The British Journal of General Practice

"As Chairman Mao almost said, you can't build the New Jerusalem without breaking a few legs..."
Phobius on White Papers, page 1367

viewpoint

Sickness Certification: Time to Scrap the Med 3?

Over the past two decades, there has been a very steep rise in the number of long- term claimants of invalidity benefit, in spite of the fact that there is no evidence from routinely collected public health statistics that the population is getting any sicker. There were 550 000 claimants in 1978-79, while in 1993-94 there were in excess of 1.5 million.[1] Clearly, there has not been a change in the health of the population which could in any way explain this almost three-fold rise.

Gaining a sick note is dependent on the relationship between the patient's condition and his regular job, and on his perception of his fitness to work. The patient therefore has to convince the doctor of his disabilities, rather than his abilities, and sickness certification is dependent on his adoption of the sick role. Dutch research suggests that self-perception of disability is pivotal, with gatekeepers and employers exerting only a small influence.[2]

However, self-perception may be influenced, not only by the specific illness or disability, but also by lack of suitable employment or opportunities for (re)training, and by adverse economic and social circumstances. The rise in unemployment figures between 1978 and 1994, from 7.5% to 10.7% of the population of working age,[3] is likely to be associated with an increase in ill health, particularly mental health problems.[4] Political expediency, financial gain to the non-worker, and the greater social acceptability of "sickness" rather than "unemployment" may all lead to a shift from the unemployment register to sickness certification.

An international study of sickness absence in 18 industrialized countries showed that absence rates tend to be highest in countries where financial liability for employee sickness is borne by a state subsidy to the employer.[5] Under the current British system, it is only after six month's sickness absence that someone may be asked to undergo the "all work" test, i.e. required to demonstrate incapacity for any job rather than his/her usual occupation. By this time, sickness behaviour may be so well established that it may be impossible to prove fitness for work.

The doctor acts as gatekeeper to the benefits system, but may be under considerable pressure to accede to the patient's request for a sick note. There may be many reasons for certification, including agreement with the patient's self-assessment of incapacity, avoidance of conflict, inability to disprove the patient's claims, or external pressure; for example, unemployment office recommendation. If a patient insists that they are incapable of work, there is very little any doctor can do to prove them fit.

Is it time to release the doctor from the bureaucracy of sickness certification, and to concentrate instead on tackling the causes of incapacity? The current situation fosters attitudes of learned helplessness, medicalized by the GP and institutionalized by the benefits system.

Fiona Ford

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The Back Pages...

contents

The Publishing Story: Who Led in 1997?

The RCGP/Boots Research Paper of the Year

It has been over 30 years since the publication of *Profiles of Disease* by Fry, who showed how a long-term clinical perspective, as observed through the eyes of a general practitioner with continuity of care, could illuminate medicine.[1] He described, with authority, how "the common diseases that commonly occur in our community, fortunately, tend to be predominantly minor conditions that are self-limiting, usually of short duration and unlikely to cause any permanent after-effects". In 1979, Stott and Davis[2] later identified four broad tasks of the consultation: the identification and management of presenting problems; the management of continuing problems; opportunistic anticipatory care; and the modification of the patient's help-seeking behaviour. We know from everyday experience that it may not be appropriate or possible to attempt all the potential tasks of the consultation on every occasion.

These issues are certainly pertinent to 1997's most influential publications. A return to the dilemmas of clinical decision-making in daily practice, far removed from the biomedical research of many of our secondary care colleagues or from the ivory towers of academia, is clearly shown. A propensity to choose a randomized (open or controlled) approach in the study design is another interesting observation. In all, a total of 14 papers were entered for the 1997 RCGP/Boots Research Paper of the Year award, from which five were short-listed for consideration by the panel of assessors.[3-7] After much consideration and debate, there was unanimous agreement that an open randomized trial of prescribing strategies in managing sore throat by Little *et al* should win the award.[3]

The authors chose the commonest presentation of upper respiratory tract illness in general practice as the topic for an elegant study, and compared the outcomes of prescribing antibiotics with no prescription or delayed prescription. Set in 11 practices in the South and West region, over 700 patients with sore throat and an abnormal physical sign in the throat were recruited to the study. They found that prescribing antibiotics for this complaint only marginally affected the resolution of symptoms but enhanced the patient's belief in antibiotics and intention to consult in the future. The results are clearly relevant to all GPs. Few of us would be surprised by the findings but the convincing evidence from the study confirms our anecdotal daily experience.

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Led by a Wellcome research fellow, the multidisciplinary research team report further findings from the study later in the year when they explore the medicalizing effect of prescribing

Acknowledgements

I would like to take the opportunity to thank all the researchers who gave permission to have their precious papers scrutinized in microscopic detail. My thanks also to the panel of nine assessors who freely gave their time to peer review the papers submitted, and to Fenny Green who conducted the orchestra of events in this, the second year of the award. The winning papers for both 1996 and 1997 will be presented at the Research Symposium on 21 May 1998, followed by a dinner at the RCGP when this year's award will be celebrated. I close by adding my gratitude to Boots who have provided financial support for both the award and the Research Symposium.

antibiotics in more detail.[4] Effective strategies for reducing reconsultations, again concentrating on the respiratory tract, was also chosen as the theme for Macfarlane *et al*'s paper.[5]

The panel of assessors was also impressed by two other papers to which they have decided to accord the status of highly commended. The first of these was "Improving uptake of breast screening in multiethnic populations: a randomised controlled trial using practice reception staff to contact non-attenders" by Atri *et al*.[6] The panel wished to particularly commend this paper for a number of reasons — it focused on an important health issue; the research was undertaken in a deprived inner-city multicultural community; it examined how the whole primary care team could work together to provide improved patient care; and it involved the formal evaluation of an educational intervention to improve the uptake of screening. Funding for the study had been successfully achieved from both the Medical Research Council and North Thames (East) Regional Health Authority.

The second highly commended paper was by Everett on "Incidence and outcome of bleeding before the 20th week of pregnancy: prospective study from general practice".[7] The assessors wished to commend this paper because it again related to an important health issue in general practice where there is a paucity of published national statistics; it related to the challenges facing the researcher in service general practice and represented a sustained personal effort over a number of years while the study was being undertaken. The work had been supported by a grant from both the Scientific Foundation Board of the RCGP and the Wessex Research Network.

What we can be sure of is that 1998 will be another year of challenge to both those who contribute their papers and those who have the daunting task of selecting a winner. Our aim must be to optimize the quality of our research opportunities and convert them into meaningful results that ultimately benefit patient care. The 1997 papers support Professor Pereira Gray's conviction that published research "is the only way to turn decision-taking from hopeful guesswork into a rational, reasonable plan of action."[8]

Yvonne H Carter

Research methods for primary care, 1 — "The New Research" and

This series of six articles aims to introduce the newcomer to the language and principles of "The New Research" and the approach to patient care that is predicated on that research. In addition, we hope to whet the appetite of those who describe themselves as 'non-academic' GPs to consider taking part in collaborative research themselves.

Why understand research?

With the rising status of primary care, its new-found academic credibility and its rapidly growing research base, general practice is a very different discipline from a generation ago. The growth of University Linked Practices[1] and primary care research networks[2] has created an unprecedented opportunity for "ordinary" GPs and their teams to take part in large, co-ordinated and rigorous original research studies.

The government's White Paper *The New NHS: modern, dependable*[3] requires all GPs to form Primary Care Groups, which will collaborate with secondary care and other agencies to put together Health Improvement Plans for their dependent population. In other words, whereas forays into the research literature were, until recently, an interesting hobby for the academically inclined practitioner, from April 1999 they will effectively become a contractual duty for all NHS GPs.

But perhaps the most compelling reason for gaining an understanding of the *principles* of research is, somewhat ironically, that we could never hope to become familiar with even a fraction of the published studies. The knowledge we acquired at medical school became out of date even before we had collected our diplomas, and the extent of our ignorance has grown exponentially thereafter. In such an environment, it is the *skills* to access and process an ever-changing field of knowledge, and not the knowledge itself, which form our most valuable scientific resource.

What is "The New Research"?

Clinical research has changed almost beyond recognition over the past 20 years. Descriptive, case-based studies published from a single institution have all but disappeared in favour of the meta-analyses and megatrials so revered in "evidence-based" circles, a development that has been lamented by some in primary care.[4]

In addition to technological advances such as the new genetics or improvements in pharmacotherapy, three *theoretical* developments (which, I contend, are not well understood by those outside the academic community) underpin recent fundamental changes in the research we undertake in primary care, and in the criteria we use to define a piece of research as valid:

1 The belief that many aspects of clinical care (such as the art of diagnosis, the use of tests and investigations, and the choice of treatment) should be determined through a logical decision sequence using mathematical estimates of **risk** and **probability**.

2 The recognition that objectivity in science does not equate with the sophistication of equipment or the precision of measurement, but with the extent to which the effects of **bias** and other distorting influences have been minimized through the fair collection and treatment of data.

3 The growing realization that both the conduct of research and its implementation are irrevocably **contextual**, both at the individual (micro) and sociopolitical (macro) level.

The quantification of risk

Traditionally, we doctors played our hunches and based our management of the current patient more or less on our personal clinical experience and the "oral tradition" of cases reported by colleagues in conversations, grand rounds, and conferences. "The New Research" encourages us to base our management on the accumulated results of hundreds or thousands of similar clinician–patient encounters — in other words, the research literature. When the focus of the analysis moves thus from individual case histories to systematically selected populations, the results allow us to express the possible outcomes of different clinical decisions in the language of probability and risk.

In the past, I might have said to a 52 year old woman with symptoms and signs of mild acute sinusitis, "Mrs Smith, your headache and nasal discharge are probably due to an infection in the sinuses. You could take an antibiotic to guarantee rapid recovery but you would almost certainly get better without one, and these tablets can occasionally cause a rash or upset tummy." Doctors and, increasingly, patients seek to inform their decisions with statements such as, "An antibiotic will increase your chance of worthwhile symptom improvement by 29%, but there is a 21% risk of developing a rash or gastrointestinal symptoms. In summary, Mrs Smith, I would need to treat 3.5 people like you to assure one additional cure, and 5 people like you to produce a significant side effect from the antibiotic".[5]

This kind of approach, in which risk estimates derived from populations are used to inform and refine decision-making at the level of the individual

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clinical encounter, was previously known as clinical epidemiology and has been popularized by Sackett and others as evidence-based medicine. Some mathematical tools for calculating probability and risk, as well as a taste of the controversies surrounding their use in practice, will be introduced in a later article in this series.

The pursuit of objectivity in scientific measurement

Doing double-blind randomized controlled trials is far more laborious and expensive than collecting the same data on non-randomized participants. It is often hard to see what difference rigorous randomization would make to a set of carefully collected results. To illustrate the fallacy of "objective" comparisons in open research designs, I have used a dataset first published in 1906 by the eminent physician Robert Bennett Bean[6] and exposed more recently by the paleontologist Stephen Jay Gould[7]. Bean's hypothesis was the intellectual superiority of the white Anglo-American race. To this end, he painstakingly measured the dimensions of two parts of the brain — the splenium (the front part of the corpus callosum) and the genu (the back part) — in around 200 brains from both white and black cadavers. A high ratio of splenium:genu was believed to indicate a prominent forebrain and, therefore, more advanced evolutionary development. Figure 1 shows his findings, which confirm a substantially higher splenium:genu ratio in whites.

One of Bean's mentors, Franklin P Mall, re-analysed Bean's specimens with one crucial difference in the methods. He made his measurements *without prior knowledge* of whether the brain he was examining was from a black or white person. Mall's results are shown in Figure 2 and demonstrate no difference whatsoever between blacks and whites in this highly dubious measure of intellectual worth.

I suspect that many readers of this journal believe as passionately in the *absence* of significant intellectual differences between the races as Bean believed in their presence. But on what grounds can we claim that, were we to repeat Bean's experiment in brains clearly labelled "black" or "white", our own measures would be any more accurate than his? As Gould comments in *The mismeasure of man*,[7] the notion that white coat objectivity is built on an ice-cold impartiality is one of the most fallacious and harmful claims made by the scientific community through the ages.

You may, like many GPs,[4,8] remain unconvinced by the explicit pecking order known as the hierarchy of evidence, which declares the double-blind randomized controlled trial irrefutably "better" than open comparisons or accumulated clinical experience,[9] and you may not applaud the Cochrane Collaboration's use of public funds to grade concealment of allocation and adequacy of "blind" assessment as central indices of methodological quality in all such trials.[10] Whatever, I would invite you to study the substantial and compelling literature that documents the consistent inability of clinicians and researchers to suspend their expectations and their prejudices when making empirical observations or interpreting the observations of others.[11,12]

Contextualizing research evidence

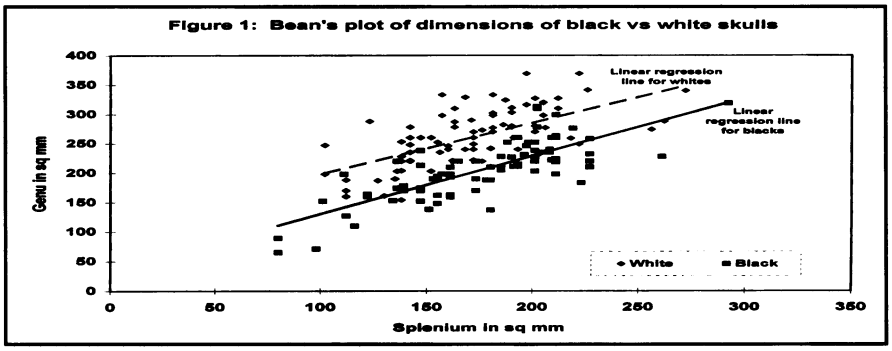
The protagonists of evidence-based medicine strive constantly to square the circle of applying clinical trial results (inevitably, imprecise estimates of average effects in population samples) to the personal, unique, and multifaceted predicament of an individual patient. More often than not, the tools of empirical science fail them in this task,[13] since these tools do not address the complex interpretive process that is the hallmark of the competent clinician.[14]

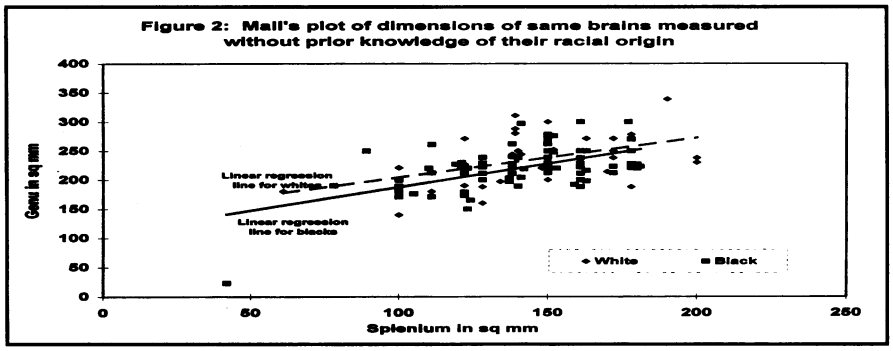
The need for contextualization and individualization of evidence-based medicine is perhaps most pressing in primary care, where problems are usually multidimensional and defy taxonomy.[15,16] I will return to this important subject later in this series.

Another, equally important, aspect of the contextualization of research is the social and political context in which it takes place. As Gould points out,[7] the men and women who built the now discredited tradition of craniology were among the most distinguished scientists of their generation. But, viewed with the lens of hindsight and from a different ideological perspective, their work is characterized by naive hypotheses, unjustified leaps of faith, and the presentation of political and ideological prejudice as scientific truth.

As the years pass, the hypotheses we choose to test through today's scientific research, and the uses to which those findings are put, will surely meet with similar incredulity and mirth from tomorrow's scientists. The final article in this series will describe a different aspect of "The New Research": the development of methods to examine the interface between "evidence-based" research findings and the social, political, and ideological context in which they are developed and received.

Trisha Greenhalgh





Paul Schatzberger
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Subject:
Dr Jeanette McGorrigan revisits Mrs Sarah Foy two days after diagnosing pleurisy.
[Full consent to publication has been obtained]

Place:
Parson Cross, Sheffield, Thursday 7 January 1988.

Technical:
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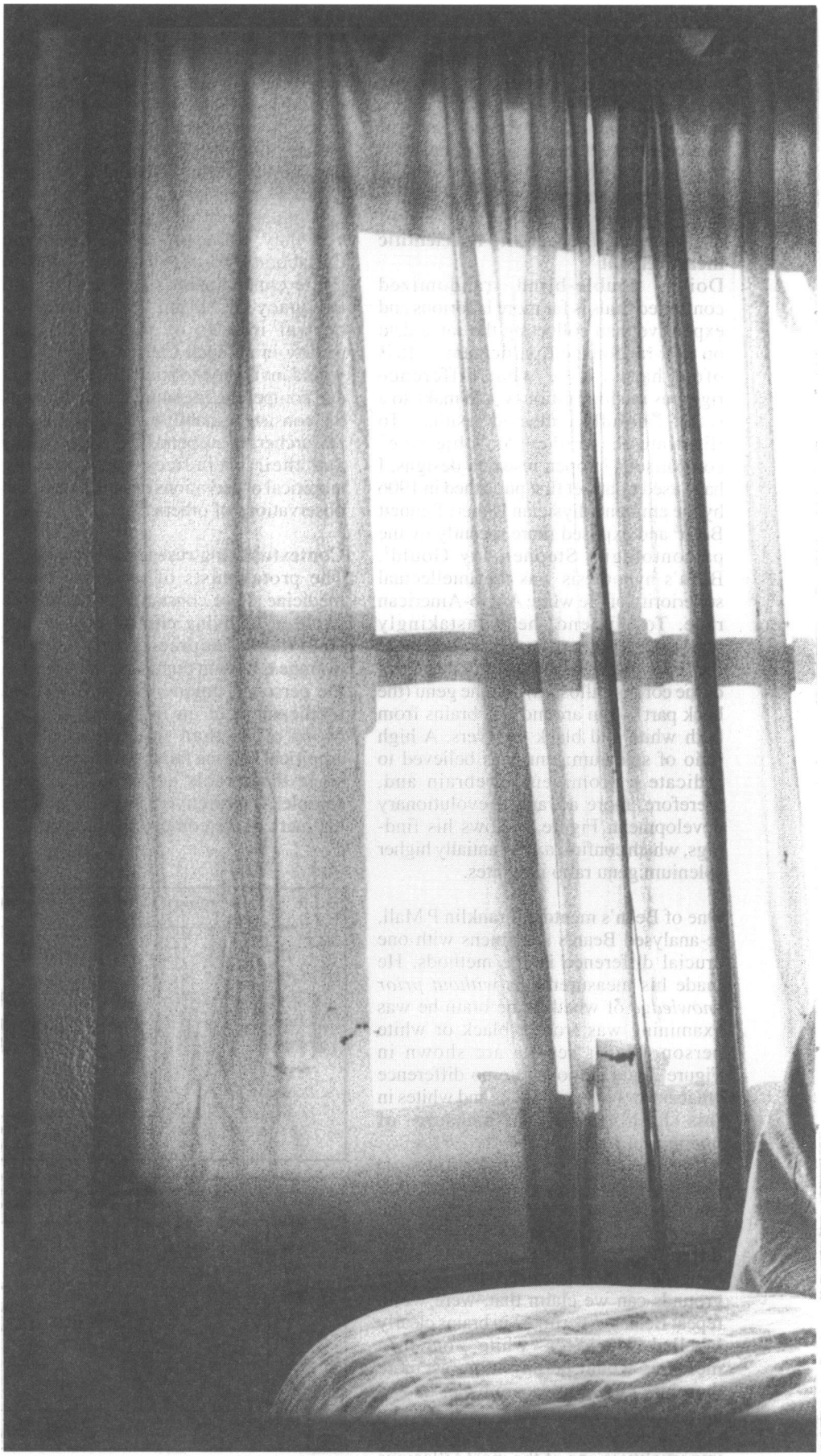
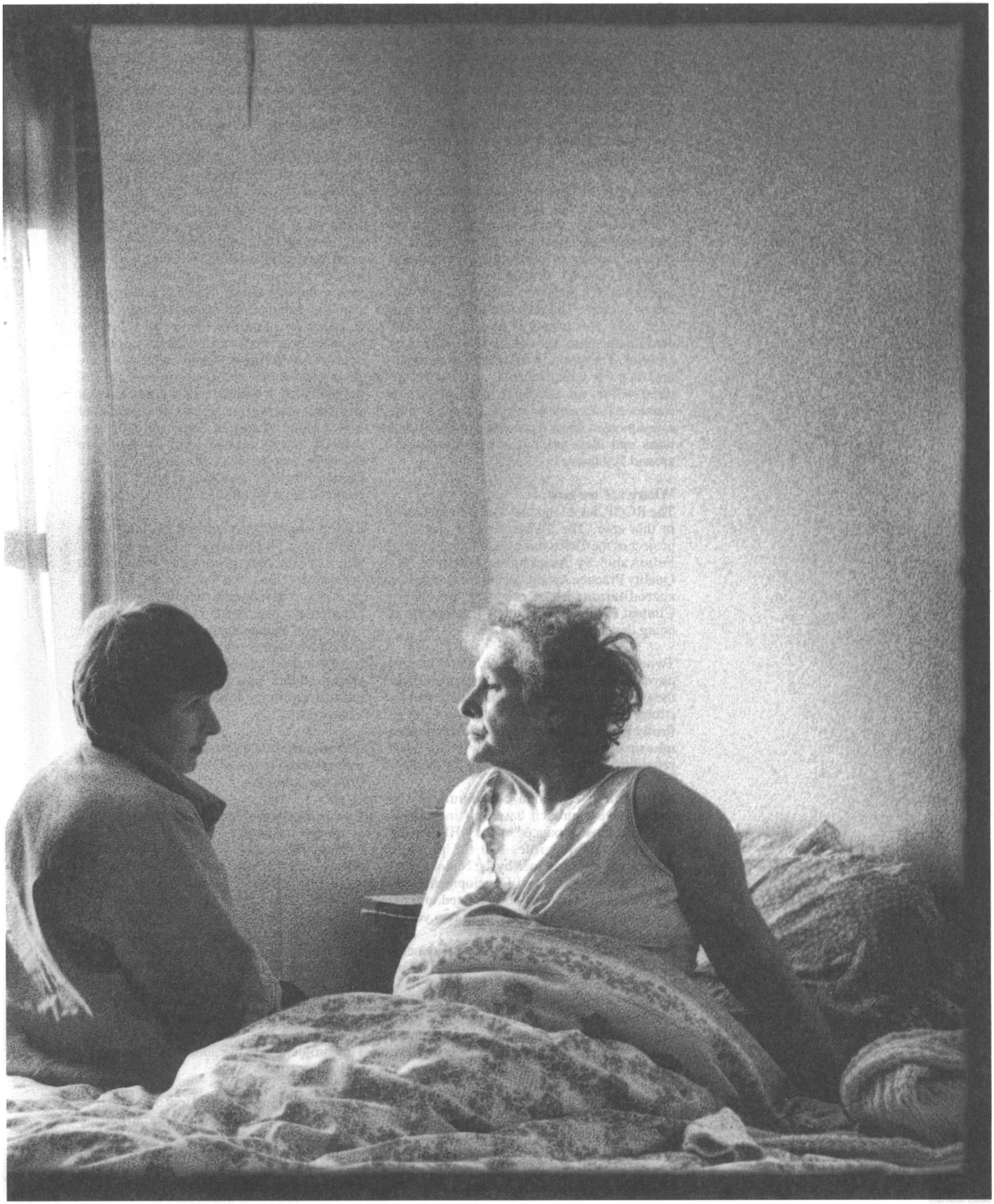
Lens: 35mm f2 Summicron
Film: TMAX 400
uprated to ISO 1250
Exposure: 1/60th sec. at f4.





Measuring General Practice — Filling in pieces of the jigsaw

One hundred medical advisers, GPs and public health physicians came together on 14 November at the Royal College of General Practitioners to explore the "measurement" of general practice — why it is necessary, what tools are around now, how well are they working, what do doctors themselves see as the best way forward.

The jargon of "performance management" began to permeate the NHS following the NHS reforms. Early emphasis was on measuring hospital activity. Attempts to capture aspects of performance in general practice, largely through prescribing or practice activity analysis, have been met with mixed success. The response to the performance indicators proposed by the NHSE last autumn illustrates the sensitivities that can be aroused. The task is to find appropriate measures that are valid, reliable, and can be applied within an educative and supportive framework. Experts on specific aspects of the assessment of general practice presented their work and ideas prior to group discussions around key themes.

Where are we now?

The RCGP has a long history of involvement in this area. The "What Sort of Doctor?" project of the 1980s has been followed by the Fellowship by Assessment initiative, the Quality Practice Award, and work on practice accreditation. More recently the RCGP Clinical Practice Evaluation Programme is being developed.

Two key themes run through the College's development in measuring general practice: they are professionally led and they have a strong developmental element. The College firmly believes that we should not attempt to measure general practice without also providing support and education for the GP.

At the other end of a continuum is the quantitative approach based on indicators, including those produced by the NHSE on the GP's gatekeeping role, and the package currently being developed by the National Primary Care Research and Development Centre in Manchester is to be validated and piloted with practices over the next two years.

Prescribing is an important part of general practice but too exclusive an emphasis on performance in this area gives a partial view. Markers of high quality prescribing are still being validated. Local audits of under- and over-prescribing practices may become more common when primary care groups have cash-limited budgets.

Since 1994, the King's Fund has worked with practices to develop a set of organizational standards for self-assessment, with the aim of fostering a culture of continual improvement. Organizational audit can engage practices and be linked to patient care, although there are no clinical criteria as such on the system. There may be difficulties in measuring performance this way, and the right balance must be struck between performance management and development and between health authority and primary care agendas.

Audit aims to help health professionals improve their performance. A recent national survey of MAAGs indicated that nine out of ten practices were now participating in some form of audit. A further survey of 700 practices in 18 districts indicated that each practice was undertaking an average of three audits a year; 81% involved clinical topics and two out of three led to change in practice. Nearly three-quarters of audits were initiated by practices themselves. Only a quarter, however, carried out a complete cycle (undertaking a second audit) to ensure recommended changes were being implemented. It was also not always clear that sufficient care was going into the selection of topics to be measured. Activity data (e.g. referral rates) can be used to stimulate discussion on the basis of comparisons, but do not constitute quality measures on their own and are not linked to patient outcomes.

The postgraduate education networks facilitate professionally-led development. One group of practices that could potentially take the lead is the training practices. They already meet with each other frequently, and, with GP tutors, course organizers, and associate advisers, they have a remit for improvement. They are subject to regular inspection and need to be receptive to change. Other potential allies are the new multidisciplinary Education and Training Consortia.

And any measure of quality cannot ignore the patient whose views might differ considerably from the physician.

Concerns about current measures — no one best way

Current indicators, by relating to overall practice organization and processes, may not tease out differing performance within a practice. Does the performance of an individual or practice team as a whole take priority? There is a tendency to constitute packages around the easily measurable. Such data are not necessarily practice-driven and therefore are practice-owned. Current measures are least likely to be taken up by poorly-performing practices perceived to have the greatest need — a form of inverse care law. This problem is being addressed by the new GMC procedures.

The collection of indicators is less problematic than their interpretation and validity of results and the use to which they are put. Indicators in general practice will only have value if they act as a catalyst for debate within the practice and with health care

managers. The process of measurement should be developmental. Use of indicators should therefore build on what has worked well in recent years, such as medical advisers' personal visits to practices, local audits involving groups of practices, and the collaboration engendered by out-of-hours co-ops. Use of easily available data enables "outliers" to be identified as a first stage. More sensitive measures are needed to bring about real change. Successful outcome measures relevant for general practice are still a way off.

Indicators need to relate to a range of dimensions within general practice, both organizational and clinical. They will only be acceptable if they have been drawn up in conjunction with GPs, and data need to be easy to collect. There must be perceived benefits/rewards for quality improvement. The process must be both manageable and affordable.

All GPs need to be engaged in the process and all practices should be enabled to look critically at the care they provide. This could be through funded practice meetings or away-days. Patients and other primary health care staff need to be involved, as should social services and other relevant agencies. There should be sufficient flexibility to allow all practices to have realistic targets to aim for.

Conclusions

Performance management, especially with the advent of Clinical Governance, remains high on political agendas. The NHS Executive, Health Authorities, Community Health Councils, and other patient organizations will require accountability from practices for their spend of public monies.

There will be increasing emphasis on population-based approaches to health care provision with the development of the new primary care groups.

There will be a continuing emphasis on external probity and compliance with national planning guidance. There is likely to be more pressure for measurement to ensure equality of access and provision. Equally, there are likely to be greater demands for openness and transparency on what currently is being delivered in primary care.

The approaches of greatest benefit will be developmental, where practices are involved in the process and where measures relate to patient care. The search for a single national package of indicators is likely to be fruitless. Building on its considerable track record in the field, the College should continue to lead the development of multifaceted approaches to performance management.

Chris Trower, Elizabeth Robinson, Steve Gillam, Jenny Wright

A short history of socialized medicine... 9

PARISH TO PANEL - Social Medicine in the Lloyd George era

Quaker philanthropist, John Bellars, had proposed a national health service as early as 1714 in his "Essay towards the Improvement of Physick". The first real progress towards this ideal occurred across the Channel — the assistance publique being established in 1797 to administer Paris hospitals, asylums, orphanages, and homecare bureaux. Later laws made French communes responsible for the sick, in co-ordination with charities, and a national system of medicine for the rural poor developed, emphasizing domiciliary care. An 1898 law on mutual aid societies gave responsibility to employers for accidents at work, further stimulating insurance societies.

In Germany, Bismarck established compulsory sickness insurance for the urban working class in 1883, primarily to outflank socialism. Mandatory autonomous insurance funds received additional contributions from employers and had greater resources than employee-funded friendly societies; activities being overseen by the state watch-dog, the *Landesversicherungsamter*; the major weakness was the exclusion of family dependents.

In 1900, 2/6 bought the elite a drawing-room consultation with an English GP, (with a shilling extra for a wrapped bottle of medicine); club patients paid three or four shillings a year and were seen in the surgery (and received unwrapped bottles!). With midwives charging10/- for first births, and average weekly wages of around £1, the parish doctor of the poor law remained a last resort, although as many as 9 of the 12 million covered by the eventual National Health Insurance (NHI) scheme may already have been members of societies offering medical care.

Fabian socialists such as Sidney and Beatrice Webb argued that better health would save money as the poor adopted more hygenic habits. The physical effects of the grinding poverty of back-street Salford (where Wellington's victory at Waterloo was attributed locally!) caused poor levels of physical fitness in recruits for the Boer War, as investigated by an Interdepartmental Committee on Physical Deterioration in 1904. Introducing his National Insurance Act of 1911, Lloyd George remarked that "a C3 population would not do for an A1 empire". His Act used state insurance allied closely with friendly societies to provide sickness benefits and access to a "panel" doctor for insured workers; like continental models, dependents were excluded.

National Health Insurance was initially resisted by doctors, but despite a rousing protest meeting at the Queens Hall on 19 December 1911, when Sir Watson Cheyne mounted the platform to the strains of *Rule Britannia*, Lloyd George announced on 2 January, that 10 000 doctors had joined the panels. The Webbs and other radicals were also disappointed, believing that the scheme would "intensify the popular superstition as to the value of medicine", impeding genuinely preventative or curative treatment. At least the Webbs believed that the poor could be persuaded to adopt hygenic habits, unlike their contemporaries, the eugenecists, known as the "better-dead" school, who held that personal habits were inherited!

Jim Ford

Bismarck's state watch-dog...

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the 70s — a golden age

Introduction

The 1970s was the decade in which general practice achieved respect and self-esteem. Throughout, I tried to fashion a clinically rewarding job for myself and enjoyable and challenging work for my fellow team members (Marsh GN, Kaim Caudle PR, 1976). I cannot recall working with anyone who did not enjoy their job.

Primary Health Care Team

As a result of the GP charter, money was made available, not for doctors themselves but for their practices.

By the 1970s, improvements were well under way and, with rent for premises and grants for structural expansion, larger groups began to form. Off-duty rotas became easier and, with fairly compliant, tolerant, and understanding patients, evening and weekend work was reasonable. GPs' families committed themselves to supporting the system. Seventy per cent reimbursement of staff wages facilitated the employment of trained, well equipped receptionists and secretaries. Practice organization became the order of the day. *Pulse* and *General Practitioner* were a major means of spreading the news about innovative changes that were taking place in this town and that. RCGP organization committees met in each other's surgeries in the evenings, exchanging ideas. Sadly, the DHSS, having successfully piloted A4-sized patient records, reneged on their general distribution (except in Scotland where they became the norm).

The structural and operational changes were necessary for the implementation of team care. GPs began to define their role more carefully and were increasingly aware that, just because problems were brought to them, they themselves did not necessarily have to solve them. As the 70s progressed, nurses became the mainstay of primary health care teams. By the time health and social services separated in 1974, the former nursing staff of the medical officer of health had largely been devolved onto practices. Because of their orientation around care in the home and their unavailability for surgery tasks, practice-employed nurses became common (RCGP 1968). They received a cool reception from the Royal College of Nurses but by the end of the decade they were so numerous — and so happy with their work — that they were accepted.

The rift between social services and health was bridged occasionally by informal links with named social workers. Liaisons with marriage guidance counsellors proved a major help in managing the large numbers of unhappy, anxious, depressed, and frustrated patients that entered GPs' consulting rooms.

The total volume of work was colossal, but with better organization, less home visiting, more staff, and increasing delegation to fellow professionals there seemed to be light at the end of tunnel (Marsh GN, 1976). Patients were encouraged to use more self-care, and the text of our first practice brochure was mostly an invocation to people to consult team members rather than doctors. Throughout all this turbulent restructuring, patient satisfaction remained very high.

Clinical Medicine

The organizational changes, and expansion and support of the team, provided GPs with increasing opportunities to show what they could achieve clinically. Most still believed that the rock on which good general practice must be set was quality clinical medicine. It would attract the necessary brighter medical graduates into the specialty. Hence, many enthusiastic GPs tried to do more and more clinically demanding work, effectively reducing the need for referral or admission to hospital (Colling A, 1977; Hart C, 1977; Hart JT, 1980; Marsh GN, 1982). That this philosophy was not universal, however, was evidenced by the enormous variations in referral rates. But for the perseverant enthusiasts, home care of worryingly sick children, spontaneous abortion, pneumonia, some haematemeses, myocardial infarction (pre-thrombolytics), cardiac asthma, severe congestive heart failure, stroke and terminal illness (pre-hospices), was part of a challenging day's work, and daily (sometimes twice daily) home visits were made quite voluntarily.

Patients seemed to love it. Mature and experienced district nurses provided expert nursing care. Increasingly, they did investigations — bloods, sputum, ECGs — monitored progress and therapy, and supervised recovery. Open access to laboratory and radiological services was becoming mandatory and was more appropriately used than by specialist departments. Treatment rooms for nurses

became common and increasingly contained ECG machines, peak flow meters, and minor surgical instruments.

Sadly, home deliveries of babies dwindled away, despite the encouraging statistical evidence, and the battle against the technological births of large centralized maternity hospitals was almost lost.

With the availability of increasing numbers of team members, services at surgeries increased, and ante-natal clinics, vaccination sessions, paediatric developmental clinics, and family planning became common place. Preventative care began to feature, and well-woman clinics were shortly to be followed by well-man clinics. Special sessions for diabetics heralded "protocol" care of clinical illness by nurses.

The GP was free to prescribe what he liked when he liked — although the warning flags of cost containment and restricted pharmacopoeia were beginning to be waved.

There was no talk of the "core content" of general practice — the sky was the limit for clinical work and there was a wonderful vibrancy in the working day. And fundamental to all this was the education of general practitioners.

Education: Learning and Teaching

The Royal Commission on medical education (1968) had adopted the College of General Practitioner's philosophy, that there should be structured postgraduate education for general practice. The College ("Royal" from 1972) began to persuade an initially reluctant profession that the MRCGP should be the benchmark qualification. A three-year training programme became the norm (Irvine D, 1972). Education of trainers and inspection of training posts began. Postgraduate education of GPs by GPs became increasingly accepted. Practices began to assign study leave to their doctors. Oxford University Press were preparing their ultimately celebrated and popular GP series of text books with an editorial board consisting solely of GPs.

Within universities, departments of general practice — frequently given other names by reluctant academics — were established. Increasing numbers of medical students saw GPs at work and received some of their education from them. Quite a few British GPs from their back-street surgeries were appointed as visiting professors in Canadian and American universities!

Research

As an essential adjunct to the expanded services being provided in general practice, and as a database for its teaching, research was needed. It was uncommon, although giants in the field, like Fry and Hodgkin, had blazed the trail and were continuing to research and write. They provided the stimulus for other GPs to use their practice as a laboratory. The RCGP's research unit in Birmingham was gathering extensive data about what was going on (RCGP 1979). The nationwide pill survey showed the enormous potential of research in general practice (RCGP 1974).

Audit was much more common and peer-reviewed journals were at last publishing articles about how general practitioners worked. For most GPs, research and audit had to be done in their own spare time once the surgery doors closed, and financial support for research assistants and data analysis was almost unknown. Compared with the expansion of surgery facilities, clinical care, and GP education and teaching, research was the poor relation.

The Future?

So, by the end of the decade the GP was proudly leading his primary health care team. He, and it mostly was "he", ordained what was necessary for his patients and did his best to provide it. He expanded his team within government constraints and welcomed attached and liaising staff. He delegated care to them.

But the clouds were gathering — hospitals were developing intensive care units with therapies not available or safe to practice at home, and patients were demanding them. Patient participation was about to take off. Team members, especially fellow professionals, such as nurses, health visitors and midwives, were increasingly discontented with a doctor-orientated system. Preventative care was about to escalate. Costs were spiralling and there appeared to be no controls. The government-ordained revolutions of the late 80s and 90s were a natural sequel.

By the early 80s the Golden Age was over and a troubled new dawn was on the horizon.

Geoffrey Marsh

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Marihuana, the forbidden medicine
Lester Grinspoon, James B Bakalar
Yale University Press £10
Drugs and the party line
Kevin Williamson
Rebel Inc. £5.99

There is little else to do at 40 000 feet, en route from Amsterdam to San Francisco, than read about drugs in general and cannabis in particular. It wasn't long before the person sitting next to me became curious. She transpired to be a retired Dutch GP and, as we headed across the Atlantic much talking but little reading got done.

As the drinks trolley came round she enquired, "You think cannabis is a dangerous drug — no?"
"Can't be too careful with illicit drugs. They say smoking cannabis can be the first step on a slippery slope to harder drugs that endanger your health. Have another gin."
"And you have a Drugs Tsar now in Britain to stop this wicked trade?"
"Yes."
"Weren't the Tsars autocrats appointed by God who relied on the knout and the Secret Police to enforce their will on the peasantry?"
"Well, yes."
"But they were overthrown when the people got a rudiment of learning."
"Um... I suppose so."
"This must be the work of a right wing government, yes?"
"Well, no. I think Mr Blair and Mr Straw want to win the war against drugs."
"War? Against the people who smoke a little dope? In Holland many doctors find it gives relief to patients with MS and AIDS. I hear that your British Medical Association says certain cannabinoids should be legalized for wider medicinal use."

And she was right. Produced in support of a resolution from the Representative Body's AGM, *Therapeutic uses of cannabis* reviews the scientific evidence for the increased medical use of cannabinoids. It is a calm dispassionate account of the pharmacology and clinical effects of cannabis. There appears to be little doubt that certain cannabinoids are effective anti-emetics, especially in cancer chemotherapy, as well as useful anti-spasmodics in neurological conditions such as MS and spinal injuries. The authors of this authoritative and accessible volume are careful not to overstate the case for changes in the legal status of cannabis. If the subject was not such an emotive one, this book would be highly persuasive.

The same cannot be said of *Marihuana, the forbidden medicine*. Unfortunately, the highly partisan stance of Grinspoon and Bakalar serves to weaken their arguments. The bulk of the book is made up of detailed, frequently moving, case histories. The persuasive power of such anecdotal evidence is not increased however by weight of volume. The impression one is left with, perhaps quite wrongly, is that the authors have only included stories that support their conviction that cannabis is a wonderful panacea that should be legalized without delay. Often valid arguments are diminished by this approach. The sceptical and suspicious reader will not be won over by over-egging the pudding. Interesting points, such as the suggestion that, because marihuana cannot be patented, the pharmaceutical companies have no interest in it, are diminished by an undertone of paranoia.

Grinspoon and Bakalar do however identify a key issue in the debate. Because cannabis was so inexorably linked to the anti-establishment movement of the 60s and 70s and because it remains classified as a Class I drug along with substances like heroin on both sides of the Atlantic, any debate about its place in society cannot be conducted solely on the basis of scientific evidence and logic. The debate touches people at a deeper level. Emotions are stirred and tempers frayed. None more so than those of Kevin Williamson. In his raw, angry book, *Drugs and the party line,* he presents, with a breathless urgency (and without the help of an editor, it appears) the case for a change in our attitude to the "drugs problem" in general and cannabis use in particular. His frustration at the approach being taken by the New Labour government reaches Kafkaesque levels of despair, that those in power cannot appreciate truths that he believes are self evident. If for no other reason, this book is worth reading to recall the vision he conjures up of Michael Forsyth, Scotland's Conservative Secretary of State, in trendy vicar mode.

Will anything change? I read today in the papers that a new survey by the market research company Taylor Nelson Sofres concludes that 68% of the population are against any compromise on illegal drugs and 55% feel that drug laws are too lenient. David Macauley, campaign director of the government sponsored organization *Scotland Against Drugs* is reported to have said "We are greatly encouraged by these results." In the current political and cultural climate, the power of the tabloid newspaper will dominate the debate on drug policy far more than either cool academics or angry reformers.

Rob Hendry

Hystories: hysterical epidemics and modern culture

Elaine Showalter
Picador
HB £16.99 207pp (0 3303 4670 9)

Hysteria lives; not as the limps, paralysis, mutism of Freud and Charcot's era, but as anorexia, chronic fatigue, Gulf War syndrome, recovered memory, satanic abuse, and, if you are American, as alien abduction. "Too soon has the medical profession claimed to have conquered hysteria with the diagnostic tools of modern medicine." says Elaine Showalter, historian of psychiatry and Professor of English at Princeton University, in this brilliantly argued book.

It will infuriate sufferers of illnesses, like chronic fatigue, who search for external causes of their disabilities, for viruses, poisons, allergies, and conspiracies. But, far removed from the insulting overtones of the word, hysteria is the body language which results from the silencing of emotional pain. By unravelling the threads of this pain, whether emotional or physical, one unravels a story, which the author calls a hystory — the silent body language, echoing the suppressed anxieties and fantasies within our culture.

Just as Freud's female patients, lacking the public voice to express their economic and sexual oppression, exhibited symptoms of "blocked speech", chronic nervous cough, or aphasia, so present day sufferers of Gulf War syndrome may be exhibiting unresolved emotions about war. On the one hand it is unmanly and illegitimate to show psychological symptoms, while, on the other hand, the Rambo-style war hero is glorified. War does make people ill: 60 000 US troops who served in the Gulf suffer from ailments as diverse as diarrhoea, fatigue, hair loss, bleeding gums, irritability, insomnia, and muscle spasms. But the National Academy of Sciences examined 19 000 and found "no single cause to support the diagnosis of a mystery ailment".

Chronic fatigue has reached epidemic proportions and, according to Dr Luisa Dillner writing in the *Guardian*, "TATT" is the second commonest reason for a trip to the GP. There is no doubting that patients' symptoms are genuine, whether psychological or organic, often interrupting careers or destroying dreams. It strikes when patients (mostly female) are at their busiest, juggling career, family, voluntary work. Sufferers blame doctors for lack of sympathy and for not finding the "fatigue toxin". But ME is a syndrome with no consistent clinical signs, with large temporal variations and strong emotional overtones. Could it be that our culture forces people to deny the psychological, circumstantial, or emotional sources of their symptoms in order to render them "legitimately" ill?

Epidemics of hysteria spread through the exchange of vivid "hystories" on TV chat shows, magazine articles, and by the Internet. Rumours, panics, and conspiracy theories are fanned by religious fundamentalism, paranoia, and exponents of alternative therapies. As we reach the millennium, these voices are reaching a crescendo. Thousands are pursuing expensive remedies without relief or cure.

What does this say about contemporary society? If hysteria persists in so many guises, what are we blocking from our collective consciousness? Recovered memories of child sexual abuse may be unreliable, but abuse, rape, and violence are everyday realities affecting our sense of security and autonomy, as much as in Freud's day. We convert our symptoms, not because we are all victims of abuse, but through our inability to speak about shame, guilt, or helplessness.

And what about modern medicine, with its fixation on the scientific "evidence-base" to the detriment of the psychological–physical interrelationship? As Charcot coached the florid behaviours of his hysterics in a hall of mirrors in order to improve his theatrical performance, does the present medicalization of society mirror the needs of the medical profession as much as those of our patients? This highly readable book is intriguing, important, and controversial. It encourages us to think more deeply not only about "diseases" but about the society we live in. To reach the truth about ourselves is health education and prevention at its keenest.

Dorothy Logie

The End of Science: Facing the Limits of Knowledge in the Twilight of the Scientific Age

John Horgan
Abacus, London 1998
PB £8.99 336pp (0 3491 0926 5)

The title *The End of Science* invites accustations of Millenial excess — how many more "end-of" books can we have? Horgan's book starts from the assumption that many of the really big scientific questions — the nature of matter, how did life and the universe begin, how did life evolve — are more or less sorted. Sure, there is a lot shouting still to come over the details, and there are indeed a few Really Big Questions left (the nature of consciousness and machine intelligence to name but two) but, assuming that over the next few decades we crack these, what then? To put it another way, is it the Truth or truth-seeking which makes life meaningful?

Over the past six years or so Horgan has sought out the *illuminati* of English-speaking scientists (a task made easier by his job as a staff writer for *Scientific American*) and asked their opinion. These conversations form the skeleton of his book, and are interspersed with lucid explanations of the scientific arguments and Horgan's impression of the men (the only woman is Lynn Margulis of Gaia fame) themselves.

As the subtitle suggests, the book is also about the nature of science itself. What sort of answers does it really give us about the world? In what sense — or in what fields — is it reasonable to talk about there being a single, all defining Truth, a complete congruence between our understanding of the world and its reality? Medicine, being essentially an applied science, does not figure, but these questions still resonate; the touchstone of evidence-based medicine is that there are universal answers — ACE inhibitors will relieve heart failure in Papua New Guinea just as well as they do in Iceland. Yet the regularities on which the science of medicine is based do not extend very far outside the body: our understanding of the failing heart will always be more reliable than our understanding of the failing marriage.

By the end of the book, Horgan's view is clear — Science as we have understood it for the last 200 years is indeed ending. From here on in there will be gizmos galore but few fundamental advances of the kind that have marked the past century. Science will be increasingly contingent, a quest for local answers rather than for "The Answer".

Just as medicine goes evidence-based in a naive search for certainty, science itself is becoming more postmodern and ironic.

Paul Hodgkin

Two films and a book: education, attitudes, and empathy

When I was a medical student, I believed that operating on people for smoking-related conditions was a waste of time and money, unless there was a commitment by the patient to stop smoking. Over the years my attitude changed as I realized it is unfair for the state, through the NHS, to penalize patients who are indulging in a legal activity. An activity, moreover, that raises revenue and is still able to be advertized.

The position is more difficult to defend when the destructive activity is illegal. Some medical students, GP registrars, and qualified doctors mistrust heroin addicts. They feel that treatment and rehabilitation is a waste of time for people who lie and manipulate to continue their addiction. Yet, we are led to believe that many young people see drug taking as fashionable, *chic* even, a viewpoint enhanced by the behaviour of rock stars and actors.

The film *Trainspotting,* based on the book by Irvine Welsh, was criticized on its release as a positive influence on the nation's youth towards taking drugs. Anyone who has seen the film realizes that it shows the ups and downs of addiction, with the downs far outweighing the ups.The action shows the effects of drug abuse without sermonizing, without a signposted moral, but it is hard to see that anyone would be drawn towards heroin on the basis of this film alone. And, because it does not preach, it has been seen by millions around the world, some of whom may have questioned their negative attitudes towards drug addicts as opposed towards the drugs themselves.

Another hard-hitting slice of life is captured in the more recent film *Nil by Mouth*, recommended viewing for any aspiring doctor as a concrete example of what tutors and trainers define as "psychosocial" problems. *Nil by Mouth* marks the directorial debut of Gary Oldman, usually seen as a somewhat over the top, quirky actor in such films as *The Fifth Element* and *Bram Stoker's Dracula*. He also wrote the screenplay, based on his childhood, growing up with an alcoholic father on an inner-city estate.

This is an uncomfortable portrayal of a dysfunctional family; hardly entertainment. Ray, the male lead played by Ray Winstone, is addicted to the legal drugs, tobacco and alcohol, and also dabbles with illegal substances. But his main addiction seems to be to power: power over his wife, his friends, his relatives. He flaunts this physical and psychological power; the terror being the inability for anyone to guess when threats will become action. Kathy Burke plays the downtrodden wife, Valerie, as a woman without any joy in her eyes. Yet, like so many other beaten women, she cannot leave this man, attracted by a force that her own mother cannot understand.

Valerie's brother Billy is an intravenous drug addict who tries to act big but whose heroin habit eats away at his relationships. This is not glamourizing drugs, but again there is no telling, just showing. The audience can make up its own mind. But I would say that the most destructive force shown is the ability of alcohol to induce jealousy, to release physical violence, to defy insight. Ray is pissed when he beats up Valerie so badly that she miscarries. Yet, when, in a *tour de force* monologue, Ray talks about his own alcoholic father, it is apparent that Ray fails to realize his own dependence on the bottle. Ray chastises his father for ignoring him as a child, for not expressing any love, but Ray attacks Valerie in front of their daughter and has already lost one wife and son to divorce.

Can a doctor see any redeeming features in wife beaters, alcoholics, drug addicts? Can we treat these patients without prejudice and judgement? Perhaps medical students and junior doctors can be encouraged to discuss their feelings and attitudes, using such a film as a catalyst.

Howard Spiro, professor of medicine at Yale University, has written eloquently of the need for medical students to retain and strengthen their natural empathy. In his book, *Empathy and the Practice of Medicine*,[1] he notes that, even in these times, medical students have not yet had all possible experiences, but that, if empathy depends on experience, novels and fiction can enlarge empathy. To those I would add films, which may be more appealing to students who rarely read. No doubt many doctors can suggest other suitable films.

Jill Thistlethwaite

1 Spiro HG, McCrea Curnen MG, Peschel E & St James D (Eds). *Empathy and the Practice of Medicine*. New Haven and London: Yale University Press, 1993.

Rooms 19–21 at the National Gallery, London

Rooms 19–21 of the National Gallery have recently been rehung. The walls of these smaller rooms are covered with powder blue hessian on which larger pictures alternate with smaller. Combined with the grey stone of the floor and door frames, this is a highly effective way to set off the paintings on show. Claude Lorrain has the first room and Poussin the second, while the principal figure in the third is Cuyp.

There is a thematic unity to be found among them — all concentrate heavily on the Italian countryside, whether real or imagined, as the scene of myth. This is best exemplified by Poussin's *Landscape with a Man being Killed by a Snake*, one of his greatest pictures. You may well have seen these paintings before, but go and look again — one of the pleasures of free admission is dropping in to look at a few such rooms at a time.

Frank Minns

Gallstone Grove, tales from tomorrow.

Episode 5: If it's the next White Paper it must be Tuesday.

There was great excitement among the partners as Dr Max Phobius announced that he would be attending a DoH seminar on the latest White Paper to come from the office of the Secretary of State for Health. Entitled "Swinging the Wheel or Reinventing the Pendulum?" it was billed as the most radical yet of the epidemic of White Papers to have impregnated the Health Service.

Phobius was encouraged to hear that this White Paper was unsinkable — nothing could possibly go wrong. A beautifully crafted keynote speech carried a clear message. "We're not just counting the deckchairs, this time we're rearranging them."

He returned to his locality steering group filled with renewed enthusiasm. But the question remained — how to turn these ideas into the new reality. The commissioning mechanism must recognize the potentially adversarial demands of different services and find a way of mediating between them. There was surely some escape from the old impasse of rights versus utility. Phobius was attracted by the arguments of the American National Heart and Lung Institute for allocating limited resources by chance (it had always worked up to now), but he felt that there should also be some element of advocacy from the individual stakeholders. Then of course there was the perennial problem of getting a broad-based involvement in the process. No, a dreary series of committees would not do this time. It was time for distributive justice to get even.

Phobius was mulling the problem over as he took his son Fritz, with half a dozen other psychopathic eleven year olds, to Quasar, a futuristic battle simulation centre on Bromley Hill, motto "Serious Fun with a Laser Gun". After being shot by his son for the 18th time, the light dawned. Here was his big idea, the ultimate interactive commissioning mechanism.

His discussion document "Serious fun on a Commissioning Run" was accepted enthusiastically by the DoH. Phobius envisaged the pilot as a multi-level process, so he arranged for four teams of psychiatrists, pathologists, surgeons and social workers to battle it out.

It worked a treat. The psychiatrists were surprisingly aggressive. With cries of "Just because you're paranoid doesn't mean they're not out to get you," they got through rounds of laser charges faster than they normally top-sliced other peoples drug budgets for 300 quids' worth of Ripoffidone. The pathologists were rather more cautious, raising their guns to fire but breaking off, muttering "now that's probably a psychiatrist, but there again it could be a funny looking social worker'. The social workers demonstrated an impressive organizational ability, and formed an integrated peer-reviewed line-management structure, with working parties considering the various aspects of the challenge, and a separate subgroup evaluating the process. In fact they were almost ready to begin firing by the time the exercise was over. The surgeons, on the other hand, swept in firing like a group of Jedi Knights working on commission. They blasted everything that moved. Unfortunately, as they were crowded together, they mostly hit one another, until the intensity of their fire fused the Catford Substation, plunging the exercise into smouldering darkness.

The observers from the DoH agreed the exercise had been a spectacular success. Phobius had successfully headed up the workstream, and the barriers between funding streams had finally been broken down. Phobius was slightly surprised that there was now only one social worker for the entire borough, but he was prepared to run with the new community general surgery scheme ("In the convenience of your own kitchen — please remember to supply a torch"). He was a little concerned that he had not yet been reimbursed for the money he had paid to Quasar, but of course these things take time. And the reduction in elective surgery and home helps would just about balance the budget.

And of course there was the heartening news that the group's budget was about to be "rightsized" soon anyway. Well, an increase in funding would always be welcome... As Charman Mao almost said, you can't build the New Jerusalem without breaking a few legs.

David Misselbrook

emma's video...

The RCGP has been presented with an award for its *BabySafe* video in the 1998 BMA Film Competition Awards.

BabySafe evolved from the hugely successful *Emma's Diary*, a step by step guide for women throughout their pregnancy. The video picks up where the book ends, taking new parents through the first years of their child's infancy and providing tips and advice on how to create a safer home environment for their baby. Split into five sections, parents are guided through the stages of the baby's development, and are alerted to everyday hazards around the home and ways to prevent accidents. It also provides an introduction to simple first aid to help parents cope confidently in an emergency.

patient empowerment...

Dr David Brooks is producting of a book on the subject of patient empowerment in primary care. He would be grateful to receive from readers examples at practice or community level with details of their effects whether positive or negative. It would also be useful to know how and when they started and how they function. He can be reached at:
The Peterloo Medical Centre,
133, Manchester Old Road, Middleton,
Manchester, M24 4DZ
Telephone: 0161 643 5005
Fax: 0161 654 7264

desperately seeking medics...

Raleigh International, the UK-based youth development charity, requires doctors, nurses, and paramedics to staff their up-coming expeditions to countries such as Belize, China, or Chile.
Raleigh International develops young people — between the ages of 17-25 — through challenging community and environmental project work on expeditions overseas. Volunteers will be expected to look after the general health of the venturers — as the 100 or so young volunteers are known on Raleigh's expeditions — and any emergencies that may occur.
It doesn't end there; the boundary between staff and venturer is thin, with medics expected to participate in arduous labouring, constructing bridges, and carrying out research, or building clinics.
Expedition medics should have at least one year's post qualification experience, be prepared to volunteer for three months, and be aged over 25. Anyone interested in applying or wanting further information should contact Raleigh International's staff office on 0171 371 8585.

now available...

Changing Gear - Guidelines for Managing the Last Days of Life in Adults, a pocket-sized booklet published on behalf of the Working Party on Clinical Guidelines in Palliative Care by the National Council for Hospice and Specialist Palliative Care Services, 0171 269 4548. Price £1.50

HRT and Thromboembolisms, produced by the British Menopause Society, now available to any interested party at a cost of £3.50 (including postage and packing). Contact the British Menopause Society, 36 West Street, Marlow, Bucks. SL7 2NB.

... and finally...

Health and Medicine on Stamps by Tom Wilson (0 9532259 0 9)
117 pp, £10.00 stg (US $16) plus £2 postage (surface mail) and packing. Twenty-five articles reprinted from philatelic magazines during the past ten years, providing an informative insight into the many aspects of 'medicine' on stamps. They include pieces on malaria, smallpox, leprosy, heart disease, and celebrities in medicine.
From Tom Wilson, 162 Canterbury Road, Ashford, Kent TN24 9QD, England.

diary

4 June
Study Day on Counselling in General Practice
14-18 June
WONCA in Dublin
10 June
IHSM Medicine for Managers Seminar - Birmingham

8-12 September
MRCGP Course

8 October
Great Careers Debate
14/15 October tbc
Minor Surgery Course

2-6 November tbc
International Course 1998/99 Module I
tbc Learning Disabilities Conference
tbc A&E Medicine Conference

11 December
Study Day on HIV/AIDS - max 90
14/15 December tbc
Christmas Lecture - max 90

Unless otherwise stated, all events take place at...
Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU
Tel **0171 581 3232**
Fax **0171 225 3047**
Email **courses@rcgp.org.uk**

Antonio Munno

General practice frightens me. For most of the time it is a gentle stream of daily encounters. But sometimes you hit a rockpool, an area of turbulence that knocks and jars and forces you to look at where you are.

It was a Friday evening. I arrived for surgery flicking the rain from my hair. My damp shirt was stuck to my shoulders and had the earthy smell of autumn leaves. Had I not stopped off at my mother's house I would not have caught the rain. Was it worth the visit for the sake of a milky cup of tea and the depressing tone of the story of her current illness? Her mood was as black as the winter night outside. The on-going symptoms as bad as ever, the side-effects from the medication worse.

"Yes ... yes, mum. I know ..." I could hear the irritated bullying voice I know I slide into when patients veer from the narrative of their story and into self-pity. It brings with it the feeling of being backed into a corner by someone who is deaf to your protest: "Go away, I can't cope with this", is what I want to say.

I leave my mother's house in a nausea of emotion: disgust at my selfishness but with a relief at getting away. On the doorstep I kiss her cheeks. It begins to rain and my shirt gets soaked.

My surgery begins. A typical winter Friday evening list bulging with extras. Mrs B comes in. She looks tired today. On her lap is the cause of the tiredness, her four year-old boy. Her eyes are lost in the distance as she tells the story of his cough and temperature and how it has kept them both awake for the last two nights.

I finish my examination and reassure her with my findings. Mrs B runs her finger across her boy's fringe and gives him a smile. "Maybe one day you will be a doctor and you will look after mummy," she says.

The shirt on my back feels cold. I run my hand through my hair. I see myself as a four year-old cradled in my own mother's arms. How many times must she have soothed me when I was unwell? How many nights did she go without sleep to watch over me? Did she ever brush my fringe with her hand and hope that one day I would look after her?

The insight is painful.

Mrs B looks brighter. She leaves and thanks me for my help. She does not know that we have both come away changed by the encounter.

web site of the month

BJ, This Millenuim bug is bugging me! I'm increasingly worried about the New Year's 2000 behaviour of my toaster and, in an effort to relieve myself of the anxiety of sleepless nights and uncalcined bread product aurorae, I turned to our old friend the Internet (as I couldn't get through to Tony Blair)....
And guess what, the NHS Information Managment group **http://www.imc.exec.nhs.uk/2000/** have something to say about it. In a section of their website which, for some reason, presumably lycanthropic, is called the Silver Bullet, they detail how to protect your computer from the millenium armageddon. Apparently you should, amongst other things, contact your system supplier (not always an easy task — perhaps you should start now in time for New Year 2000 morning!) and do a back-up!
Other sources of information are the CSSA, BHIA, BCS, IEE groups. **http://www.cssa.co.uk/**, **http://www.bhia.org/**, **http://www.bcs.org.uk/** and **http://www.iee.org/**
These contain links to the usual suspects, IBM, Intel, and Microsoft, who all surprisingly claim to have the problem sorted (to varying degrees) and to not worry of course until they want to sell you the Universal Widget Patch the week before "00" (as the Cobol programmers would have it) that will "cure" all 2000 problems. Everyone's got an opinion.
As those tertiary specialists of the profession, the spin doctors, say: "New Labour, New Silver Bullet", take once a day with Gin; and as the website disclaimers say: "The author accepts no liability for the information here and any action is taken at the risk of the user". So don't blame me alright!!
I still couldn't find anything about my toaster. Back to the sleeping pills and cereal then.
Rob, www.schin.ncl.ac.uk

our contributors...

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Geoffrey Marsh retired in 1994 after 34 happy years of general practice in Stockton-on-Tees. He published continuously throughout that time and continues to do so...

After a gilded youth in Dundee, **Rob Hendry** has acquired mid-life respectability as a medical adviser to the Medical and Dental Defence Union of Scotland.
Paul Hodgkin is now co-director of the Centre for Innovation in Primary Care, Sheffield: a charity set up to "support innovators and innovations in Primary Care, and add to the 'foresight' capability of the profession".
Commander **Frank Minns** RN is an authority on anti-submarine warfare, grand opera, and Poussin.
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James Willis

Schrödinger's Anaemia

"I see, I think I understand now — you don't know what's wrong."

He's got it. He's here in my evening surgery to find out why the consultant he saw this morning wants him straight into hospital. Something about "ulcers". Grey, anxious face. Deep lines deeper. Brave, frightened eyes. Time to recap before he leaves to face the weekend's wait.

"Three reasons you could be anaemic..." Tick off the fingers. "... it could be your arthritis doing it all by itself, it could be the new tablets affecting your bone marrow, or it could be the naproxen giving you an ulcer in your stomach which is bleeding. So at the moment we're covering all three possibilities. You stopped the sulphasalazine as soon as I rang you. The consultant has asked you to stop the naproxen until he's looked in your stomach, and when he's done that, and we know what's going on, we can get back to treating your arthritis."

I make a joke of it as he goes out through the door, "At the moment we just have to treat you as if you've got all three..."

Except that it isn't a joke. In a very real sense, at this moment he **has** got all three. Like the quantum physicist Schrödinger's imaginary cat, which is somehow both alive **and** dead until the moment you open the box and look inside, this man really has, in effect, got all three things at once, in a kind of weird superimposition, until we resolve the matter by reading the tests.

No joke at all. It is the reality I'm having to work with at this moment. Utterly different from the reality that will appear in retrospect or to an external observer. That way it's all going to seem wonderfully simple. We're going to have a nice clear diagnosis; perhaps we will know he had a bleeding ulcer all along. Then we'll be able to write that down and perhaps code it in our computer. Fixed. Definite. Countable. Simple. That will be that. That will be **him**. But it isn't like that at the moment.

At this moment, and for that matter for the weekend ahead, he's going to go on having all three problems, mutually-exclusive though they are. Or actually he's going to go on having more than three; the subtle variations on the possibilities which are open are almost limitless. And my job, certainly, is to deal with all of them at once. So that's the way it seems when I've finished my surgery. I've seen a patient with a gastrointestinal haemorrhage, one who is profoundly anaemic from a toxic reaction to Sulphasalazine, and one whose essential treatment for rheumatoid arthritis has been summarily stopped. And that was just one of the patients, one who actually came for a different reason entirely — because he thought he might die over the weekend from something called an 'ulcer' eating away in his stomach.

So he was right, I didn't know what was wrong. And that is the way it is all the time when we are actually doing medicine, particularly when we are doing general practice. It doesn't look that way in retrospect, or to an external observer, and we often try to conceal this truth from the patients. But if we forget this we allow everybody, including **ourselves**, to vastly underestimate the size and the difficulty of our role.