The British Journal of General Practice

viewpoint

Evidence-based Parenting

It was 3 am on the day of our son's 5th birthday when he came into our bedroom in tears, clutching his ear — his recent cold had developed into another bout of otitis media. Only that week I had read a systematic review on the treatment of otitis media with antibiotics, casting doubt on their use. Rather than rushing straight for the starter pack of co-amoxiclav in the medicine cabinet, I chose to try a dose of paracetamol, feeling good about my evidence-based approach to the management of our child's illness. Two hours later, with our son no better, doubts were growing about the validity of the paper I had read and I began to recall an RCT suggesting earlier pain relief in children who were given antibiotics. Moreover, it was his birthday party the next day. He lapped up the new 'banana medicine' and after another hour we were all asleep once more. The party was a great success and Joel did not mention his earache again.

A week later, the all too familiar sequel began. We were having to speak louder and louder to get through to Joel until the point came when we spent the whole day shouting at him to obtain any response at all. As the weeks of deafness passed, Joel became increasingly isolated — no longer the happy, sociable, vociferous child, but a sad boy who stopped joining in the conversation and instead went to play alone with his toys. This was not our first experience of deafness with Joel, but it was by far the worst. Previous audiograms had shown only mild hearing loss from the common pattern of intermittent glue ear. We accepted the evidence-based advice of 'watchful waiting' but it cannot be understated how frustrating this can be, to lose the child you know for months at a time while waiting for the effusions to clear.

Being a parent is a difficult enough task as it is. The combined role of doctor and parent can be harder still, particularly in the middle of the night when one does not want to bother a colleague. However, trying to be an evidence-based medical parent becomes a daunting job. As a GP I try my best to keep up-to-date and practice evidence-based medicine for my patients. Indeed there is a certain satisfaction in providing treatment which one knows is supported by scientific findings, but evidence-based medicine has been charged with ignoring the personal aspects of patient care. Current research on the role of antibiotics in otitis media focuses on specific clinical measures and ignores important broader outcomes relating to the child and its carers. Equally, most of the RCTs on the treatment of glue ear have looked at hearing level only, failing to consider the social issues surrounding a child who is significantly deaf for a large proportion of his or her formative years. In this post-modernist era, it is these uncertainties that make evidence-based parenting so difficult. The evidence you are so used to applying in the surgery takes on a different hue when it relates to your own family. What appeared to be a well-designed, relevant trial, suddenly lacks the answers you are looking for.

Medical parenthood has highlighted for me some of the problems of applying evidence-based medicine. It can appear relatively easy as a doctor to take the paternalistic attitude of denying antibiotics for a child with a sore throat or earache, knowing you are on strong scientific ground. Evidence-based medicine is about using the best evidence that is appropriate to the individual patient but experiencing evidence-based medicine at first hand as a parent can be a trying time when your feelings run counter to the best evidence. I have found myself struggling between my rational beliefs supported by scientific evidence and my personal, emotionally charged desires to do something for my son. It is precisely this conflict between facts and feelings that is often encountered in the consultation. We need to appreciate that, although the specific issue in question may not have been fully answered by research, what evidence does exist can be hard to accept for the patient or the carer. The ability to acknowledge and communicate the disparity between a patient's demands to act and the evidence which promotes doing nothing, is central to implementing evidence-based medicine, particularly in general practice where many conditions are self-limiting. This message has been brought home to me only too clearly by my efforts to be an evidence-based parent.

Jon Emery

The Back Pages...

contents

The RCGP Spring Meeting, Exeter, April 1998

Like good theatre, sex, power, money and love formed the guts of the College's 1998 Spring Meeting. The first weekend after Easter saw over 450 delegates, including 40 nurses and as many managers, gather on the beautiful arboretum campus of Exeter University for an interprofessional conference entitled *A job for life? The future of general practice*. Sir Geoffrey Holland, vice chancellor of the University of Exeter, opened the conference with a welcome and warm encouragement for the advancement of academic general practice. Dr Hans van de Voort, director of the Dutch College of General Practitioners, gave the first keynote address "The future of general practice in Europe". He spotlighted social and cultural differences between European states. The UK scores high on measures of masculinity: we lag behind in our acceptance of women and men as social equals, UK men do less child care, and fewer UK women hold high career positions. But the UK scores relatively well on the power of the individual to influence his or her destiny, and on measurements of craving for certainty in our lives — we are amongst the "cooler" European states. But huge differences in attitudes, health beliefs, consultation rates and general practitioner incomes exist between the countries. These are bound to mitigate against a unified system of general practice in Europe.

My highlight of the weekend came at Friday teatime when Professor Per Fugelli, from Oslo, spoke on the tension between evidence-based medicine and personal trusted knowledge. *Phronesis* was the word he borrowed from Aristotle to encapsulate this unique and essential feature of family practice. He stood hunched over his lectern, uncomfortable from a recent skiing accident. His delivery was passionate, his conviction unshakeable. His masterly use of literary as well as scientific sources illustrated his thesis that humanistic general practice requires an open mind, critical evaluation, and the ability to change, combined with long-term, personal, enlightened commitment. It seemed to me that he was talking about love.

Saturday morning's keynote presentation heard Professor Ann-Louise Kinmonth deliver a quick fire *tour de force* on the future of general practice in the UK. Although we have strong leadership, education and training, general practice's academic base remains weak, she said. And how will we make general practice attractive to young doctors to fill the 1 000 unfilled principal posts available now, and reverse the 20% reduction in applications for vocational training schemes?

After lunch, Professor Mike Pringle elegantly identified six tension points for the future of the individual practitioner. It will no longer be good enough to say "trust me, I am a general practitioner", he said. We will have to be overtly accountable to ourselves, patients, partners, primary care teams and groups, the profession, the NHS, and to society. This was a high class, seamless and thoughtful piece of lecturing from the next chairman of College Council.

The College president, Professor Denis Pereira Gray, presented at a teatime parallel, returning to one of his career themes, personal doctoring. He marshalled a formidable body of evidence in favour of personal care. New to me was an axiom his practice has adopted, crucial to generalists, that "feelings are facts".

Margaret Buttegieg, Martyn Evans, David Kernick, and Iona Heath locked horns in debate on Sunday morning over the motion "The RCGP should be replaced by a Royal College of Primary Health Care". Although the motion was defeated by a five to one majority, there was more general support for the idea of an additional co-ordinating organization, perhaps called the College of Primary Care.

Professor Stuart Murray concluded a terrific weekend of ideas and insights with his William Pickles lecture "The vision of a poet" in which he laid down a challenge to general practitioners to bridge the gulf between what we do and what we say we do.

Conferences don't just happen. Michael Hall and his team worked tirelessly to put on an inspirational Spring Meeting.

Nick Bradley

The ***RCGP Careers Support Forum*** was established in September 1997, with several main objectives;

- to identify particular groups of doctors who have difficulties with career choices or planning, such as non-principals and registrars;
- helping doctors to deal with career dilemmas caused by changes in the structure of the health service;
- to liaise with organizations with roles in careers support in general practice and developing methods for the delivery of careers advice and support.

A conference is scheduled to take place at the College in October, entitled ***The Great Careers Debate,*** which will look into the issues surrounding career support in general practice.

The Forum is chaired by Dr Maureen Baker, Chair of the RCGP Services Network, and meets four times a year. Volunteers are being sought to establish a group known as the ***Friends of the Forum***. The group will work closely with the Forum and will be asked to contribute ideas and opinions on important issues under discussion.

Write to Dr Maureen Baker at the College for further information.

G7

Make a chain to break the chains...
Hundreds of doctors and nurses will be at the centre of the biggest humanitarian event since *Live Aid* or the *Free Mandela* concert. On Saturday 16 May, they will join 100 000 people in a mass human chain which will surround the leaders of the G7 rich nations' meeting in Birmingham. The biggest ever campaign of aid agencies, churches, economists and trade unions, will call for the G7 to break the chains of debt which trap one billion of the world's poorest people. They will call for the cancellation of the unpayable debt of 50 of the world's poorest countries to mark the millennium.

Why should the medical profession be at the heart of the protest? As economic growth stalls, so health indicators deteriorate. Africans now pay four times more on debt repayments than on health. Countries like Uganda spend as little as £1.50 per person on health per year (£860 in the UK). What kind of health care can you buy for such a ridiculously small sum, in the midst of an AIDS epidemic? How can you treat diseases of global concern like tuberculosis adequately? Much of the health gains of the 1970s, like the children's mass immunization campaign, have been wiped out. A large percentage of Africans no longer have access to any form of modern health care. Common diseases like respiratory infections are increasing and those which were nearly conquered like polio and cholera are back, with a vengeance.

South Korea, Indonesia and now Japan have been promised loans of nearly $100 billion to bail them out of their current crises because they threaten the stability of London and New York's financial markets. But the rich nations have stalled on giving just $8 billion to Africa. The debt for the 20 poorest countries (£1.4 billion) represents less than the UK government's subsidy to the Channel Tunnel rail link.

As we weep into our popcorn over Spielberg's slavery epic *Amistad*, it should be remembered that the number of slaves who died during the passage to America was about 1.5 million. The UN Development Programme estimate that 21 million children will die before the millennium as a result of the debt crisis. The scale of suffering is horrific. And we are the slave-masters. If you are looking for something more real than moral indignation, please join us in Birmingham.

Dorothy Logie

5 Good Reasons For Going To WONCA...

Number 5

According to legend, Diancecht, the Irish Aesculapius, carried out limb and scalp transplants in the fifth century BC. We have no concrete evidence to confirm this but we can still literally see evidence of our recent medical past, since many of the buildings used in the teaching and practice of medicine are still standing throughout the country.

Some hospitals have been in constant use for over two centuries. Others have changed sites while retaining their original names. Notably in the cases of Dr Stevens' and Mercer's Hospitals, both names and sites have been retained, though their function is no longer clinical. Sadly in some cases, sites and names have disappeared with the amalgamation of hospital services.

For many years, Belfast, Cork, Dublin, and Galway have been teaching centres but, until the foundation of the (later Royal) College of General Practitioners and, in 1983, of the Irish College, GPs played no part in the education of medical students — the vast majority of whom would enter family practice without any previous experience of the discipline. Present day students and their patients owe a huge debt of gratitude to the founders of these Colleges.

We hope that WONCA guests will find time to visit places associated with the great names of our past.

John Fleetwood Snr

conference of royal colleges on international activities

A conference of UK and Irish Royal Medical Colleges was held on Friday 13 March 1998 to discuss areas of mutual interest in relation to international activities.

Delegates unanimously agreed that the Conference had been a very helpful, timely and innovative starting point for future development. Support was echoed for better coordination of and greater information sharing on the enormous range of the Royal Colleges' international interests, contacts and activities.

Presentations on current activities from four Royal Colleges — the RCGP, RCN, RCP and RCS — gave an overview of the various stages of development of and focus for international activities. Dr David Nabarro, from the Department for International Development (DFID), outlined new task-focused goals to implement the objectives of the White Paper *Eliminating World Poverty*. Mr Ken Newnham of the DTI advised on the role and focus of the DTI and DoH's Health Sector Group, and the ways in which it fosters a coordinated approach to promoting UK expertise in health care.

It is evident that there is a large amount of both informal and formal activity and interest both in the UK and overseas from the colleges' membership and networks in all royal colleges. All forms of medical education — from undergraduate to teacher training, to specific skills training, assessment and validation processes — as well as international qualifications were discussed. The colleges also found they had in common the areas of the world in which they worked. There was much discussion of the need to overcome professional barriers and find ways to collaborate. David Nabarro emphasized the multiple channels and partnerships needed to take forward international development projects to improve health for poor people, through key areas such as better sexual and reproductive health, improved child health, the reduction of debilitating disease, and the improvement of drinking water and environment.

Calls were made for better use of existing resources, such as the BMA and the Department for International Development, and channels of communication such as the Academy of Royal Colleges. The area of international qualifications will be explored at the Academy.

There was strong support for a new forum for discussion to follow the Conference, for example inter-collegiate working meetings to follow up the themes raised, taking a geographic or thematic approach. Both DFID and the DTI have pledged further support and the RCGP will be exploring this with them further.

It was noted that the issue of overseas doctors training in the UK was to be addressed by a sub-group of the Advisory Group Medical and Dental Education, Training and Staffing (AGMETS).

The Conference was an initiative of the Royal College of General Practitioners who organized and hosted the event. It was made possible through a grant from the Health Sector Group of the Department of Trade and Industry and the Department of Health.

clinical governance

The March meeting of RCGP UK Council was enlivened by the emergence of the term 'clinical governance'. What exactly is clinical governance?

It is a key element of the recent White Papers and it challenges the profession to develop further recent approaches to raising the quality of provision of care to patients, and to support health care workers in their work. A paper by the Chairman of UK Council, John Toby, sets out three distinct areas of clinical governance: governance by clinicians of clinicians; support of clinicians by managers; and the involvement of clinicians in the governance of the NHS. In debate, Council noted that clinical governance is multi-faceted and still developing. The College recognizes, however, that it had already produced work relevant to the development of clinical governance, including practice accreditation and the selection and monitoring of training practices.

UK Council felt that it is important to build on this work and ensure that other relevant factors are included in clinical governance. As Primary Care Groups are to be introduced by April 1999, it is essential that the College plays a full and appropriate part in the development of clinical governance and offers a comprehensive service to assist members and other colleagues to demonstrate high quality and to address issues for improvement. Dr Toby will write to all members with a summary of the issues surrounding clinical governance and submit papers to June Council on further developments in clinical governance and possible methodologies for it.

Dr Judy Jones is the RCGP/PPP Healthcare Fellow in Commissioning of Care. Her two year programme of work has begun with a literature review and interviews with appropriate stakeholders. She expects to use thse interviews to develop a questionaire which will be sent out to a random sample of general practictioners.

Dr Jones would be delighted to hear from members who have information about examples of good practice in commissioning or the names of people whom she should include in her preliminary interviews with the 'movers and shakers' in this field.

Contact, via Mandy Smith at the *Journal* office.

A short history of socialized medicine... 8

Social Medicine and the State

Rising mortality brought a sense of urgency to public health between 1831 and 1844, the mortality rate per thousand rising from 14.6 to 27.2 in Birmingham and 16.9 to 31 in Bristol.The statistical and epidemiological principles underpinning public health science were known 150 years earlier; Edmund Halley (of the comet) having devised the life table in 1693.

The Poor Law Commission reported on the "Sanitary Condition of the Labouring Population" in 1842. Chadwick, its energetic secretary, was convinced that epidemic fevers were due to miasmas arising from decaying material (the "health destroying gas" from the paupers' mass grave in Preston, caused John Caterall and his family to forsake their parlour for the kitchen in 1849). The Report recommended the appointment of "a district medical officer independent of private practice...with...responsibilities to initiate sanitary measures", although Chadwick generally invoked civil engineering solutions through drainage and water supply. Public health reports, such as that for Ormskirk, pointed to such responses: "Open middens, pigsties, and cesspools are crowded upon dwelling-houses... refuse stands in open cesspools;...this summer...36 cases of cholera...19 deaths." In Ashton-under-Lyne, 50 families shared two privies and 46% of 2800 Bristol families lived in one room; in 281 Manchester cellars, five persons shared one bed. A Royal Commission into the Health of Towns led to municipal legislation promoting urban improvement; the emergency influx of starving Irish causing Liverpool to appoint the first Medical Officer of Health in 1846 and the 1848 Public Health Act established a General Board of Health.

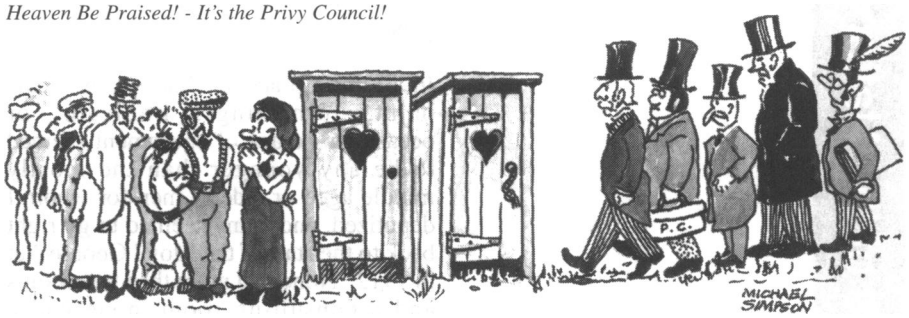
Although Chadwick's theory was supported by John Snow's mapping to water supply of the 1854 cholera outbreak, England had decided against being "bullied into health" by bureaucracy and Chadwick was pensioned off. A new sanitary authority, with the well-connected and diplomatic surgeon John Simon as chief medical officer, was established under the Privy Council. The professionalization of public health followed massive medical documentation under Simon on dangerous industries, hospitals, accidents, dwellings, poisonings and mortality and was completed by the formation of the Society of Medical Officers of Health in 1873.

The 1875 Public Health Act led to the appointment of many more medical officers of health, although Simon himself resigned when his department was transferred to the parsimony of the Poor Law Authority. Poor Law responsibilities drew local government attention to health issues. The Metropolitan Poor Act of 1867 permitted treatment of the non-pauperized sick, and the Medical Relief Disqualification Act of 1885 removed some of the stigma of pauperism from those receiving only medical assistance.

As the century advanced, many authorities developed workhouse hospitals with good medical and nursing care. Among cotton towns, Oldham and Blackburn took the lead, though Blackburn earned a rebuke from the Local Government Board for finding workhouse patients in "maggoty beds" with "bed sores the size of dinner plates".

Jim Ford

Heaven Be Praised! - It's the Privy Council!



Sources
1 Porter D. *Companion Encyclopoedia of the History of Medicine.* Public Health. London: Routledge, 1994.
2 Rosen G. *A History of Public Health.* USA: John Hopkins University, 1993.
3 Morgan N. *Deadly dwellings - the shocking story of Housing & Public Health in a Lancashire Cotton Town.* Preston: Mullion Books, 1993.
4 Cherry S. *Medical Services and the hospitals in Britain.* Cambridge: CUP, 1996.
5 Rose M. *The Relief of Poverty 1834-1914.* London: Macmillan, 1986

the 50s

A prevalent but erroneous notion is that the BMA was against a national health service; on the contrary, the BMA gave precision and direction to the move towards a national, comprehensive scheme. In 1929 it published its report *A General Medical Service for the Nation*, revised it in 1933 and published *Essentials of a National Health Service*. During the war it set up a medical planning commission, which published a report in 1942 advocating many of the principles to be repeated in the Beveridge Report issued six months later, and ultimately incorporated in the NHS.

There were differences of opinion within the profession, broad general support for the main principles but universal opposition to a whole-time salaried service for all GPs and hospital doctors, and this was made clear to the coalition government. To be employed by municipal authorities as servants of the Medical Officer of Health, where doctors would be trying to serve their patients in a rigid hierarchical structure, was anathema. Nevertheless, a Special Representative Meeting of the BMA on 4 May 1945 committed the profession to a 100% medical service for the nation.

The chance to implement the Beveridge Report and bring in the Welfare State, including a comprehensive health service, came in July 1945 with the election by a large majority of a Labour Government. The charismatic rebel Aneurin Bevan was appointed Minister of Health. He began immediate confidential talks with the profession but they got off to a bad start. Labour was thirled to the policy of a salaried service and conflict was inevitable. The mood of the country for post-war reforms was strong and widely expressed; it was easy to accuse the BMA of trying to thwart these aims. Its opposition was vociferously expressed to what it saw as a threat to the freedom of the profession inherent in the salaried service.

the 60s

NHS general practice entered the 1960s in a state of terminal illness, and left it in pretty good health, on a more steeply ascendant curve of confidence than we had seen before or have seen since.

After five years as a principal in Notting Hill, between 1959 and 1961 I was a trainee epidemiologist for the Medical Research Council (MRC). In those days the MRC still clung to a certain aristocratic dilettantism, so salaries were abysmal. There were fairly good holidays, so all of these I spent earning a bit more doing locums in industrial working class practices, first in Kilburn, Holloway, and Camberwell, later in Mardy and Ferndale in the Rhondda Fach. That gave me a fairly wide underview of the industrial general practice at that time.

In all those practices, hardly any of the paint, furnishings, linoleum, or occasional scraps of equipment seemed to be any younger than the mostly middle aged or elderly men for whom I deputized, and many seemed to go right back to the start of the Lloyd George Act in 1912. None had more than two rooms and a consulting room, none had a patient's toilet, one of the Welsh practices had a receptionist, and nobody had a nurse.

The Mardy receptionist certainly earned her wages. She seemed to see about the same number of patients as I did, issuing prescriptions (mostly repeats, but she initiated antibiotics on much the same indiscriminate criteria as most doctors) and certificates of incapacity for work. At my first session, she used prescription and certificate pads already signed by the boss, but when these ran out I was presented with a stack of them to sign, which I readily agreed to do, this evidently being the local custom. The only way to meet the demands of a working day with enough left over to practice just a little bit of clinical medicine for a few of the most obviously reversible gross illnesses — like undiagnosed and untreated insulin-dependant diabetes, Addisionian anaemia, or mitral stenosis with advanced heart failure — was simply to meet expectations. These were, of course, extremely low.

In my experience, the situation was only marginally better than that reported by Collings in his famous *Lancet* report in 1951. In more affluent areas practice was certainly more genteel, and real country practices were probably more clinically self-reliant, though obsolete.

The National Health Service Act, fixing 'the appointed day' as 5 July 1948, was put on the statute book on 6 November 1946 (the NHS (Scotland) Act was passed on 21 May 1947) and stalemate ensued for some months until Bevan wrote a reassuring letter to the BMA offering to discuss the main objections. But most of 1947 and the Spring of 1948 passed in fruitless bickering and bitter recrimination on both sides.

On 7 April 1948 Aneurin Bevan made a statement to the House of Commons: "I have been trying to find out for myself what it is that is really and sincerely worrying the doctors." He repeated his assurance that he had no intention of introducing a salaried service and offered amending legislation to this effect, an apparent climb-down. Behind this bare account of the historical facts is a remarkable story known to few which suggests Bevan was more our friend than his reputation gave him credit for. At least he was a pragmatic politician.

One of the members of the Labour Party National Executive, to which Bevan reported weekly during the final negotiations, was Mrs Jean Mann, MP for Coatbridge and Airdrie, who, with her family, lived in Scotstoun, Glasgow. She was a patient of mine, whom I saw every Saturday afternoon, as I considered she needed medical treatment and her Parliamentary duties made this difficult to arrange. After these consultations at her home we talked, over afternoon tea, of the political situation; she knew I was a fervid supporter of the concept of the NHS and spoke freely, but in confidence. Thus I had a blow-by-blow account of the proceedings of the National Executive. At one stormy meeting, the Executive insisted that Bevan adhere to the policy of a salaried service. Aneurin retorted: "You want an NHS; I want an NHS; you can't have an NHS without the doctors; if you don't let me meet them half way you get no NHS; either you let me negotiate, or I resign — now." He meant it, or at least they believed he did. He got his way, he made his placatory statement to the House, and the rest is history.

Three weeks before the 'appointed day' the BMA issued a statement saying that, in spite of the doubts entertained by many doctors, the profession as a whole now found it possible to give the NHS its support. "This decision reached, the profession will do its utmost to make the new service a resounding success. Only the best is good enough for the public service and we shall do our utmost to provide it." Bevan had the last word: "It remains only to wish you all good luck, relief — as experience of the scheme grows — from your lingering anxieties, and a sense of real professional opportunity. I wish you them all, most cordially."

To those of us who lived through these stirring times after the dark days of war, the memories of 50 years ago are still vivid. This personal account may help to put the record straight.

Willie Fulton

In 1948, GPs had asked to be left alone, so they were left alone. Hospital specialists had no illusion that they could provide buildings, nurses, operating theatres, X-ray departments, laboratories, office workers or cleaners out of their own pockets, and were happy to be salaried so that these necessary means of production were provided by the state. GPs insisted on sturdy independence, even if this meant working in rat-holes where even a typewriter was exceptional. This allowed some established industrial GPs with huge lists (up to 4000 per GP in those days) to delegate their work to assistants, while they spent their time in London making sure that the allowed nothing to change — whom College pioneer Ekke Kuenssberg aptly named the "Absentee Landlords".

It must be hard for young GPs to imagine the love other few believers in general practice felt for the College in those days. For us it seemed a candle in otherwise total darkness. Leading opinion formers in the London medical schools, like Clark Kennedy at the London and Domhorst at St George's, frankly derided any future role for GPs as clinicians.

Fortunately young doctors proved even more reluctant to enter clinical squalor than most of their established seniors were to get out of it. By 1966 recruitment of GPs had fallen to crisis levels. In the USA, the consequences of virtually all GPs trying to be specialists was sending costs through the roof and our Ministry of Health belatedly recognized that you can't have effective hospital specialists if they aren't supported by effective community generalists. GPs got angry in the only way custom allowed, demanding that if they had to work in the arsehole of medicine they should at least be properly paid for it. Resignations from the NHS poured into the BMA, to be held as trump cards as they played the state for a better contract.

Ever since 1948, it had been an article of faith that GPs should spend their money as they wished. Horses for courses. Some patients in waiting rooms have bladders, some don't. Why impose toilets on everyone? Letters to consultants can be so much friendlier if handwritten rather than typed. Why should all of us be compelled to have secretaries, when some of us can really appreciate a good car? Something snapped, and sophistry of this sort lost credibility even within the profession. So we go to the 1966 Package Deal, the GF Charter, which for the first time provided earmarked money from the state to provide a large part of the necessary infrastructure for GPs' public service.

In 1965 I had moved out of a wooden shed into the first health centre in Wales, employing my wife as a secretary/receptionist, and an SEN, both part-time. With 2000 patients and a house bought for £100 we were just able to manage. The 1967 Charter changed our lives, by meeting 70% of the cost of office and nursing staff. The following year this helped us start what became a 25-year programme of systematic proactive care. Good clinical medicine had become possible, though still at a high personal monetary cost.

As for the College, suddenly it gained material resources to back its rhetoric, and could look forward to primary care teams rather than backward to a sentimentalized past when GPs were supposed to have been omniscient and omnicompetent. Setting up a serious scheme for GP training, with costs met by the State gave the College a practical task which kept its feet on a forward path for the next 25 years.

Julian Tudor Hart

From Cradle to Grave: Fifty years of the NHS
Geoffrey Rivett
Foreward by Tony Blair
King's Fund, London, 1998.
PB 506pp £25.00 (1 85717 148 9)

When I first heard that Geoffrey Rivett was writing a 50th birthday history of the NHS, my heart sank. Senior civil servants may have uniquely privileged managerial overviews, but they rarely understand the shop floor. Having spent their lives reading and writing safely inoffensive documents, we expect the usual platitudes and lists of people who can't be left out.

Which reminds me, for the *n*th time, how wrong it is ever to stereotype people and expect too little of them. This is a splendid book, which really does need to be on the shelf of every postgraduate centre, and be read by every doctor and medical student. If anyone wonders why GPs, until 1967, used to work in squalid glass-fronted shops, unpainted for 30 years, and then moved into purpose-built units; or whether postgraduate centres are something we always had; or how serious clinical work was possible with only rigid endoscopes and no imaging other than X-rays... the answers are all here. The scope of Rivett's material, and his control of it throughout his narrative, is remarkable. As well as telling a coherent story about the shape of hospital and GP care, he connects this with key developments in clinical medicine, and the way these fed back to determine the shape of the evolving service. He includes plenty of material about nurses and nursing, and seems to have been sufficiently exasperated by his colleagues to keep his mind open to what patients had to put up with. He virtually ignores the lives and work of vast numbers of other health workers in hospital and community services, from lab technicians and porters to home helps. When they do get in , as in the "Winter of Discontent" he tells us nothing of what those discontents actually were. Whether any doctor could live on the wages of hospital cooks or cleaners would make an interesting physiological study. If there is ever a second edition, this needs attention.

Apart from sheer drudgery and a good sense of humour, I think he has achieved his exceptional hold on the reader because of his consistent personal standpoint, not explicit but clearly apparent, which gives integrity to the whole book. Where he has strong opinions he doesn't hide them, but presents them in language that helps readers to interpret things differently if they wish. What is this standpoint? Geoffrey came into the DoH a couple of years before Sir George Godber relinquished office as Chief Medical Officer, and clearly he never met the like again. So far as one man conceived the NHS as a whole, this was Nye Bevan, and so far as any one man implemented that conception, this was George Godber. The positive achievements of establishing the NHS as an effective, equitable, popular and exceptionally cost-effective nationalized industry were mostly reached in George's reign. This provides the core of this history, against which cumulative confusions since 1974 can be understood.

They can be understood, but does Geoffrey understand them? I think not, but he's in plentiful company. Like almost all policy people, Geoffrey accepts uncritically Enoch Powell's *Infinite Demand on Finite Resources*, John Fry's *Wants>Needs>Resources*, and Thwaites' fancy mathematical expressions of these. He sees this unsustainable model as the central problem of the NHS, and this underlies his bleak and visibly disintegrating view of our future. Nowhere does he search for empirical evidence to support these formulae, or consider alternative ways of thinking and seeing. But that would entail shifting the problem beyond the NHS into the society it serves, asking a more fundamental question: why, as modern societies get richer, do they become less able to afford improvements in socially effective health services at the same rate as improvements in cars, computer games, or junk food? This paradox is inexplicable within current received wisdom, because current wisdom contains some weird thinking about how much of our gross social product gets allocated to social purposes.

But just as it's wrong to expect too little, it's stupid to ask too much. This book is a splendid and lasting achievement. Somebody else must deal with the Emperor's clothes.

Julian Tudor Hart

Why, as modern societies get richer, do they become less able to afford improvements in socially effective health services at the same rate as improvements in cars, computer games, or junk food?

How to Read a Paper, the Basics of Evidence Based Medicine.

Trisha Greenhalgh

BMJ Publishing Group, 1977

PB 196 pp £14.95 (07279 11392)

The book is an expanded version of recent *BMJ* articles by Dr Greenhalgh, and is more readily assimilated as a result. The book introduces the concept of EBM, presenting convincing arguments for its importance and relevance, whilst acknowledging its limitations. EBM is not about replacing clinical decision making and negotiation with patients and colleagues, or dictating what we must or must not do, but provides clinicians, patients, healthcare planners and commissioners with good information to inform discussions and choices. Many GPs will soon be acting as commissioner as well as practitioner, and we are all potential patients, so perhaps EBM, like it or loathe it, is relevant to our work and lives.

This book is an excellent introduction and guide to the crucial processes of EBM: defining a question, searching for relevant published literature, assessing its relevance and quality, and applying the findings to real situations. There is little in this book that a keen follower of EBM hasn't read before in other papers and books, but many will wish that they had read this first, as it brings the subject to life. The reader gains a basic grasp of the essentials quickly and easily, obtaining an overview of the various facets of EBM plus ample guidance on further reading. The book is richly illustrated with simple examples and analogies, without being patronizing.

Whilst *How to Read A Paper* doesn't explore the issue of general reading and how to browse through journals, that has been covered elsewhere.[1] If the reader is at least interested in EBM, then this book will guide them through the basics of the process, whilst being a stimulating and enjoyable read for what can be a dry subject. The consumer's guide to statistics is a particularly good summary for the reading clinician, and the chapter on drug trial reports contains a section that could result in a sharp falling off in one's invitations to meals at pharmaceutical expense. Perhaps one could spend the resulting free time on searching for the evidence. A good book, buy it; happy evidence hunting.

1. MacAuley D. READER: an acronym to aid critical reading by general practitioners. *Br J Gen Pract* 1994; **44**: 83-85

Mark Gabbay

Midwives

Chris Bohjalian

Chatto and Windus, 1997

£9.99 (0 7011 6700 9)

Several years ago I was present at a home delivery that could have turned into my worst nightmare. The appearance of meconium in the second stage heralded the delivery of a bottom: this was an undiagnosed breech delivery. Fortunately mother and child are doing well: I was invited to the christening. This is a book about two mothers who were not so lucky: one in labour, one in charge of that labour.

A work of fiction embedded in fact, the story is narrated by Connie, Sibyl's daughter, 14 years old at the time her mother was arrested after the home birth from Hell. Sibyl is a lay midwife in a country dominated by medical malpractice cases and litigious patients. In the USA, most babies are delivered in hospital by doctors, assisted by nurse-midwives. But to cater for those women who want a less interventionist pregnancy, lay midwives are prepared to offer home births. These midwives are trained on the job by other experienced women. They have no formal qualifications and no professional insurance. Sibyl became a midwife following a familiar American 60s experience of dope smoking, acid dropping and protesting against the Vietnam War. As Connie describes them, lay midwives dress in flowery floating dresses or dungarees, the mothers they look after are potters or artists or teachers, but never doctors' or lawyers' wives.

The book centres on the delivery of a preacher's wife deep in the State of Vermont where the snowy weather has a part to play in the disaster that unfolds. The events of the birth are intermingled with Connie's thoughts on adolescence, the relationship of her parents and the expensive lawyer they employ, and the trial that threatens to tear her family apart.

This book has not put me off home deliveries but I imagine that people reading it with a hospital bias will have their prejudices reinforced. The author works just a little too hard to stereotype the sandal-wearing, alternative types who support the lay midwife movement.

Midwives is a good book for a winter's night, after a busy antenatal clinic. And it certainly made me ask: What would I have done in the circumstances?

Jill E Thistlethwaite

Emergency Ophthalnology

Hung Cheng with M.A. Burdon, S.A. Buckley, C. Moorman

BMJ Publishing, London, 1997

PB 335 pp, £49.00 (0 727 9086 18)

"Comprehensive, yet readily accessible", is this handbook's accurate self-description. Ophthalmology traditionally receives less attention at medical schools than other specialities, and the dilemma facing any handbook author is balancing easily accessible brevity against a necessarily more detailed reference work. The non-ophthalmologist, for whom the book is intended, needs a method of quick reference, based on presenting symptoms and signs, rather than a tome of unreadable detail, based on anatomical and pathological divisions.

Cheng and his co-authors have attempted to fulfil this need by using a problem-orientated approach, each chapter heading reflecting a situation rather than a part of the eye or a disease. The use of algorithms and boxed lists assists the reader to access information rapidly. In keeping with this approach, the first chapter deals with history taking and examination methods, instead of the more usual anatomy and physiology, a knowledge of which is assumed.

The bulk of the book deals with well-known ocular emergency and general practice topics, such as the red eye, trauma, visual loss, flashes and floaters, headache, lumps and bumps, and is highly relevant to any primary care practitioner. Excellent photographs are used to illustrate physical signs. Unfortunately, chapters are not introduced with an overview of their contents, and this can result in loss of direction while reading. For example, the chapter on visual loss has 40 pages, and is divided into seven subsections, the titles of which should have appeared as a list of contents. There are numerous typographical errors, some of which could confuse those unfamiliar with the subject, especially the assertion that eyedrop allergy is treated with the YAG laser! Two particularly important chapters cover contact lens problems, and post-operative problems. The increasing use of contact lenses, and the trend towards day surgery, makes an informed approach to these subjects essential.

This useful and relevant handbook will benefit anyone who takes the time and interest to become acquainted with its method of problem solving.

Robert Murray

digest

The Medical Interview

Lipkin Jr, Putman, Lazare
Springer 1995
HB $50.00 643pp
(0 357 94257 2)

The doctor-patient relationship is at the centre of medical care. It has a strong influence on patient compliance with medical advice and health care outcomes. Problems with the doctor-patient relationship are common. An ineffective doctor-patient relationship has a damaging effect on both on the doctor and the patient, resulting in increased health care costs.

This book is the first of a series looking at the "Frontiers of Primary Care" by the American Academy of Physician and Patient, with the overall aim of applying theory to practice. The book takes a wide approach and brings together a large amount of literature on the topic, with contributions from over 70 authors. The first three sections look at the framework and function (I), the structure and process (II) and the context of the interview (III). Included in these sections are a number of difficult topics, including an understanding of relationship barriers and the importance of the doctor's feelings during the interview. The chapter on patient education and changing patient behaviour is particularly interesting, with clear guidance on educational and behavioural techniques: an area that is often confusing. There is a section covering specific interview situations, the old and young patients, taking a sexual history, terminal care, and the difficult area of breaking bad news.

For the teachers of interview skills there is a good section covering the theory of teaching medical interviewing and the methods involved in teaching these skills. These methods include direct observation, role-play, and simulated patients. Finally, the important aspect of interview outcomes is considered. These outcomes are related both to the type of doctor-patient relationship, and to the role of patient satisfaction in the process.

I would strongly recommend this book for those interested in improving their understanding of the "consultation", for training registrars, and for established practitioners.

Peter Orton

Regeneration

Directed by **Gillies MacKinnon** 1997 GB

This is a film, like the book from whence it sprang, to appeal to those of us who enjoy our art most when it comes with pain attached. Pat Barker's trilogy, of which *Regeneration* is the first book, centres around the mercurial character of Dr WHR Rivers, neurologist, psychiatrist, anthropologist, and academic who, during the first World War, tended to the minds of the shattered souls who returned from battle with what became known, erroneously as it happens, as 'shell shock'. From 1916 he was the senior psychiatrist at Craiglockhart Hospital in Scotland, where, among his patients, was Siegfried Sassoon, with whom he formed a lasting and significant bond.

The title refers to the process of 'regeneration' of the war wounded, and also to the legendary study carried out by Rivers and Henry Head from 1903, in which the latter had cutaneous nerves in his arm surgically severed, while the pair studied meticulously the restoration of functions over the following four years. Indeed, the primitive nature of contemporary medicine forms a subtheme throughout the film, as Rivers' essentially humanitarian therapeutic approach, influenced by the early psychoanalysts and utilizing the study of dreams in particular, is compared with the barbaric methods of more 'medicalized' behavioural methods of treatment, exemplified by the incremental use of electric shock as a treatment for mutism.

Visually the film pulls no punches, from the initial sequence where the camera floats above a sea of mud in which are embedded human forms, some still writhing. The plot and characterization, however, suffer from the imposed linearity of compressing a complex book into 113 minutes of cinema. Jonathan Pryce as Rivers appears less military, more socially capable, than his biography would indicate, but the essential humanitarianism is beautifully played. As Siegfried Sassoon, James Wilby exemplifies the charisma, allied to steely will, that this remarkable man must have personified. The central irony of a war hero, in full possession of his faculties, being denounced as insane for his criticisms of the operation of the war and the dilemna imposed on his psychiatrist, is carefully explored. Long before *Catch 22* there was never more poignant a double bind than choosing between saving the patient's life but undermining his life's cause, by untruthfully declaring him insane and risking that life by declaring him fit to return to the trenches.

This is a virtuous, well made, perfectly acted, and thoughtful film. Like its namesake book, it highlights the contempt and anger held by the soldiers for those safe in England who not only glorify and champion the war, but also vilify those soldiers who crack under the primeval conditions. As I write, we flirt again with war, in the Middle East, and people who, like me, have nothing whatever to fear from it, are once again blithely advocating military action as the principled response. Certainly, see this excellent film, but read Pat Barker's trilogy and give it to everyone you know.

David Tovey

Gallstone Grove, tales from tomorrow.

Episode 4: Catford makes it big.

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 once again of Hubert Grauniad, the sociology rep. Sociotherapy was big now, and the departments of some of the newer universities had lost no time in flooding the market with their products. The University of Catford had taken a notoriously aggressive marketing line with their Post Modernist Sociotherapy — PoMoPee for short.

Grauniad had been one of the founding academics at Catford when he and a handful of colleagues had rented a few rooms in Eros House, above the Catford Gun Shop, and floated their new University on the Stock Market. The University had expanded rapidly, edging out a few pizza parlours and a cut-price tyre warehouse across the South Circular. Now Grauniad was chauffeured in a classic 2CV, and was rumoured to be a confidential adviser to the Minister for Psychotherapy.

"Hi man, how's it going? Hey I've got to tell you about our relaunch of some good old fashioned pills. The time is ripe. All the old medications are patent expired. All we have to do is dream up new formulations. Catford's going to make an absolute killing."

Phobius voiced his concerns. "But why a return to drug therapy now? What about your release of 'PoMoPee 17?'" Grauniad shifted uncomfortably. "'PoMo?' he sneered. "We're dropping that now. Haven't you heard Derrida's sold out to the Pacific Rim? The market's about to be flooded with PoMo generics. Anyway, it's the right time to get out. Eros House is in turmoil with the "Semiology Adverse Reaction Survey" reported in last months *BPMJ*." The *British Post Modernist Journal* had replaced the *British Medical Journal* for some years now, sitting unopened in its classic blue plastic wrapping in the consulting rooms of doctors up and down the land. "When it was just the Turner prize going to bisected cattle we could keep it under wraps, but now that every pensioner and bored househusband in South London is flour arranging with the best self-raising granary, and blowing up the sewers in front of the Horniman Museum for their PhD project, well I can tell you there are some lawyers sniffing the air."

Phobius paused, looking concerned. Grauniad continued "We've hired a few unemployed pharmacologists on the cheap. We plan to launch a revolutionary new product range designed for routine administration to the 27% of the population now resident in nursing homes. The basic product is a nightly pill containing 200 mg trimethoprim and 50 mg of trimipramine, called *Gerrifix*. It prevents UTIs, and guarantees the staff a good night's sleep. Then we have *Gerrifix forte* with 100 mg trimipramine, making every granny a happy granny. Finally there is *Gerrifix Plus* which includes 5 mg trifluoperazine, to cope with the more challenging residents."

Phobius had some misgivings about these new developments in therapeutics. "But aren't we in danger of medicalizing the social problems faced by the frail elderly? What about their individuality, their autonomy? I'm not at all sure of the ethics of that sort of prescribing." Grauniad interjected, "Yes, but have you considered the ethics of the market, Max? I feel I must take the strongest possible anti-restrictive stand on this one. Anyway, who cares about autonomy anymore? When did you last see a report request from Social Services with the space for the patient's consent completed?" Phobius couldn't answer that.

Grauniad paused to check the intercom was onto the Heisenburg-talking-to-a-vase-of-begonias screensaver and continued. "Anyway, Catford is facing meltdown if we don't move on this now my friend. Between you and me we're going to dump the stock at a high on Professor Pastrami." Phobius interrupted, "Do you mean Tortellini, the ex-manager of the Pizza Parlour?" "Yes, as I said, Professor Tortellini. The rest of us are floating a new academic department on the Stock Market and we'll leave Ravioli to take the heat, so we want you on board as a guarantor of our clinical and ethical integrity."

Phobius paused, considering the gamble. But ethics had always been his strong point. It had to be yes.

David Misselbrook

uk council, march 28

Primary Care - Current Developments
John Toby introduced papers setting out the current developments in primary care, in particular the College responses to the recent White Papers *The New NHS* for England and *Designed to Care* for Scotland. The response to the Welsh White Paper *Putting Patients First* will be sent to the Welsh Office shortly. The responses noted the emphases on high quality care, partnerships and co-operation but expressed concern about the resourcing of education, quality improvement and research, all of which will be needed to support high quality care.

Council noted that the College would respond to the Green Papers for England and Scotland *Our Healthier Nation* and *Working Together for a Healthier Scotland* by the deadline of 30 April 1998. Council suggested some areas which required more attention in the Papers, including teenage pregnancies, drug abuse, resource allocation and clearer targets for England. April CEC will develop a response which will be submitted to the June meeting of Council for noting.

Parliamentary Report
Council noted a report of recent Parliamentary activities. These included a visit to the College by Paul Boateng, Under-Secretary of State for Health to discuss mental health issues. The College presented oral evidence to the Health Committee's Inquiry into the *Relationship between Health and Social Services*. College representatives were able to emphasize to the Committee the importance of appropriate co-operation between primary and social care, and point to the integrated system of health and social services already operating in Northern Ireland.

Scott Brown reported on *Integrated Health and Social Services in the UK - The Way Ahead?*, a seminar organized by Dr Brown in Belfast, in conjunction with the Northern Ireland Health and Social Services Board. The seminar discussed the history of the integration of social and health services in Northern Ireland and noted that the existing flexible and versatile UK model of primary care could facilitate a real integration of health and social services throughout the UK.

Practice Accreditation
John Toby gave a progress report on the work of the Practice Accreditation Working Party. Practice accreditation is an important initiative, especially in view of the emphasis of the practice being the unit which delivers primary care. It will be linked to the work already done on the Quality Practice Award and to the College's future work on clinical governance. A further report will be submitted to Council.

Examination for Membership and Summative Assessment
Council debated a discussion paper from John Toby which set out various options on how the MRCGP might fit in with summative assessment under the Vocational Training Regulations. There were a number of issues which required further thought. The College needs to support Registrars who face various assessments in their year in general practice. The integrity of the modular examination needs to be maintained. The College has to consider the implications of the decision by Joint Committee on Postgraduate Training for General Practice (JCPTG) in November 1997 to agree in principle that candidates who are successful in the MRCGP and have a satisfactory trainer's report should be considered to have satisfactorily completed summative assessment.

Council noted that there is a clear desire within the discipline to rationalize the process of assessment for entry to general practice and to continue the collaboration with the other interested parties. Council re-affirmed its view that all doctors on completing vocational training should demonstrate their competence for independent practice by passing the MRCGP. In agreeing to continue the present arrangements, Council accepted that it was important to support Registrars and to continue to work towards a greater rationalization of the process of assessment.

Recognition of Hospitals for VT
Council approved the next stage of the setting up of a Hospital Recognition Committee for England and Wales. The Vocational Training Regulations give the JCPTGP more power to approve hospital posts for vocational training. The Hospital Recognition Committee will receive reports from faculties on posts and make recommendations to the JCPTGP for approval. Faculties will now be invited to tender for the work of administering the Committee, the resourcing of which has already been allocated funds in the 1998-99 College budget. Council noted that in Scotland a similar structure will be administered by Scottish Council.

The Doctor's Bag
Council welcomed a report from the West of Scotland Faculty on the essential and desirable drugs and equipment to be included in a doctor's bag. Council agreed that the Faculty should develop their work further by building on the work carried out by the Tamar Faculty and carrying out a review of the literature. It is hoped that a report will be submitted to the November meeting of Council where dissemination of any final document will be considered.

Date, Time and Place of Next Meeting of UK Council
Friday 26 June, Glasgow, hosted by Scottish Council and the West of Scotland Faculty.

Voluntary Confidential HIV Testing
Council approved a report from an Intercollegiate Working Party on Voluntary Confidential HIV Testing in Pregnancy. The report states that there is clear evidence that transmission of HIV from an infected mother to her child can be greatly reduced by interventions such as anti-retroviral treatment during pregnancy. It sets out recommendations on information for pregnant women, education and training for staff, and care and counselling.

Fellowship
The Committee on Fellowship will meet in May 1998. Nomination forms are available from the Clerk to the Committee on Fellowship, RCGP, 14 Princes Gate, London SW7 1PU, 0171 581 3232 x233. Enquiries about Fellowship by Assessment should be made to the Vale of Trent Faculty, Department of General Practice, The Medical School, Queen's Medical Centre, Nottingham NG7 2UH, tel 0115 9709391.

our contributors...

Jon Emery is a GP in Oxfordshire

Nick Bradley is a GP in Exeter

Julian Tudor Hart, in a *Lancet* essay of 1971, first described his Inverse Care Law. He is the President of the Socialist Health Association. His current enthusiasms include a salaried GP service for the South Wales valleys

Willie Fulton is a Founder Member of the RCGP. He was secretary of Glasgow LMC for 35 years. In his time he has studied mathematics, meteorology, physics and English, programmed computers, driven buses and been a trade union rep. He stopped doing locums in his 80th year.

John Fleetwood Snr is a Member of the ICGP and founding Council member of the RCGP in Ireland

Mark Gabbay is a Senior Lecturer at the Department of General Practice in Liverpool

Robert Murray is a consultant ophthalmologist at the Borders Hospital in Melrose, Scotland

David Tovey is a GP in Herne Hill, South East London, and a postgraduate tutor at King's College Hospital

Susan Woldenberg Butler is a freelance writer, presently based in rural Tasmania. She has an exuberant E mail style...

All our contributors can be contacted via the Journal office

Bruce Charlton

Oh Col-oh-nell Flastratus!

Some months ago I had a bizarre dream in which I was vouchsafed a secret which would ensure my wealth and success. I shall share the secret. It was the title for a comic novel — a title so loaded with humorous potential, so funny even in its own right, that it would (I was assured) guarantee classic status for any book. The title was *Oh Colonel Flastratus!*

The important factors about this title were twofold. That the word 'Colonel' should be spelled conventionally but pronounced in three syllables - 'Col-oh-nell'. Somehow this had to be communicated to the potential audience through advertising. And secondly the exclamation mark at the end was vital in order to demonstrate the correct tone of exasperation.

My reason for mentioning this dream is not its silliness, but the fact that for several minutes the event possessed a quality of profound significance. The dream had all the subjective hallmarks of a transcendental or mystical episode. On awakening I wrote down the title and puzzled over its meaning and consequences. Quite abruptly it dawned on me that, whatever its numinous attributes, the objective content of my experience was nil. The only 'funny' thing about 'Oh Colonel Flastratus!' was the surrealist absurdity of my having attached significance to it.

* * *

Such experiences are not uncommon — the psychologist Abraham Maslow wrote extensively on the subject. He labeled the phenomena 'peak experiences' or PEs. Peak Experiences are those moments, lasting from seconds to minutes, during which we feel the highest levels of happiness, harmony and possibility.

The subjective significance of peak experiences is uncontroversial — they may take the form of a religious conversion, a person's whole life might change as a consequence. The objective significance is more ambiguous — the pronunciation of 'Colonel' and the use of exclamation marks are hardly the stuff of Zen enlightenment.

Nevertheless, such things happen, even in mathematics and science. A recent example was Andrew Wiles, the mathematician who solved Fermat's Last Theorem — a problem which had defeated three centuries of numerical genius. After working for seven years Wiles announced success, only to find a flaw in the reasoning. Another year of work ensued, then: 'Suddenly, totally unexpectedly, I had this incredible revelation... It was so indescribably beautiful; it was so simple and so elegant. I just stared in disbelief for 20 minutes.'

Indeed, peak experiences seem to have a special relationship to creativity. Jacob Bronowski emphasized that creation exists in finding the oneness, likeness and pattern that underlies difference. This applies equally to the sciences and the arts. He quotes Samuel Taylor Coleridge: "beauty is unity in variety".

* * *

Peak experiences seem to be the result of a 'significance alarm' going off in the brain. When things are working properly, this alarm will only be triggered when something really 'important' has happened that is worthy of sustained attention. So we are often correct to take peak experiences seriously.

However such insights have the potential to mislead as well as enlighten. The nature of 'significance' is seldom transparent, and we cannot take the content at face value - after all, mystical states can be induced almost at will by certain hallucinogenic drugs. Humans will believe almost anything when drunk or delirious.

Perhaps the best approach is to regard PEs as a fascinating enigma, a code which could contain a message of profound import. On the other hand, after laboriously cracking the cipher, we may find - not the secret of life, but a pointless pun. The distinction may be crucial. And after all, we would not want to start a cult of Colonel Flastratus!