, beidh an craic go h-iontach" (Join us, the craic will be mighty)

See you there.

Muiris Houston

Clinical practice guidelines — what's the point?

Too many, of variable quality, often concerned mainly with containing costs, of limited relevance to my patients and too much like cook-book medicine - why should I bother?

All or some of these points continue to be made by clinicians. Since guideline development (especially evidence-based guideline development) takes tremendous effort, and then implicitly expects clinicians to put in further effort to shape their practice towards the recommendations of the guideline, it really is important to respond to these concerns.

There are a very large number of guidelines in existence. For instance, in asthma alone, investigators recently found over a hundred local guidelines in current use. There is also substantial variation between guidelines. The international guidelines on the management of hypertension may use the same evidence but they are not explicitly evidence linked and do not always agree on recommendations in important clinical areas. No wonder general practice teams feel rather confused about the messages.

The role of guidelines in cost-containment is a continuing concern to users and developers alike. Many so-called clinical guidelines produced under the auspices of health authorities and health boards are actually 'access to secondary care' permits, with very explicit considerations about who may be referred for what and when and to whom. An access protocol for local health service use is not necessarily a clinical guideline and clear distinctions should be drawn between them.

And then there is the question of relevance. Of all the concerns about guidelines the issue of relevance is the most tricky and intellectually challenging. Let us set aside the question of whether randomized controlled trials are the 'gold standard' for evidence and the role of cohort studies. The new methods for grading recommendations can take this into account to some extent. No, the biggest challenge is for the individual doctor or nurse in consultation with a patient.

Faced with an individual patient for whom guideline recommendations for best practice have to be set into the context of the patient's wishes, other clinical problems, past history and, importantly, the clinician's experience, decision making is far from easy. Translating research and epidemiolological evidence into decisions for individual patient care does not smack of cook book medicine. It takes a highly trained professional to make the right decisions and to maximize the gain for the individual patient. Guidelines, good guidelines that is, make the task of being a general practitioner more, rather than less, intellectually demanding.

Where do we go from here?

So what is going on behind the scenes to support guideline development and to recognize these challenges? It would be fair to say that the NHS and the Royal Colleges in England have been rather less organized than colleagues in Scotland and the Netherlands. Rather than having an orchestrated programme, guideline development has emerged from a number of settings, supported by the national clinical audit funds (such as the Acute Low Back Pain guideline), from Research and Development funding (the North of England Guidelines on Recurrent Wheeze in adults and on Stable Angina are good examples) and from special interest groups such as the British Thoracic Society. Quality control has been variable and has been made more difficult for individual project leaders and Colleges because the ground rules on what constitutes an evidence-based guideline have developed at such a pace as to outstrip the pace at which a guideline can be developed.

Something had to be done! It has been interesting to watch the emergence of a mature working relationship between the Royal Colleges and the NHSE in England as joint agreements have been reached on a programme of work, competitively bid for and led by the Colleges, and on an NHS guideline quality assurance programme commis-

sioned from St George's Hospital Medical School. Based on the now-deceased NHS Clinical Outcomes Group, and presumably under the auspices of the new National Institute for Clinical Excellence, there is now a rolling programme of commissioning for national evidence-based guidelines for England.

And what of the role of the Royal College of General Practitioners in England in this frenzy of activity?

We have been particularly fortunate in having a group of College members who are recognized internationally as being experts in guideline methodology and who have been prepared to give their time to a whole range of activities in what is now known as the College Effective Clinical Practice Programme. Starting with *Report from General Practice 26* (on development and implementation of guidelines) the Programme went on to workshops on guidelines and then to a series of masterclasses attended by effective clinical practice leaders from many of the other Colleges.

But the main activity in the Effective Clinical Practice Programme has been to develop a very small number of guidelines to the highest international standards — a small number not just because it is not possible to cope with an ever expanding workload, but because there is a policy not to overload general practitioners with too many guidelines at once. Development to the highest standards is something to do with pride in the College being at the forefront of this work to support general practitioners and their teams and in being an institution which has an interest in improving clinical standards, as well as ensuring technical quality. So far only one national evidence guideline has been published by a College in the English NHS programme — the Acute Low Back Pain Guideline — although more are imminent from other Colleges.

Next on the RCGP list is a joint venture with the Royal Colleges of Nursing and of Physicians, together with the British Diabetic Association, to develop a guideline for the management of non insulin-dependent diabetes. The first instalments of the guideline, on foot and eye care, will be published in late 1998. And yes, we have learned lessons from the less than satisfactory dissemination process for the Back Pain guidelines. Recent research has shown that many copies of the guideline only got as far as the practice administration waste paper bin and we are actively examining better means of targeting the materials.

From the perspective of implementing research evidence into practice, however, the most exciting initiative will be the new Clinical Practice Evaluation Programme (CPEP). Approved by Council in March 1997 and now jointly funded for an initial development period of two years by an educational grant from Merck, Sharp and Dohme, and by the NHS Executive in England, CPEP will focus on helping to improve care for four conditions — asthma, diabetes, CHD and depression. Using audit criteria based on evidence, CPEP is intended to allow practices to examine the quality and outcome of their care, and to contrast it with colleagues practising in areas of similar health and socio-demographic characteristics. Held under the guardianship of the College, the information will become a picture of the changing shape of British General Practice and will be of use to PCAGs and MAAGs, and potentially to a wide range of other initiatives such as Fellowship by Assessment and Practice Accreditation. The development programme will be looking for partners even as you read this article — contact the author for further information!

Overall, then, guidelines and the challenge of taking evidence into practice are providing interesting times - not to be missed, I suggest. Indeed, I suspect the new NHS Acts, with their emphasis on 'clinical governance' and on guarantees on quality, will mean that the RCGP Effective Clinical Practice Programme will be very much centre stage for the millennium.

Allen Hutchinson

SIGN - ah, to be in Scotland now that guidelines near...

The Scottish Intercollegiate Guidelines Network (SIGN), formed in 1995, has recently published its 21st guideline. The collaboration and cooperation involved in the development of SIGN guidelines is helping to promote a sense of ownership and a shared commitment to improving patient care in Scotland.

The RCGP in Scotland is a founder member of SIGN, which includes representatives from all the Royal Colleges and their faculties in Scotland, plus the Scottish GMSC, Nursing, Pharmacy, Professions Allied to Medicine, and patients, through the Scottish Association of Health Councils.

The development methodology has evolved through feedback from the end users, with more technical support for SIGN groups, along with considerable modifications to the presentation of the pilot editions. Patient involvement at all stages is also being encouraged. Whilst there will always be room for improvement, and many will continue to debate their validity, both SIGN and the RCGP are adopting a proactive approach to national guidelines and their implementation.

SIGN guidelines are distributed widely in Scotland free of charge, and provide an information base for strategic planning and resource allocation, as well as a means of keeping up to date. The RCGP are keen to emphasize that the guidelines are only a tool and that clinical judgement is still essential at all stages of patient care. Implementation of the national guidelines is a local issue, and in some cases only one or two guidelines are chosen for specific action each year.

*The RCGP Guidelines Group in Scotland is ensuring a multi-disciplinary approach to implementation by involving all members of the primary care team. Following a nation-wide consultative process a number of initiatives have been started including a new primary care website SIGNet (**www.rcgp-signet. co.uk**), the guideline newsletter Signature, summary sheets outlining key points, and local practice-based implementation projects.*

The RCGP Guidelines Group would certainly agree that cook-book medicine would be a recipe for disaster, in Scotland we are finding that the proof of the pudding is in the implementation.

Patricia Donald

Guidelines — why they don't work yet

I am not yet a 'guidelines' fan. At least not for applying to the generality of everyday meetings between doctors and patients in the consulting room. To explore the philosophical grounds for my position, I will revisit the issue of whether to prescribe antibiotics for routine respiratory illnesses — a fair test as it is a common problem, and a relatively simple and self-contained issue. If guidelines don't fit here, they will have a problem elsewhere.

Thirty years ago, I carried out my first general practice research project - an RCT of antibiotic against placebo in new episodes of respiratory illness. There was no benefit to antibiotic takers. This has been confirmed many times since, both generally and for sub-sets of respiratory illness - purulent sputum, sore throats and pink ear drums. But antibiotics are still prescribed for more than half such illnesses and doctors vary fourfold in their propensity to prescribe. Biomedicine neither explains that variation nor predicts the near random likelihood that the next patient with a respiratory infection will be prescribed an antibiotic. However, subsequent more 'behavioural' research and a better conceptual model of what happens at consultations helps explain the gap between RCT evidence and practice.

Non-medical influences on medical problems

Our 1976 'sore-throats' photograph study confirmed that non-medical influences on consultations significantly influence doctors' prescribing patterns, and the more complex 1980 'psychotropics and antibiotics' study showed that psychotropic-using mothers had children who consulted more and received more antibiotics for respiratory illness than children of other mothers. The psychotropic and antibiotic peaks were not time-related, suggesting families as much as individuals were patients.[1]

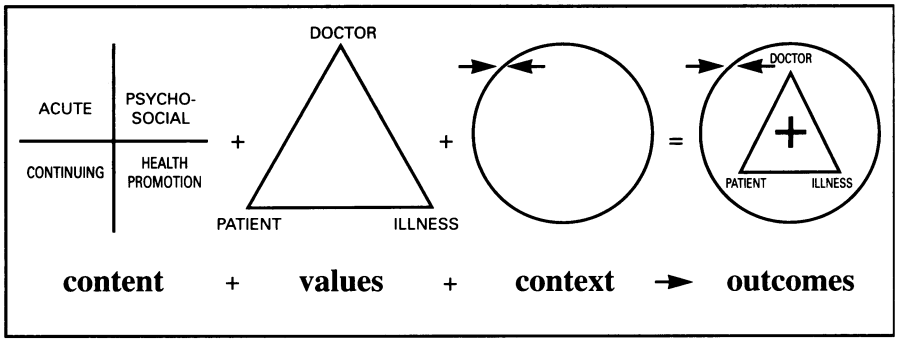
More recent work on consultation length has shown that doctors with different consulting styles detect different proportions of patients' co-morbidity (physical and psychosocial) and deal with different proportions of the needs they are aware of.[2,3] Faster workers and shorter consultations predict more 'medical' interpretations and more antibiotic prescribing, particularly when doctors are less patient-centred or when they change styles to a less patient-centred pattern of working than is normally preferred (the effect, or sometimes the cause, of work stress).[4]

Building a conceptual model of 'process'

Any credible definition of quality starts with an assumption that 'needs' are recognized, negotiated and prioritized. The Stott & Davis model shows the potential richness of opportunity and interpretation open at each consultation. The behavioural work referred to above indicates that values (of doctors and of patients) and the context in which consultations take place affect the needs prioritized and the process of the care which follows. It can be argued whether context constrains how values are expressed, or whether values determine how context is modified, and both interpretations do occur. It seems certain, however, that both context and values intervene between content and outcome. (My present working model is reproduced in the figure below.[5] The model is explanatory in the setting of antibiotic use for respiratory illness, although not necessarily predictive — scarcely surprising given the many potential influences on decision making which it embraces. Does this model have the power or ability to predict or explain health outcomes as well as process outcomes?

An outcome or quality measure

Most recently we have developed newer needs and outcome measures to evaluate consultations. This has involved creating first a hierarchy of needs (40%



References

1 Howie JGR, *Research in general practice*, chapter 16, p208-223, Chapman & Hall, London, 1989.
2 Howie JGR, Porter AMD, Heaney DJ, Hopton JL. Long to short consultation ratio: a proxy measure for quality of care for general practice. *Br J Gen Pract* 1991; **41**: 48-54
3 Howie JGR, Hopton JL, Heaney DJ, Porter AMD. Attitudes to medical care, the organization of work, and stress among general practitioners. *Br J Gen Pract* 1992; **42**: 181-185
4 Howie JGR, Porter AMD, Forbes JF. Quality and the use of time in general practice. *BMJ* 1989; **298**: 1008-1010
5 Howie JGR, Addressing the credibility gap in general practice research: better theory; more feeling; less strategy. *Br J Gen Pract* 1996; **46**: 479-481.
6 Howie JGR, Heaney DJ, Maxwell M. Measuring quality in general practice. Occasional Paper 75. London: RCGP, 1997
7 Feinstein AR, The need for humanized science in evaluating medication *Lancet* 1972; ii: 421-423.

of patients with a 'physical' problem also have either a psychological or social problem or both) and second an outcome measure which we have called 'enablement'. (This asks about patients' ability to understand and cope with their problems and their health and life generally as a result of their consultation.) Positive outcomes are influenced by changes in context — increased consultation length makes more people more enabled; more time is needed to make patients with more complex problems equally enabled. The doctors who enable people most are likely to be the ones who are more patient-centred.[6] In short, the same model that explains process, can also predict health gain.

Finding the place for guidelines

Guidelines work best for single disease presentations where good evidence on process predicts real biomedical health gain. They are ill-fitted to settings where needs are multifaceted, values important, context influential and outcomes behavioural. The majority of general practice consultations fit this description. The model I have used to support this contention is perhaps general and permissive rather than predictive, but the philosophical distance it puts between managing organic need and achieving behavioural outcome has face validity. Similarly the research evidence I have advanced may be circumstantial, but cumulatively it does more to support than to disprove my argument that guidelines are not yet the main answer to improving quality in general practice.

Paradoxically, I do believe that general practice should be accountable. But Feinstein got it right in 1972 when he wrote that "until the methods of science are made perfect for all the important distinctions of human phenomena, our best approach to many problems in therapy will be to rely on the judgements of thoughtful people who are familiar with the total realities of human ailments."[7]

'Guidelines' are not yet often enough based on 'methods of science' that explain or predict the 'important distinctions of human phenomena' sufficiently well to become a central strategy for improving the general quality of consultations in our discipline. More good social science and less inaccurately targeted biomedicine might help!

John Howie

Research that has not seen the light of day

Throughout my years as a researcher there have been a number of questions posed in daily practice that seemed worth testing, but that have yet to be subjected to critical analysis. The following are two of the more challenging questions that have frequently recurred, but for a variety of reasons it has not been possible to mount sufficiently robust studies to test my beliefs.

The majority of textbooks highlight the importance of examining the ear of fevered children. Having your ears poked with an auriscope does not appeal to the majority of children and, if I'm honest, what I can see in a few seconds of twisting and turning in an ear canal is often beyond my ability to come to an accurate assessment of the eardrum. From clinical experience, any inflammation of the eardrum is usually associated with earache, but in children without earache the appearance of the drums is usually normal. Why then should I subject children to unnecessary examination?

My view is that in children with upper respiratory symptoms but no earache, examination of the eardrum should not be a mandatory procedure. I would go further and suggest that, by examining the ears, some minor inflammation of the drum would be noted which allows the doctor to feel justified in prescribing antibiotics. By examining unnecessarily, we may prescribe unnecessarily. The study I had planned involved two groups of children with upper respiratory tract symptoms but no earache. In group one, the children would, in addition to examination of the nose and throat, have an auriscope examination, and in group two the children would have no ear examination. My hypotheses where that
a) there would be no difference in outcome for the two groups.
b) in group one the doctors would be more likely to prescribe antibiotics.

Having obtained the necessary statistical advice about the number of children required to show significant differences in outcome, the next step was to obtain ethical approval for what I thought was an interesting piece of original work. It was at this point that I came up against the paediatric establishment, which was horrified that anyone would deny young children a full examination. Despite my plea that there was little evidence that I could find which justified the examining of all children with no earache, the beliefs of experts prevailed and ethical approval denied. I still think it is a question worth answering as many procedures in medicine are built into beliefs about good practice when the evidence to support these approaches has yet to be defined. For example: how often is the use of the stethoscope merely a ritual rather than an essential examination?

Another example related to "good practice" in the management of urinary tract infection. The major textbooks emphasize the importance of examining the urine and sending a mid-stream specimen to the laboratory. In women with uncomplicated cystitis how many of us actually examine the urine and send MSSUs to the lab? Not many, I suspect. We make a judgement on clinical grounds and prescribe appropriately, and probably ensure that a lot of laboratory time is not wasted by examining unsatisfactory specimens. My plan on this occasion was to conduct a study where two groups of female patients with cystitis were compared: in one group, MSSUs would be carried out and, in group two, no urinary investigations performed. My hypotheses were that doctors would prescribe on the basis of presenting symptoms and not on the results of urine tests, and that there would be no difference in outcomes for the two groups. Again, the strong views of experts on ethical committees have made a study based on not examining the urine almost impossible to carry out.

At a time when guidelines for care are constantly adding to our mail, the evidence for much of what is recommended in managing common problems in general practice is based on the belief of secondary care experts. "Being seen to be good" is frequently based on time-honoured traditions rather than on the pragmatic experiences of doctors faced with the constraints of time. The need to make clinical judgements based on methods of working which fly in the face of dogma and accepted truth will continue to be part and parcel of daily practice. It would be nice to think that we could identify some ethical committees which understood why we wish to seek evidence to justify our apparently non-scientific approaches to common problems.

John Bain

Working Abroad Seminars
The BMA's International Department requires volunteers to speak (briefly) at 'What's It Really Like' seminars on the opportunities/challenges/ difficulties facing young doctors who wish to work overseas.
Contact **Isabel Fish**, International Department, BMA House, Tavistock House, London WC1H 9JP
0171 383 6231

One-Day Seminar
on the exploitation of research results of
Health Telematics Projects, Framework IV
The Wellcome Trust, London

The seminar will demonstrate new technologies and processes emerging from the EC-funded Framework IV programme. The technologies have strong market potential and offer innovative market solutions in the area of multimedia patient records, coordination tools, departmental sysytems and advanced imaging, integration platforms and regional networks.
For more information and a registration form please contact **Mary Marshall**, IETT
on tel **0171 628 9770**
or fax **0171 628 7692**

HIV/AIDS working party

Shifting Care or Shifting Costs?, a joint RCGP/RCP conference on sharing care in HIV and AIDS, took place at Princes Gate in October 1997.

The conference attracted over 100 delegates and received very positive feedback. Speakers included Professor Ian Weller, Dr Chris Ford, Dr Surinder Singh, Professor Michael King, Dr Judy Bury and Professor Tony Pinching.

These are the summary points from the October conference:

- Involving GPs in HIV care remains essential but formalized shared care may not be the best approach.
- We need to use the skills of the GPs and the advantages of primary care in ways that are beneficial to the patient.
- Clear, appropriate, two-way communication is essential, but is not without risks (for example, a tendency to forget the patient and only remember the disease).
- Secondary care should promote primary care involvement and refer patients' primary care issues to the primary care specialists.
- Combination therapy should be initiated by specialists but GPs need to understand side-effects and interactions.
- There are dangers of dismantling services before long-term benefits of combination therapies have been evaluated.
- Need for more leadership from central government so that there could be more consistency in care provision in different parts of the country.
- Commissioning should be collaborative, i.e. involve GPs and patients but don't expect GPs or patients to lead commissioning.
- Encourage more GP involvement in HIV testing including antenatal testing.
- There is a need for more effective, culturally sensitive care for children and families affected by HIV.
- Patients should choose where they wish to die.
- Unlike HIV care, drug users are often best managed in a shared-care model.
- GPs need more on-going training and support to become involved in HIV care and the care of drug users.
- All services need to have confidentiality and anti-discrimination policies.
- The concept of confidentiality in general practice needs to be reviewed (for example, the involvement of reception staff).

To continue the debate, a follow-up conference was arranged at the RCGP in December 1997. Dr Jane Anderson (hospital consultant) and Gregg Battle (GP) continued to 'define roles'. "Was the on-going worry about communication in HIV medicine a way of expressing our discomfort about our fears about our roles?" asked Dr Anderson. The real need for GPs, patients and specialists to understand the role of GPs in primary care was again expressed by Dr Battle; it was emphasized that managing people who are infected by HIV infection in primary care is about adding care and not worrying about our roles.

The combined messages from the four workshops on antenatal testing (Sandra Dick), more HIV testing in primary care (Chris Ford), managing drug regimes (Nick Theobald and Jonathan Sheldon) and cultural sensitivity (Judy Bennett) were concise and clear:

First, it is now important that HIV testing is normalized and that the particular strengths of primary care (continuity, one-to-one relationship, local access) mean that general practice will inevitably be more involved. We need to banish for ever the question of HIV testing being hindered by insurance medicals; quite simply they should NOT, as recommended by the their association (ABI) in 1994.

Secondly, two points from the drug workshops: managing complex drug regimes in general practice is a routine part of our everyday work, and non-compliance (recently updated to non-adherence) is another normal fact of GP life, not something deviant.

Thirdly, and all of us need to develop this, attempting to be culturally sensitive often means using fairly coarse and insensitive methods of communication — a paradox if ever there was one. One example would be in the context of taking a sexual history. The genuine difficulties in asking diverse groups about sex, sexual activity and practices were highlighted.

All in all, it was a successful day, perhaps best summarised by Dr Gregg Battle who was commenting about his role as a non-expert, but an interested family doctor:

> The magical and mystical thing that is general practice enables me as a GP to converse with patients about a host of problems — including the intricacies of their HIV drug regime — which is both supportive and therapeutic.

Noel Bell
Judy Bury
Chris Ford
Surinder Singh

.. a new guideline for niddm

Three Royal Colleges are working with the British Diabetic Association to draw up a new national clinical practice guideline for people with non insulin dependent diabetes.

A multi-disciplinary team from the Royal College of General Practitioners (RCGP), the Royal College of Physicians, the Royal College of Nursing and the British Diabetic Association, with expertise in all areas of care for diabetes in adults, have been commissioned to work together on the two-year project. Recommendations on good practice will be produced from the collated evidence.

The project is being directed by Professor Allen Hutchinson, Director of the RCGP Effective Clinical Practice Unit at the University of Sheffield. He said:

> This is one of the largest multi-disciplinary guideline projects to be undertaken in England. It is expected to provide valuable, research-based materials which will support clinicians in their everyday work. Patients and their carers will be the beneficiaries of this project, the prime objective of which is to improve access to the best research information on diabetes care and so to improve quality of care.

One of the special features of the project will be the information produced for patients themselves, available in an easily accessible format. Advice for Health Authorities who commission services for people with diabetes will also be provided.

Clinical practice guidelines are of limited value without an accompanying programme that uses the guidelines to influence care. Thus an important element of the project will entail the establishment of pilot schemes to examine how the guideline recommendations can be put into practice.

Further information can be obtained from Professor Allen Hutchinson, Department of Public Health, University of Sheffield, ScHARR, Regent Court, 30 Regent Street, Sheffield S1 4DA. Tel: 0114 222 0813. Fax: 0114 222 0798 or from Ms Paula McDowell, Guidelines Initiative Officer, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London, SW7 1PU. Tel: 0171 581 3232. Fax: 0171 225 3047.

A short history of socialized medicine... 5

The Age of the Apothecary - The dawn of primary care

At the Dissolution, generous severence payments enabled skilled ex-monks to take up the profitable trade of apothecary, demand being encouraged by new overseas trade. As members of the Grocers' Company, apothecaries sought professional status like Physicians and Surgeons. King James I's response was emboldened by Privy Council concern for the health of his subjects, and the Society of Apothecaries became established in 1614.

During the 1600s, secularization of the parish formalized Tudor Poor Law, parish officers' duties including collection and distribution of poor relief. Justices guaranteed paupers' access to parish relief and their orders frequently record medical treatment, such as transport from Ashton in Lancashire to St Thomas's Hospital for successful treatment and visits to London to seek the Royal Touch for the "King's Evil" (tubercular cervical adenitis). Routine work went to apothecaries such as Peter Dent, William Frisby, Edmund Halfhyde, Artemas Hinds and Charles Gilman - all paid by Cambridge overseers between 1685 and 1758.

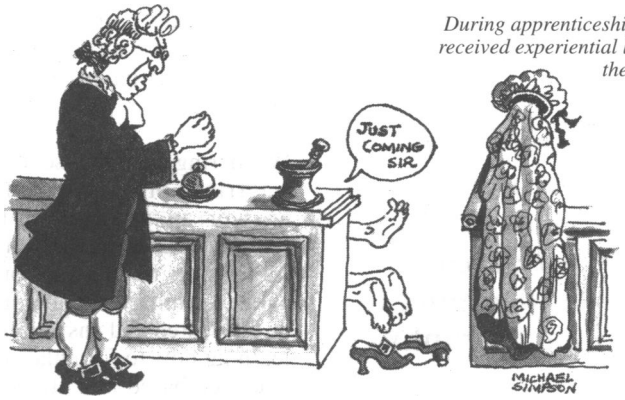
London had barely one hundred fellows, candidates and licentiate physicians of the Royal College of Physicians by 1702, but almost a thousand apothecaries (in continental cities the proportions were reversed). During apprenticeship, apothecaries received experiential learning behind the shop counter whilst their master visited wealthier patients. Relations with university-trained physicians were poor and the RCP had the right to supervise their practice. Apothecaries were obliged to make up physicians' prescriptions and could only charge for dispensing — not for "practising physic" (ie giving an opinion) as most did this *gratis*.

William Rose, the London apothecary, was sued in 1701 by the RCP for practising physic. His fee of £50 was no help! Initial judgement for the physicians was later reversed — their Lordships ruling that the poor would be oppressed, and that the nobility would have to pay physicians for their servants. Sick persons "in case of sudden accidents or new symptoms appearing in the night time, generally send for an apothecary", knowing that a physician would not attend "if at dinner or abed".

By 1783, 80% of English practitioners in Simmon's Register were described as "surgeon- apothecary", reflecting broadening expertise in response to the demands of the newly industrialized nation by including the country surgeon's practical skills, possibly acquired in army or navy service, as well as man-midwifery. Demand for economic drugs stimulated innovative production techniques — many pharmaceutical companies, such as British Drug Houses, trace their origins to pre-1800 apothecaries. Ironically, within a short few years of formal recognition by the Apothecaries Act (1815), the professional description was superseded by "General Medical Practitioner". A successful apothecary could, however, make an academic transformation later in life, by adding an MD (as did Edward Jenner in 1792), for the canny and ancient universities of Aberdeen and St Andrews would oblige by post — in return for a modest fee and recommendations from two colleagues!

Jim Ford

*During apprenticeship, **apothecaries** received experiential **learning behind** the **shop counter**...*



Sources

1. H J Cook. Policing the Health of London, p13, Social History of Medicine, 2, 1989.
2. A Fessler. The Official Attitude towards the Sick Poor in Seventeenth-century Lancashire, pp87-101, Proceedings of the Lancashire and Cheshire Historical Society, 1950.
3. J G L Burnby. A Study of the English Apothecary from 1660 to 1760, Wellcome Institute for the History of Medicine, 1983.
4. "Medical Practitioners", Webster and Pelling in "Health Medicine and Mortality in the 16th Century", pp.172-178, Cambridge U P, 1979.
5. I Loudon. Medical Care and the General Practitioner 1750-1850, Clarendon Press, Oxford, 1986.

Homage to Kilgore Trout: towards the evidence-

Wandering the universe for 3000 years is a terrible price to pay for trying to answer an unanswerable question...

The original concept of evidence-based medicine was of an educational tool. It was a method doctors could use to tame the excessive quantity of published research and keep up to date by reading only what was appropriate to the care of their own patients. In the past few years it has been vilified, praised, taught in workshops, and appropriated to every branch of health care. So now we have evidence-based nursing, evidence-based dentistry, evidence-based psychiatry, evidence-based audit, evidence-based practice, and, of course, evidence-based health care.

My own involvement with EBM began during an idle half-hour in Thorne's Students' Bookshop in Newcastle-upon-Tyne. While looking for a book on statistics I picked up (by chance, of course) *Clinical epidemiology: a basic science for clinical medicine*. I immediately noticed the dedication: to "Kilgore Trout, J.G.L., Francois Marie Arouet, and the Emperor's new clothes" and couldn't resist it. I bought the book, and have spent many hours since being entertained and educated by it.

Kilgore Trout (b 1907) is a fictional science-fiction writer created by the real-life science-fiction writer Kurt Vonnegut. At least one novel purportedly by Trout himself has been published. "Venus on the Halfshell" is a lurid saga of the 3000 year, pan-galactic quest of Simon Wagstaff, "an earthman with an eye-patch, levis, and shabby grey sweater...a man drunk with immortality gained during a sexual interlude with an alien queen." He seeks an answer to the question "why are we created to suffer and die?" After unlikely adventures on many planets he finds an answer to his question, but it would be unfair to reveal it here — you'll have to track it down for yourselves!

If we can't navigate this ocean of evidence (or at least understand its cartography) we run the risk of unwittingly harming patients...

Wandering the universe for 3000 years is a terrible price to pay for trying to answer an unanswerable question. Evidence-based medicine is also a quest for answers to questions but, in order to avoid a similar fate, the questions must be structured and answerable. As well as learning how to formulate questions, the evidence-based practitioner needs to be able to find the evidence, to understand some basic epidemiological principles and statistics, and to know how to appraise research findings critically. This is a formidable body of skills and knowledge to acquire. Workshops on evidence-based practice are an enjoyable and effective means of starting out, but the process needs to be sustained, and undoubtedly requires considerable investment of time and effort by the practitioner.

It's reasonable to ask here: is it worth it? General practitioners are already very hard-working people — many would say overworked. Why should we embark on this complex, technically demanding process? Can we find the time? Can't we rely on experts to tell us what we need to know? What relevance have likelihood ratios, or numbers needed to treat, to the multi-faceted presentation of illness in general practice, which requires (as we all learn with our mothers' milk) interpretation in physical, psychological and social terms? Isn't there a danger of concentrating on biomedical problems to the detriment of a holistic approach?

Some GPs who attended a workshop on teaching EBM felt that it was not only a useful educational method ("a process of life-long, self-directed learning") but also potentially empowering for GPs and primary health care teams. The real test, however, is whether it can enhance patient care in daily practice.

What has surprised and delighted me is the way in which I have been able to use evidence-based practice within the consultation. By thinking of ways to express patient's problems as structured, answerable questions, the problems are clarified and the solutions become easier to define. By sharing questions with patients I can include them in making informed choices about their management. I've been gratified by the way patients have responded to this approach.

For example, a woman in her sixties suffering from chronic obstructive airways disease presents with increased shortness of breath and persistent cough especially at night, despite a recent course of antibiotics. I wonder if she has heart failure, discuss this possibility with her and ask what her own concerns are. She is worried in case she has lung cancer. We agree that we need to find out whether she has either condition. I know that electrocardiography is sensitive but not specific for heart failure (a SnNout in

EBM terminology). A chest X-ray shows no change from five years before and an ECG is normal. When I see her the following week with the results of her tests I am able to reassure her. She is relieved (and her shortness of breath and cough have improved).

In consultations about hypertension I ask the patient: why do we treat it? Many don't know exactly why, or what the treatment does. I ask them: "why do you think it's important to treat your high blood pressure?" I spend time explaining the concept of risk and how risk may be reduced. We review other risk factors such as smoking, family history and cholesterol, and I show the patient how we can estimate their individual risk. I use Rod Jackson's prognostic tables for this (available on the CEBM website, ***http://cebm.jr2.ox.ac.uk***). Then we discuss what steps (including lifestyle changes) could be taken to reduce their level of risk, and whether they think it's worth doing (not forgetting to include discussion of potential harm resulting from the treatment).

This style of consultation redefines "treating hypertension" and makes it explicit that the aim is to reduce cardiovascular risk. The GP needs to be familiar with the tools of quantitative evidence-based practice, such as number needed to treat (NNT), the difference between relative and absolute risk reduction (RRR and ARR), and to keep up to date with developments and controversies in therapy (such as: do statins have a class effect?). This is about as "biomedical" as you can get. Does it debase the holistic nature of the general practice consultation? Does it malevolently warp the GP's "apostolic function"? The answer to both of these questions is emphatically no. By clarifying the patient's "biomedical" situation it actually helps both GP and patient to identify and address other agendas, including psychological and social ones.

Qualitative research can also be used to inform evidence-based consultations. For example Kai's work on parents' difficulties and information needs in coping with acute illness in pre-school children shows that parents are not reassured if the GP merely tells them "it's a virus". This is particularly so if the child has previously been prescribed an antibiotic a few days later in a similar situation. They may also have (from the GP's perspective) an exaggerated view of the potential seriousness of the illness. Taking an evidence-based approach the GP formulates questions to address parents' anxieties and information needs as reported in Kai's paper. The GP uses structured questions both to explore their fears and to enable them to increase their understanding of what is happening. These might include "how often do you think that children with this kind of illness develop meningitis?" or "are children often permanently harmed by this kind of illness?" The decision whether or not to prescribe antibiotics (for example for sore throat or otitis media) is a joint one, based upon the GP discussing with the parent current evidence about effectiveness. Simple "bites" of evidence are useful here: "90% of sore throats are better in a week whether the patient has antibiotics or not", "80% of children with earache settle without antibiotics in 2 to 7 days". Most parents seem to appreciate this approach and agree with a decision not to prescribe antibiotics. However, if they believe strongly that a small likelihood of being helped is better than none I respect their views and prescribe.

Consultations like these are now part of my daily practice. The evidence-based consultation makes diagnostic and therapeutic dilemmas explicit, increases the efficiency of the GP's continuing learning and empowers patients to share in decision-making. In this kind of consultation the GP is both teacher and student and is open about what he or she does and does not know. We have more effective interventions available to us than ever before, but an overwhelming quantity of evidence about them is published week by week. If we can't navigate this ocean of evidence (or at least understand its cartography) we run the risk of unwittingly harming patients or missing opportunities to benefit them (and modern benefits and harm can be very great). In this environment, the fundamental principle of evidence-based medicine — learning how to recognize what we don't know — becomes an essential skill for the clinician.

The evidence-based consultation is not yet part of routine practice: why not?

Toby Lipman

Further reading and resources

Sackett DL, Haynes RB, Guyatt GH, Tugwell P. *Clinical epidemiology: a basic science for clinical medicine.* London. Little, Brown 1991

Sackett DL, Richardson WS, Rosenberg W, Haynes RB. *Evidence-based medicine: how to practice and teach EBM.* London. Churchill, Livingstone 1997

Greenhalgh P. Workshops for teaching evidence-based practice. *Evidence-based medicine* 1997;**2**:7-8

Lipman T, Rogers S, Jones Elwyn G. Evidence-based medicine in primary care: some views from the 3rd UK workshop on teaching evidence-based medicine. *Evidence-based medicine* 1997; **2**:133-135

Trout K. *Venus on the Halfshell.* London. W.H.Allen 1976

Balint M. *The Doctor, his Patient, and the Illness.* London. Pitman 1964

Kai J. Parents' difficulties and information needs in coping with acute illness in pre-school children: a qualitative study. *BMJ* 1996;**313**:987-90

Spodick DH. Commentary on "Electrocardiography was highly sensitive but only moderately specific in detecting chronic heart failure." *Evidence-based medicine*1996;**1**:155.

Comment on: Davie AP, Francis CM, Love MP, et al. Value of the electrocardiogram in identifying heart failure due to left ventricular systolic dysfunction. *BMJ* 1996;**312**:222

Del Mar CB, Glasziou PP. Antibiotics for the symptoms and complications of sore throat. *Cochrane database of systematic reviews*, 1997*

Glasziou PP, Hayem M, Del Mar CB. Treatments for acute otitis media in children: antibiotic versus placebo. *Cochrane database of systematic reviews*, 1997*

The Cochrane Library on CD-ROM. (* the two reviews above can be found within 10 seconds by a simple search on the CD-ROM)
Best Evidence on CD-ROM. Collected structured abstracts with critical appraisals plus editorials and glossary of clinical epidemiology terms from ACP Journal and Evidence-Based Medicine.
CEBM website. http://cebm.jr2.ox.ac.uk
Bandolier website. http://www.jr2.ox.ac.uk/Bandolier (this is great because it has a quick and easy search engine and I can never find the paper copy of Bandolier I need when I need it)
Medline on the internet. There are several sources with different search engines. The BMA provides free Medline on the internet to its members.

digest

Poetry and Healing; a Doctor's Education in Empathy, Identity and Desire, by **Rafael Campo** (W Norton HB 270pp £16.95, 0 393 04009 7) veers from writing of elegance and clarity, as in the author's magnificent account of discovering that one could be non-WASP and gay and survive at an Ivy League campus, to narcissistic preciousness. Worth buying if only for the opening sentence, right up there with *Anna Karenin* and *Lolita.* Alternatively, wait for April and the publication of **Surviving the Fall - the personal journey of an AIDS doctor** by **Peter Selwyn** (Yale, 0 300 07126 4)... Meanwhile, readers of **AR Tindall's Medical Terms: Their Roots and Origins** (Swets and Zeitlinger, 90 265 1498 0) are already prepared for the large bottomed woman braying like a goat who wanders through the surgery door. "Steatopygic aegophonist", they'll scribble in the casenotes. Note the diphthong. Tindall's stout in their defence. 'Aegophony' from *aigos* pertains to the sound of goats, 'egophony' to oneself, so pity the slipshod North American. Should come with complimentary anorak, and rather good fun. **AL**

ABC of Work Related Disorders

ed. **David Snashall**
BMJ Books, 1997
PB 169pp £26 (0 7279 1154 6)

The *ABC of work-related disorders* is part of a series published by the BMJ Publishing Group and, contrary to expectation, is not written in a traditional encyclopaedic format. Instead it arranges 16 subject areas (including occupational asthma, building-related diseases, dermatitis, stress, musculoskeletal disorders, cancers, fitness for work and women's health at work) into chapters, each with clearly labelled sections, summary boxes and photographs. It is chiefly aimed at general practitioners who wish to know more about work as a cause of illness and injury.

David Snashall emphasizes the need to take an occupational history of patients presenting with conditions that may be work-caused or made worse by work. He reminds doctors that they can obtain guidance from the Employment Medical Advisory Service and the Faculty of Occupational Medicine.

The chapters are written to a standard formula, with easy-to-read sections on background, diagnosis and management. However, each author has chosen to include additional information, such as on prevention, legal considerations and workplace assessment. The GP cannot be a expert in these fields, but, for workers without access to an occupational health department or trade union, there may be few other places where they will turn for help and advice. The GP can, at least, point them in the right direction.

An exemplary chapter is the one on neck and arm disorders by Mats Hagberg, professor of work and environmental physiology at the National Institute for Working Life, Solna, Sweden. Hagberg explains clearly the work and non-work risk factors that may be associated with upper limb disorders, including the contribution of psychosocial, age, sex and physiological elements. He finishes with a cautionary note on "RSI" and points out that "almost every doctor will see patients who relate their pain syndrome to keyboard work, and management is seldom easy or straightforward." Hagberg advocates early reporting of symptoms and a multidisciplinary management that emphasizes keeping people in work — albeit with modified tasks, workstation evaluation and regular review. He cautions against patients going down the compensation route, so that their condition becomes "medicalized" and they lack "the motivation to attempt rehabilitation".

It was a smart move by the editor to commission sections on legal aspects, including the reporting of occupational diseases, civil claims and the role of the Health and Safety Executive in assessing fitness for work and absence from work.

The book scores highly by not restricting itself simply to an "abc" list of conditions and diagnoses. The coverage on medical confidentiality and ethics is essential as surveys have demonstrated that employers and GPs do not always understand the correct procedures for dealing with confidential medical records in a work context. The chapter "Working with an occupational health department" is excellent, though wrongly titled: it should have been "working with employers". Most employers do not have an OH department, and it is in these organizations that conflicts over patients' medical details are more likely to arise. The chapter, in fact, tackles both types of workplace and concentrates equally on the relationship between doctors and employers (ie non-medical managers) as with qualified OH staff. The examples of good and bad letters from doctors to employers are very helpful.

A curious strength of the book is that it lacks clinical depth, an inevitable consequence of dealing with the entire discipline of occupational medicine in less than 70 pages. There are many good reference books on occupational medicine — Hunter's *Diseases of occupations* and Raymond Parke's *Occupational lung disorders* are two that come to mind — many of which are included in the boxed sections on further reading.

This straightforward guide will take no more than a few hours to read through and will draw much-needed attention to work-related illness. It is a ready reference for the GP with only limited time to spend with each patient and, overall, a document that encourages an approach to ill health management beyond the GP's surgery. It is more detailed and a clear advance on the Health and Safety Executive's 1993 guidance *Your patients and their work,* and infinitely more useful than the woeful European Commission publication *General practitioners and occupational diseases*, produced in the same year. What it cannot do, however, is provide GPs with the extra time to do the investigative work and liaison with employers that are required to do the job properly.

John Ballard

A Social History of English
Dick Leith
Routledge, 1997
PB 301pp £12.99 (0 415 09797 5)
Language is Power; The Story of Standard English and its Enemies
John Honey
Faber
PB 298pp £8.99 (0 571 19047 2)
English as a Global Language
David Crystal
Cambridge University Press, 1997
HB 200pp £12.95 (0 521 592 47 X)
Wired Style; Principles of English Usage in the Digital Age
ed Hardwired
HB 176pp $17.95 (1 8888 6901 1)

The worldwide importance of the English language has probably never been greater, and is still growing. There has been a plethora of publications to explain and exploit the phenomenon, four of which I have read recently.

The most general is Dick Leith's *A Social History of English*. This book is at once erudite, accessible and engaging. Designed mainly for a general audience, Leith steers us through the Celtic, Latin, Anglo-Saxon, Norse, and French origins of English. He describes a recurring pattern of initial political domination, in which the conquering language becomes the language of law and government, followed by some resurgence of the subject language to a varying degree, leaving a hybrid which, in its turn, falls to the next conquering wave. Throughout the book he emphasizes the variability and vitality of the language throughout the ages. He gives fascinating examples of words which, over the years, have completely changed their meaning. Who would have thought that *lewd* started out as meaning layman, *buxom* as obedient/respectful (bow-some) or *knight* as servant?

Grammar, the *bête-noire* of many a student of my generation and older, is made interesting! The chapter on pronunciation is perhaps a little too technical for the lay reader, but much of the detail can be missed out without losing the sense of the piece. Likewise, the small theoretical section of the book was designed for students of linguistics rather than dabblers such as myself.

In the chapters on grammar and pronunciation Leith devotes some time to describing the processes that have slowly caused the convergence of what were many forms of the language towards the standard form most widely used in print and broadcasting today. The invention of the printing press and increased mobility due to improved transport created the pressure for a form of the language that all could understand. Later the publication of Samuel Johnson's dictionary accelerated this process. He clearly has some reservations about what he sees as the appropriation of what was considered to be a 'correct' form of the language by the ruling classes in the 18th and 19th century. This group, he contends, deprecated other forms of English and associated them with lack of education and sophistication. Leith believes that Standard English became a tool of the ruling class, whose pedantic adherence to specific forms of grammar and pronunciation was a means of maintaining their exclusivity. This process continues, but in the late twentieth century, he argues, it is education as much as 'breeding' which is distinguished by use of language.

Whilst Leith decries this limitation of English to what he sees as merely one dialect, John Honey in his book *Language is Power* extols the virtues of Standard English. He disputes the notion held by others that all languages are equal. He does not believe that the dialects of, for example, North East England, Lowland Scots or Black American are sufficiently rich to be used to discuss complex subjects. Although he recognizes the importance for social cohesion that use of the vernacular has for minorities, he argues that, given that the purpose of language is communication, one form, widely understood by all, is clearly preferable to many forms less well understood. Those who speak a dialect are at a disadvantage in a world which revolves around the standard form. He accuses those sociolinguists who see the imposition of Standard English as class hegemony of being unwittingly complicit in the continued oppression of minorities. He starts with the premise that, like it or not, Standard English is the language of power and influence; therefore teaching Standard English, rather than oppressing, liberates and empowers the disadvantaged. He goes on to suggest, moreover, that we need an English Academy on the lines of the French to preserve our language. Having read Leith's book, I was less persuaded. Much of the wealth of English has been due to its ability to adapt and absorb new words and structures.

Both Honey and Leith have good chapters on international English. Unsurprisingly Honey wants everyone to speak Standard English, while Leith extols the virtues of the 'New Englishes' arising in different parts of the world. David Crystal's book, *English as a Global Language*, sets out to explain why English has become so important on a worldwide scale. I was very disappointed by this book. I had been looking forward to reading it, having enjoyed his thorough and very readable *The Cambridge Encyclopaedia of Language*. This book, however, was repetitive and rather shallow, as if he had padded out some lecture notes. It could really be summarized in one sentence: English became important because Britain was the leading imperial power, closely succeeded by America, the leading economic power, which held on to influence just long enough to secure the position of English in broadcast media and more recently on the Internet.

Which takes me to *Wired Style: Principles of English Usage in the Digital Age*, from the editors of *Wired*, that glossy style mag for techies. If the liberties we all take with Standard English get John Honey hot under the collar then this book will induce full-blown anaphylaxis. Published on loose-leaf lurid green paper and with chapter headings such as 'Screw the Rules', *Wired Style* encourages writers on the Net to "Welcome inconsistency. Play with grammar and syntax. Appreciate unruliness". Included with examples of the sort of 'out the box' (sic) journalism to which they hope their contributors will aspire, the editors provide a glossary of acronyms and IT terms, ironically not listing several they use themselves. One can almost feel the cringing embarrassment that these self-same editors will feel when they look back at this effort ten years from now. Definitely one for the Anorak who has everything.

I would strongly recommend Leith's book for the general reader, and, for those interested in language, Honey's book is a good read. If you have a fascination for computer kitsch, then *Wired Style* may have something for you. Alas, I cannot recommend David Crystal's book at all.

Brian McKinstry

digest

Isaiah Berlin 1909-1997

I don't think that Isaiah Berlin, the historian of ideas, who died in November at the age of eighty-eight, ever wrote anything about general practice, but his views and philosophy are of importance to us all, and of relevance to our work as GPs. He was born in Latvia in 1909, spent much of his life as a distinguished academic in Oxford, and, in the course of his long life, saw the rise and fall of Marxism in Russia and Eastern Europe and of Thatcherism in the United Kingdom. An evening on Radio 3 on 8th December was devoted to his life and thought. His intellectual gifts were astonishing, as was his talking speed (he was reputed to have been timed at over 300 words per minute) but more unusual was his ability to inspire his students, and many contributors were ex-students.

Central to Berlin's philosophical view is pluralism: the concept that in human society we have a multitude of radically different and apparently irreconcilable political, philosophical, economic and religious views, expressed in ways that form a spectrum from the verbal to the violent. Where he differed from many of his contemporaries, however, was in his assertion that there are no theoretical or philosophical constructs which can reliably guide us to resolution of conflict between opposing views. Therefore, we must often accept the discomfort of living with disharmony and its consequence, human conflict. Michael Ignatieff, who narrated part of the programme, suggested that our survival as a species in the next millennium may depend on our capacity to live with difference, to celebrate diversity and to empathize with and tolerate views other than our own.

Is this high-flown stuff relevant to the small world of general practice? I think so. Many of the problems which our patients bring to us have their origins in disharmony and conflict. The young mother struggling with small children and a background of discord and violence in her own childhood, the boy being bullied at school who presents with enuresis, the depressed widow in sheltered housing who has fallen out with her children are all examples. General practice defines itself in terms of relationships[1] and our ability to empathize with our patients,[2] with whom we may share a community, is vital, even if we cannot undo or alter the factors causing the problem. We are also continually reminded, by meeting our patients in the consulting room, of the extraordinary diversity of human nature and behaviour. An ability to tolerate and enjoy this diversity, and to learn from it, is, I believe, central to our professional existence.

The other impression that I was left with from the evening was that at the root of Berlin's thinking is hope for the future as a quality independent of the rigour of his thought. I suspect that this lies at the heart of his popularity with his students. It is an essential quality for survival and growth in any discipline from theology to general practice, and has been in short supply at critical times in British general practice over the last decade. Seumas Heaney wrote of the Irish conflict some years ago: "Optimism is a response to evidence; hope is a state of the soul." Isaiah Berlin exemplified that distinction.

John Gillies

1 McWhinney I. The Importance of being different. William Pickles Lecture 1996. Br Jn of Gen Pract 1996;**46**:433-436.
2 Heath I *The Mystery of General Practice*. Nuffield Provincial Hospitals Trust. London, 1995.

Molecular genetics for the clinician

D J H Brock
Cambridge University Press, 1993
PB 289pp £17.95 (0 521 42325 2)

The astonishing speed of discovery in genetics, with almost daily extensions to the range of even common diseases for which a genetic basis can be assumed, has captured the public imagination. The demand for advice is beginning to increase dramatically. As the front line of the health service, primary care is bound to be involved to an ever-increasing extent. Most patients, rightly, believe that primary care is the place they should start their quest for information and guidance.

Members of the primary care team who are likely to be involved include not only general practitioners but practice nurses and attached community nurses. It is doubtful if a superficial knowledge is sufficient to provide the explanation and advice which an increasingly informed and sophisticated public requires. An appreciation not only of the facts, but of the underlying mechanisms are needed to convey convincing and relevant information to those who need it.

There is clearly a place for a book which can fulfil these requirements. I started reading Brock's text with high hopes. In his Introduction, Brock recognizes the needs I have outlined and obviously hopes that this book will fill the gap. Sadly, I was soon disappointed. Perhaps the title should have forewarned me. Molecular genetics is all about molecular biology and it becomes clear that this is not the same as clinical genetics. I do believe that all clinicians need to understand the essence of molecular genetics and something about the remarkable techniques which have underpinned the current explosion of genetic knowledge and the investigation of patients with potential or actual problems, but an entire book devoted to the topic is more than we require. The book is well written and might become a valuable reference volume for the practice library. It is sad, however, to realize that the writer cannot resist the extensive use of acronyms and abbreviations, which so many clinical scientists seem to regard as evidence of their intellectual maturity, completely ignoring the needs of their readers. With a great deal of concentration it is probably possible to extract information when it is needed but the book would have been immeasurably improved if he had avoided the temptation. My search for the right text continues.

Clifford Kay

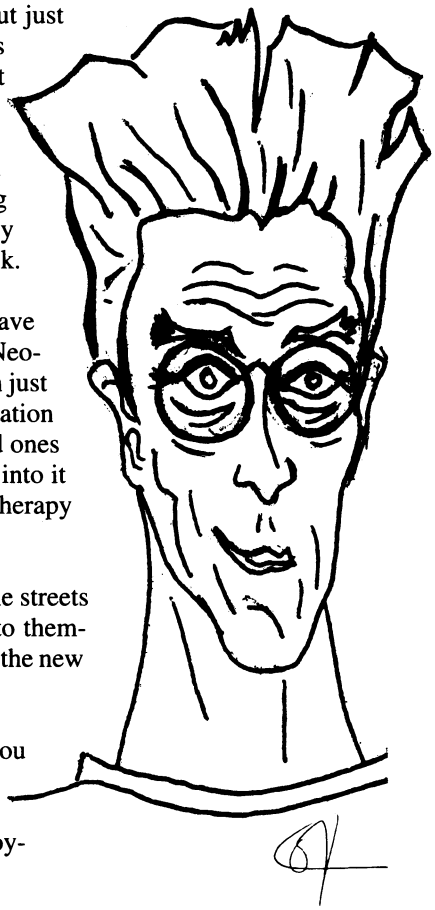
Gallstone Grove — six tales from tomorrow

Episode 1: The Sociology Rep.

Dr Max Phobius, senior partner of the Gallstone Grove Group Practice, was disturbed by the shrill voice of Evangeline Fetlock, his receptionist, announcing the arrival of the Sociology Rep. After the near self-destruction of the pharmaceutical giants the Humanities Academics had filled the therapeutic vacuum. Dr Phobius had become quite fond of the bearded, Kaftan-and-Hushpuppy- wearing Sociology Reps, uniformly in their late fifties. Their free drug samples were infinitely preferable to their predecessors', although he hadn't quite got used to the lentilburgers and organic rice at the sponsored lunches - he still had fond memories of those semi-defrosted black forest gateaux.

The Rep, Hubert Grauniad, greeted Phobius warmly. "Hi man, how's it going? I've come to give you a date for our relaunch of Self Actualization Therapy."

Phobius sighed. He sometimes longed for the old days of computerized prescriptions. Just press three function keys and forty-seven quids worth of pills get printed out just like that. It was much simpler than the psycho-social reorientation that he was supposed to be giving now. Phobius fiddled with the Virtual Reality headset control built into the couch. He had only just mastered the lates programme in the current class of Postmodernist Antidepressants "PoMoPee 16". He had quite come to depend on it himself. Just lying there letting the Mona Lisa show you round the insides of an Argentine slaughterhouse whilst quoting clips of W H Auden. He still didn't understand how it worked, but it certainly seemed to sort out his endorphin balance, and it kept the patients coming back.



"So what is Self Actualization Therapy?" asked Phobius. Hubert Grauniad gave a half smile as he rolled a joint. "That's the beauty of it Max. It's a straight Neo-Freudian Client-Centred Personal Growth scene. Any side effects and we can just blame the patients. We load the whole thing in Sustained Release Formulation onto a series of disposable Septium Laptops — you know, the old fashioned ones that cost £25 and will never quite fit into your top pocket. The patient talks into it through the pin-mike, and it reflects back his thoughts in a client-centred therapy format through the earpiece."

Phobius seemed to be struggling with an elusive memory. "So we will see the streets filled with people with mental health problems walking around muttering to themselves, listening to the voices in their ear telling them what to do?" Somehow the new policy sounded familiar, but he couldn't quite place it.

Moments later the intercom sprang into life: "It's Hubert Grauniad to see you Doctor." The door opened and in walked Hubert Grauniad. That is to say another Hubert Grauniad. Dr Phobius spoke softly with that air of carefully constructed non-possessive warmth that makes Doctors so terminally annoying. "I believe you owe me an explanation, Hubert?"

Grauniad 1 seemed quite unfazed. "Oh, it's cool. Grauniad 2 here is an Android Rep — it's the most efficient way of doing business." Grauniad 2 spoke for the first time. "I'm sorry for the mix up Phobius. In fact I'm the real Grauniad. Grauniad 1 here is a Holographic Rep — convincing isn't he? You can just see a slight wavering of the horizontal hold if you look hard. Anyway, I must be going." And he went.

Phobius was not quite sure as to the social niceties of conversation with someone who might or might not be a hologram. Grauniad 1 spoke up, "Oh I know what you're wondering, but does it matter which of us is real? We are all the same, except the artificial ones have a digitally enhanced empathy facility. We're far more human than real people. If you can't tell the difference between us then we are all the real Grauniad."

Phobius paused. Hadn't he been piloting PoMoPee 16a as Grauniad arrived? Had he turned off the VR projector or not? Was he virtually certain that the multiple Grauniads were real, or was he just fairly certain that they were Virtual Reality? It was ten years since he had last prescribed a Valium. But he was virtually certain he could lay his hands on one if he looked hard enough in the bottom of his bag.....

David Misselbrook

fellowship and awards

The Fellowship Committee will be meeting on 27 May 1998 and members are asked to give thought to appropriate nominations. Fellowship by nomination forms need to be received by the end of April and the President will be writing to all faculties shortly.

RCGP COLLEGE AWARDS
The Awards Committee will meet on 3 June 1998 and nominations are also sought for this year's College Awards. A full list of awards is now available on request in the new booklet *College Awards*. This gives details of all College Awards: both by nomination and competition.

The John Fry Award
Nominations are sought for the 1998 John Fry Award. This award is in the form of a silver medal that will be presented at the College AGM. It is presented to a younger Member or Fellow of the College who has promoted the discipline of general practice through research and publishing as a practising GP. Nominations for the Award should be made in confidence to the Chairman of the Awards Committee, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU. They should include supporting information on the work of the nominee aged 45 years or younger at the closing date of the award and should be accompanied by a submission from the nominating/sponsoring College member, together with an additional letter of support. Additional details are available from the Clerk to the Awards Committee at the College for those interested in the Award.
Closing date: 30 April 1998

The Patient Participation Award
Nominations are sought for the 1998 Patient Participation Award. The award, to the value of £1000, is to be used either to benefit the patients of a practice or to further patient participation in the UK. Applications or nominations may be accepted from any member of the practice team, patient group, or patient of a practice. For a copy of the criteria please contact the Clerk to the Awards Committee.
Closing date: 30 June 1998

The Bill Styles Memorial Award
The RCGP invites applications for this year's Bill Styles Memorial Award, to be presented to a younger Member or Associate of the College. It is intended to encourage younger GPs to further their education either within the UK or by travel abroad. Applicants must be Members or Associates of the RCGP and aged 35 years or younger at the closing date of the award.

The award takes the form of a project grant that will be awarded in two stages: half at the AGM in November and half on completion of the final report. A certificate signed by the President and Chairman will be presented along with the cheque at the AGM. Additional details and criteria are available from the Clerk to the Awards Committee.
Closing date: 30 June 1998

Further details and application forms from:
***RCGP**, 14 Princes Gate, Hyde Park,*
London, SW7 1PU
Tel 0171 581 3232 Fax: 0171 589 3145
Catherine Messent
Clerk of the Awards Committee
Ext 246, cmessent@rcgp.org.uk

a new chairman for plg...

The RCGP Patients' Liaison Group (PLG) has a new chairman - Patricia Wilkie. Patricia, who takes over the two-year post from Charlotte Williamson, has strong links with medicine, working part-time as a researcher and lecturer. She joined the PLG five years ago from the Patients' Association, where she was chairman.

Patricia gained a PhD in genetic counselling from the Department of Psychology at Stirling University in 1992, after studying how sufferers of genetic disorders, such as adult polycystic kidney disease, are affected when they learn the full implications of their condition. She has also carried out academic research into genetics, HIV, haemophilia, kidney disease and, more recently, the cost of prescribing between hospitals and general practitioners. She also lectures on ethics and research methodology to nurses and doctors.

As well as voluntary work, her many responsibilities include membership of the RCGP Ethics Committee. She has published numerous books and articles, including *Ethical Issues in Qualitative Research in Palliative Care* and *The Expectations of the Modern Patient.* Patricia hopes her medical knowledge will be an advantage in her new role and she has already selected a number of projects she feels are of importance, including the provision of better information about medicines so patients can make better decisions, the extent to which patients can be partners in general practice, and the benefits and risks of medicine-taking in general practice.

diary

Forthcoming RCGP Events

January 22/23
Minor Surgery Course

February 10-14
MRCGP Course

March 24
Conference on
Medical Negligence

March 31
Conference on A&E Medicine

April 10/12
Easter

April 17-18
Spring Symposium - Exeter

April 24
Conference on
Managing Drug Users -
Edinburgh

May 8-9
GP 98
Sterling Events, Birmingham

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

May 21
Research Symposium -
Regent's College, London

June 4
Study Day on Counselling in
General Practice

June 11-14
WONCA - Dublin

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

Susan Walker

Viruses and standard variations

The latest publications on the risks of breast cancer for HRT users have already caused many headaches for GPs. This time the media have been much more moderate in their reporting than has been the case in previous 'scares' and the Department of Health has been quick to provide us with the necessary information.

Still I wonder how many of us could honestly say that we had no difficulty in grasping the significance of the small increases in relative risk and the more variable change in absolute risk and then succeeded in explaining it all to our anxious patients.

I freely admit that I was forced to unearth my dog-eared, A level "Textbook of Statistics" in order to make sense of it all. (In passing I was surprised to note, according to my doodles in the margins, that I [SW] seem to have been in love with KS, during that hot summer term all those years ago. Perhaps that is why very little statistical learning penetrated my love-fevered brain?)

My point is that if doctors struggle to understand the concepts of statistical risk, how much more confusing it must be for our patients. The development of accessible means of expressing risk is important. Kenneth Calman has covered this in his article "Risk, language and dialects"(*BMJ* 1997; **7113:** 939) where risk is expressed as the chances of one person in a small village being affected by a certain condition (1:1000) or one person being picked out of a line stretching from Land's End to John O'Groats (1:1000,000).

As doctors become less paternalistic, patients must become more informed and able to make quite complicated choices. Classes in 'Health and Medicine' could become part of the school curriculum. If we could teach our children the basic differences between bacterial and viral infections, and the effectiveness of antibiotics in one and not the other, we may be able to prevent the development of bacterial resistance because our patients would be less likely to demand unnecessary prescriptions. Education in the recognition and symptomatic treatment of commoner self-limiting illnesses would reduce GP workload and empower patients, making them less dependent and probably increasing their sense of well-being. The balance of risk and advantage, beneficial and unwanted effects, and basic statistical concepts are surely within the comprehension of most people, if taught well and at a time when learning is easiest, i.e. during the school years.

Richmal Compton in her *Just William* books has her hero pronounce that "Germs is a pet name for Germans." Perhaps in a few years time he could correct himself by adding "Unless they're viruses such as Epstein Barr which you catch from kissing girls. Yeuch!"

web site of the month

Dearest Doc

Whilst doing some Internet research into guerrilla movements of the 20th Century I came across a Journal called *Bandolier* and instead of being full of tales of derring do in Dalmatia and of desperate last ditch defences in Darkest Peru I found to my disappointment that *Bandolier* is a health-related journal!!! Apparently it is called *Bandolier* because it "contains bullet points of evidence-based medicine"!!? Anyway I thought you might be interested so: **http://www.jr2.ox.ac.uk/Bandolier/**
Anyway Doc, I was so distracted by this that I looked for some more of this Evidence based medicine stuff on the Web. To my consternation I find that these people are Rubik Cube worshippers!!! See: **http://cebm.jr2.ox.ac.uk/docs/hiru/ebmj/default.htm** - *Journal of Evidence Based Medicine.* Plus: **http://hiru.mcmaster.ca/ebm/default.htm** - for the proof.
Despite a well-dodgy looking Rubik's cube the upshot is that purpose of Evidence-Based Medicine is to help clinicians keep up to date with new developments in medicine that are based on reliable evidence with expert commentary. This is then applied to "improve the quality of clinical judgements and facilitate cost-effective health care" and on that basis it seems quite a good idea. Check it out.

Rob Wilson, Sowerby Centre for Health Informatics, **http://www.schin.ncl.ac.uk/**

our contributors...

Roy Woodward is GP coordinator of the associate physician scheme in Liverpool. He lives in Ormskirk, Lancashire
Rosalind Bonsor is a GP from Lathom, Lancashire, and a community clinical teacher for Liverpool university
Sarah Carr is a management consultant from Warrington
Jill Thistlethwaite is senior lecturer (community education) in the department of general practice at Leeds
Richard Hayward, author of "Disability Care" in the *RCGP Members' Reference Book 97/98*, is a part-time GP in Newcastle-under-Lyme, Staffordshire. He is completing a postgraduate thesis on infection and hospital architecture.

Professors of general practice...
nowhere to be seen,
then four arrive at the same time...
Allen Hutchison is director of the RCGP Effective Clinical Practice Unit in Sheffield, **John Howie** holds the chair in Edinburgh, **John Bain** the one in Dundee, and **Clifford Kay**, until recently, the chair in Manchester.

Muiris Houston is a Gaelic-speaking Dublin GP, medical writer, keen fisherman and golfer
Patricia "You'll-have-had-your-tea"
Donald is RCGP Clinical Guidelines Coordinator in Scotland and a GP in Cramond, which is genteel even by Edinburgh standards
Toby Lipman practises in Westerhope, Newcastle-upon-Tyne, and has unquenchable enthusiasm for evidence-based practice. Probably.
Jim Ford is a senior medical officer with the NHS Executive in Leeds. Before that, he was a GP
John Gillies works in Selkirk, out of Glen Luce and Malawi. He is an enthusiastic researcher, and implements guidelines for Borders Health Board, which sounds rather sinister
John Ballard is the editor of *Occupational Health Review* which for some reason seems to involve a lot of hanging around in Parisian bars
David Misselbrook is a GP in Catford, South East London, and course organizer for the Lewisham vocational training scheme. As the inventor of Max Phobius, his street credibility is bound to soar. T-shirts available soon.

Elaine Duncan exchanged the dreary post-holocaust environs of West Lothian for the delights of northern Spain, La Coruña in Galicia
...**Brian McKinstry,** on the other hand, was not so lucky and remains a GP in Livingstone.
Susan Walker is a GP in Belfast.

All our contributors can be contacted via the Journal office

Elaine Duncan

In Galicia

As a GP, the idea of finally starting work in a foreign country was daunting, but having managed to acquire a Spanish husband, Spanish farmhouse, Spanish-speaking dog and what must surely by now be a sufficient quantity of the Spanish language there seemed to be nothing else for it. And patients are the same the world over, aren't they? Well, sort of.

"Galician patients, they are different," a well-meaning Catalan GP told me, before going on to comment that, in the casualty department of the Barcelona teaching hospital where he trained, medical staff drew lots for the Galicians, as happens with overdose victims, drunks and members of the "Psychopaths for a Fair Deal in A&E" Society.

The reason for this daunting reputation? A certain obliqueness of speech, a certain reservedness of character, a certain, well, downright refusal to give a straight answer to a straight question seems to lie at the heart of it all.

"You will have problems," a neurologist friend pronounced with the solemnity of Mystic Meg. "Our new colleague, he is Andalucian, and today I hear him speak to a patient in the next-door booth. After fifteen minutes of conversation he eventually shout: 'But look here, do you have pain, or do you not have pain?!' "

I felt chastened. I felt apprehensive. But it will be okay, I told myself, because we GPs have something special. We have Communication Skills.

And so, armed with these, off I went, and it seemed to be alright; conversation appeared to flow along similar "isn't-that-awful-how-long-has-it-been-bothering-you/I-went-to-the-specialist-and-he-said-it-was-nerves" kind of lines and I felt pleased, until the day when one patient, asked how long she had been using the condom as her method of contraception, looked at me strangely and replied: "Right till the end."

At this point, I had to take a deep breath and tell myself firmly that these things happen; after all, I still remember that patient in West Lothian who, after listening patiently to my careful explanation that one of her liver tests was abnormal, said finally: "So Doctor, how many livers have I got, then?"

And at the end of the condom consultation, when all seemed lost as the conversation swung crazily from the date for a possible IUD insertion to large home-made chorizo sausages (was this some local method of contraception?), I discovered that the patient was planning on bringing me several at her next appointment for having been so nice and understanding...

Communication apart, there are interesting differences between my Spanish patients and their British counterparts, not least in the complaints they bring to my door. "Tired-all-the-time", "It's my PMT" and that insidious scourge, "abdominal bloating", are nowhere to be seen; no, the Spanish Señora has other, weightier matters to contend with. "Varicosities" (small thread veins of the thigh), "Low Blood Pressure" (normal blood pressure), and "Mareos" (useful catch-all term covering vertigo, vomiting, fainting, anxiety crises, and generally not feeling right) are what worry the woman of today in Galicia — if anyone has any evidence-based references for these ills, the mule train arrives here monthly.