viewpoint

Prepare for your retirement...

Asked his age when over 70, Harold Lloyd replied: "I am just turning 40 and taking my time about it", (*The Times* 23 September 1970). Most older people think, with Bernard Baruch, that old age is always 15 years older than we are now. Professor Livesley[1] reminds us that we all grow older and that we should act now to improve the lot of the elderly, so that growing older is truly preferable to the alternative. He insists correctly that elderly people should be included in clinical research. For example, recent research from Leiden[2] concludes that "treating hypertension does not reduce life expectancy and it might prevent functional impairment", e.g. from stroke.

Hippocrates knew, but some today forget, that the diagnosis and course of illness is different in youth and age. Not everyone would agree that "invariably in young people one diagnosis is the outcome and one body system is all that may be diseased". As students we were told: "listen to the patient, he is telling you the diagnosis!" Often in younger patients the message is clear but it is not usually quite as explicit as in "Hi! doc" medicine. We must listen with care to all our patients but especially to older ones who may have communication or cultural barriers.

Social isolation may compound treatable disability due to, for example, deafness, visual impairment, painful feet or incontinence. Regular checks for those over 75 discover these.[3] Important for the future is the prospect of postponing disability by regular physical activity,[4] healthy diet and no smoking.[5] This suggests the need for increased health education through adult life and especially at retirement.[6] Professional education is also needed to ensure that older people are treated appropriately and with dignity to avoid mismanagement towards the end of life.[7,8]

The British Geriatrics Society celebrated its half century last year. Many of the advances envisaged when the situation was reviewed in 1960[9] have been achieved. Medical progress and the trend towards integration of geriatric and general medicine has gone ahead more rapidly than some political issues such as housing, long-term sheltered or nursing care and pensions policy which, nearly 40 years ago, required urgent decision and action. Professor Livesley urges us to insist on appropriate training of medical, nursing and paraclinical staff and reform of professional examinations and continuing medical education so that our younger colleagues are able to manage our problems effectively when we retire. We also need to look after our own health and to badger our politicians to fulfil their promises.

JJ McMullan

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"the lessons from the mistakes of the 1980s carried within them, could they but be learned, the seeds of a better time ahead..."

Marshall Marinker, on the 1980s, page 1452-1453

contents

Postcard I

What's it like? Brilliant. And I met lots of friends here too, all on their holidays. Denis, looking very presidential. He has a very strong Irish connection and looked doubly pleased. Did you see his picture on the WONCA website in his Bloomsday outfit. (***wonca.ie***) John Toby smiling, as only one can when you have just been mentioned in the birthday honours. Iona Heath, looking very Vice. Mike Pringle was photographed by an Irish national daily newspaper, eating smoked salmon and Clonakilty black pudding. Tough life for the chairman elect.

Who else? Yvonne Carter, chairperson of research. Bit of a burden this title at such a junket because you must go to all the academic sessions. No coffee drinking or idle chatter allowed. Philip Evans looking very international. Almost everyone was here. Lots of other people who appear in the front half of this journal were here too. All those serious types talking shop.

Amazing to think that the entire conference centre was built just for these four days (and was completely gone 36 hours later). Bit of a problem with the background noise at first but that was sorted out. Some wag suggested that we imagine we were all in one great big Irish pub. They all seemed to understand what he meant – practice I guess. It was just a huge party from start to finish. Great music: traditional, rock, pop and jazz, and riverdance, lunchtimes and evenings. And you should have seen the stampede to the floor at the ceilidh dancing.

I suppose I should mention the academic programme. After all, we all need the PGEA points and back at the surgery we cannot pretend that we had too good a time. One of the highlights was the plenary on Monday when four doctors described what it was like to be ill and what it felt like to be a patient. Simple procedures turning into nightmares. Doctors not listening to doctors. Anthony Clare led the discussion. It was just like *In the Psychiatrist's Chair* but with 4 000 people in the audience. It was very moving; no wonder they got a standing ovation. Other highlights were the debate on evidence based medicine – I think the protagonists, Kieran Sweeney and Tim Lancaster, secretly agreed on the way forward, so the split decision was pretty fair. A bit disappointing for those of us who wanted to see some blood. Richard Smith gave some incredible insights into the future of the consultation with patients more informed than doctors as a result of the Internet, and Trish Greeenhalgh managed group work with 120 doctors.

You guys who stayed glued to the telly at home missed a great four days. With 4 000 delegates from 77 nations it was much better than the World Cup.

Domnhall MacAuley

Postcard II

I was able to attend the 15th World Conference and the WONCA Council meeting in Ireland due to the generosity of the RCGP (UK) which provided me with full sponsorship as part of the RCGP Nepal Project. I take this opportunity to thank all the authorities and staff of the RCGP, especially Dr Philip Evans and Ms Sarah Young who were instrumental in establishing this relationship.

My participation in this conference was a new experience, as this was the first time I had attended a WONCA World council meeting as a new council member. This gave me first-hand experience of the structure, composition and function of WONCA. This will certainly help me in promoting the concepts and fulfilling the objectives of WONCA not only in Nepal, but also on a broader scale, in the Middle East and South Asia Region.

This conference was attended by the largest number of delegates, 4 000, from 77 countries, giving the widest variety of plenary topics and scientific papers. Although impossible for anyone to attend even a fraction of the sessions, I found those I participated in increased my knowledge and gave plenty of food for thought. The symposium on rural health was of special interest to me for obvious reasons! I also had the opportunity to attend the WONCA Rural Health Working Party meeting.

On the social side, events were plenty and not only gave a glimpse of Irish culture but also were excellent opportunities to meet various people, including such important delegates as Drs David Game, Ramakumar, Peter Lee, the outgoing and incoming WONCA Presidents, Drs Goran Sjonell and Bob Higgins, as well as President Elect Dr Michael Boland, and the RCGP President Professor Denis Pereira Gray.

Participation in such a world event is very important to people like me who work almost in isolation in developing countries.

Shatendra Gupta

Postcard III

Along with the 269 other Australian delegates I undertook the 24-hour plus flight to Dublin to take part in the WONCA conference. As I only had six days I debated the wisdom of such a long trip for such a short time, but sitting in the huge barn-like auditorium with almost 4 000 other delegates, waiting for the opening ceremony to begin, the excitment was palpable and promised that a treat was in store. The following days made good that initial promise.

Highlights of the three and a half day conference included the depth and breadth of the posters and presentations. The focus on the humane side of medicine, began with the opening speech of Mary McAleese, the President of Ireland, when she spoke of the caring nature of family doctors and the enormous burdens they carry for the sake of their patients.This continued with a moving plenary session presented by four doctors who had suffered life threatening illnesses and how their treatment by the various medical establishments had affected them.

The smiling faces of the conference organizers and their ready willingness to help in any way made life much easier.

The down sides were the rainy and inclement weather (I thought I had come to Summer but instead it seemed worse than a Melbourne winter !) and the dodgy acoustics which made many fascinating presentations almost impossible to hear. However it was a credit to the dedication and committment of all that many audiences strained their way through a presentation that seemed like it was being presented in an echo chamber.

So was it worth the long trip? A most decided YES. The chance to interact with colleagues from 77 other countries and to ponder and discuss the many facets of general practice has generated new energy and committment and a sense of belonging to a global endeavour. Roll on Durban, 2001.

Lyn Clearihan

Postcard IV

No More Screening Please!!

My life has become surrounded by screens. Video screens, television screens, computer screens, cinema screens and advertizing screens. So when I attended (what turned out to be a wonderful day) at the Wonca Conference and sought out what I had anticipated being the non-visual, soothing calmness of lyrical voices wafting on their chosen subjects, I was horrified to find every seminar invaded and clogged with overhead, computer and slide screens.

I wish that medical presentations became screen-free zones for several reasons:

- Overheads and slides distract ones attention from looking at the speaker.
- The audience invariably fix their attention on the multicoloured abominations almost forgetting the human presence presenting.
- They invariably read ahead of the speaker.

This is probably a reflection of a wider change in society which is becoming increasingly dependant on visual imagery and less conversant with the rich oral tradition. Audiences stop listening to the speaker and start to read what is written on the slide/overhead. Thus any deviation, flourish or illuminating comments that do not appear on the screen are lost. Slides allow bad speakers to get away with bad presentations. Many speakers now just end up being readers of slides. They do not have to create a connection with their audience and can merge into the background, becoming merely an auditory aid to the visual presentation The art of oration is being eroded, if not demolished. Slides enable speakers to produce meaningless, lists of signs, symptoms, causations, side effects, interactions etc. which are unmemorable, non-prioritized and impractical. I am getting tired of “filler in” pictures of speakers’ homes, towns and universities.

The main argument in favour of slides and overheads is that they are excellent for presenting clinical, statistical data and visual diagrams in a non emotional, “scientific” format which can be scrutinized by a coldly clinical audience. I accept that for such data slides are the best medium.

However, the interpretation and application of what is learned from the analysed data requires people to make value judgements. Value judgements require people to engage in emotional and ethical topics which are more fully explored in an oral/aural tradition. The connection between speaker and listener engages a rich variety of psychological, social, emotional and analytical issues with a subtlety that is unnattainable by visual slide (as opposed to sign language) communication.

One last request, when I do die, no overheads, just oration please**.**

Austin O’Carroll

The birth of the randomized controlled trial

If you have not yet decided on your summer holiday reading, may I recommend a book whose rich contents belie its uninspiring title. *Non-random reflections on health services research*[1] commemorates the work of Archie Cochrane,[2] who inspired an international movement dedicated to the systematic collation and indexing of all randomized controlled trials in clinical research.[3]

The credit for conducting the first recorded randomized controlled trial in human subjects, though previously assigned to Fletcher,[4] should probably go to the distinguished epidemiologist Sir Austin Bradford Hill,* whose work, like Cochrane's, spanned the pre- and post-NHS era in British medicine.

Scientific progress then, as so often in history, was profoundly influenced by the pressures and constraints of war. In 1939, the young Dr Cochrane found himself a prisoner of war at the hands of the Nazis. He spent four years as a medical officer, often in sole charge of 20 000 underfed prisoners who were regularly plagued by epidemics of typhoid, diphtheria, jaundice and sandfly fever. Yet according to Cochrane's autobiography, only four prisoners died during this time, three of whom were shot by the Germans![5] This experience left him with a lifelong faith in the exceptional recuperative powers of the human body coupled with a cynical view of the real value of conventional medical therapy. It also persuaded him of the need for concurrent controls when testing the effectiveness of medical interventions.

Streptomycin, a promising new therapy for tuberculosis, was discovered in 1944 in the USA, but wartime deflation had precluded purchase of significant quantities of almost anything in dollars. Bradford Hill, working with the Medical Research Council (MRC), secured enough streptomycin to treat only 50 patients, and he persuaded the MRC, using arguments well ahead of their time, that the only ethical way of distributing this limited quantity of the drug was in a carefully controlled trial designed to answer the simple question (see Box 1) "what is the effectiveness of streptomycin in acute bliateral pulmonary tuberculosis compared with conventional therapy (bed rest)?" Bradford Hill insisted that allocation to experimental and control groups should be by random codes in sealed, sequentially numbered envelopes.[6]

Box 1: The hypothesis-driven question

The research of randomized controlled trials is designed to gain precise answers to simple questions framed in the general format of the scientific hypothesis ("If we do A, will B result?"). An important skill in applying the findings of such studies to one's own practice is to convert complex, open-ended questions such as "Should I treat (and if so, with what?)" and "What would happen if I did nothing?" into uni-dimensional, hypothesis-driven questions such as In adult patients with disease X, will treatment with drug Y (compared with placebo or drug Z) produce significant improvements in length or quality of life?"

Quantifying benefit and harm

The results of the MRC streptomycin trial are shown in Box 2. The mortality of untreated individuals over the six-month study period was 27%, a figure now termed the control event rate (CER). This mortality rate was decreased in relative terms by 74%, but in absolute terms by only 20%, with streptomycin therapy, proportions now termed respectively the relative (RRR) and absolute risk reduction (ARR). An ARR of 20% means that five patients needed to be treated with streptomycin to prevent one additional death that would otherwise have occurred – the number needed to treat or NNT.[7] The relative risk of dying in participants on bed rest alone compared to those on streptomycin – the relative risk or odds ratio (OR) of death in the two groups – was 1.27, and the number needed to harm or NNH (see box) is 1.6.

These terms, along with the confidence intervals (see below) surrounding the NNT and OR, have become accepted shorthand for expressing in quantitative terms the risks of particular outcomes in untreated (or conventionally treated) patients, and the benefits and potential harm that particular therapies can add.[8] The NNTs of some modern therapies are listed in Box 3. It can be seen that some treatments that are well established, such as giving antibiotics for simple sore throats, have absurdly high NNTs (i.e. they make virtually no difference to outcome), whereas others that have been patchily adopted, such as antidepressant therapy for neuropathic pain, have very low NNTs (i.e. they are highly effective in terms of the outcome measured).

Why randomize?

Making people better is the doctor's stock in trade. But as Cochrane's

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Acknowledgements: I thank Dr Andrew Herxheimer and Dr Brian Hurwitz for directing me to the historical sources mentioned in this article. Responsibility for any errors is mine alone.

wartime observations showed, many of our patients would get better without our attentions[5] (or because of our attentions but without, or despite, specific therapy).[9] If there had been no control group in the streptomycin trial, and if all survivals were attributed to the effect of the drug, the NNT would have been estimated as 1/0.93 or just over one patient, instead of five. In other words, the drug would have been deemed almost five times as effective as it actually was.

The unique feature of randomized controlled trials is not simply that they provide a comparable control group with which to measure the course of a disease and the non-specific response to the doctor's attention. Comparative groups matched for age, sex, ethnicity, severity of disease, and any other known feature that might be expected at the outset to influence prognosis or responsiveness to treatment, can be readily assembled without actually randomizing subjects one by one to the different groups. But it is only with random allocation that we can control for unknown or unmeasured variables. It is precisely because so much of general practice is a "grey area" – i.e. our work centres crucially on the unknown and unmeasured influences on health and illness – that randomized controlled trials are particularly necessary in primary care research.[10]

When allocation to experimental and control groups is not truly random, three distorting influences (biases) have been shown to operate:[11]

- subjects with a poorer prognosis are more likely to end up receiving the control intervention;
- the overall results are more likely to show a beneficial effect of the treatment; and
- the magnitude of the estimated benefit will be larger.

Kleijnen *et als*' review shows a "dose-response" effect of adequacy of randomization, with the largest effects of therapy being consistently demonstrated in the least rigorous experimental designs. Their findings suggest that if we accord non-randomized (or inadequately randomized) trials the same status as true randomized controlled trials, we will systematically overestimate the benefits of new treatments.

The play of chance

Although effective randomization ensures that there are no systematic differences between the comparison groups, important baseline differences (for example, in severity of disease) may still arise by chance. It is therefore crucially important when assessing the validity of published trials, especially small ones, to ensure that the groups were comparable at baseline in all features that are known or suspected to influence outcome.

Even if this is the case, differences in responses to treatment may arise by chance. The confidence interval around a result (such as a NNT or odds ratio, as shown in Box 3) indicates the range within which the "true" difference between the groups probably lies, a point that is explained in more detail elsewhere.[12] Confidence intervals that overlap the point of zero difference between the groups indicate either that there is indeed no difference or that the study was too small.

Conclusion

Randomized controlled trails are expensive, difficult to organize, and, some would say, too "pure" in design for the murky waters of primary care[13]. They cannot address complex, multidimensional questions or explore the lived experience of illness. Later articles in this series will uphold the value of other research designs, especially qualitative methods, in such contexts. But there is a real place (indeed, an urgent need) in primary care for more quantitative estimates of the efficacy of interventions, derived from rigorous randomized controlled trials and expressed as shown in Box 3. The practitioner who aspires to high qualityprimary care has nothing to fear, and much to gain, from these tools.

Trisha Greenhalgh

Box 2: Results of the first recorded randomised controlled trial in medical research, showing a) effectiveness and b) side effects of streptomycin therapy in tuberculosis

	(a) Death from tuberculosis				*(b) VIIIth nerve damage*			
	Yes		*No*		*Yes*		*No*	
Control group (bed rest alone)	14	a	b	38	0	a	b	52
Experimental (streptomycin) group	4	d	c	51	36	c	d	19

For primary endpoint of death:			
Control event rate (CER)	= a/(a + b)	= 14/52	= 27%
Experimental event rate (EER)	= c/(c + d)	= 4/55	= 7%
Absolute risk reduction (ARR)	= CER – EER	= 27–7	= 20%
Relative risk reduction (RRR)	= (CER – EER)/CER	= 20/27	= 74%
Number needed to treat (NNT)	= 1/ARR	= 1/0.2	= **5**
Relative risk (odds ratio) of dying on bed rest alone compared to streptomycin	= (1-EER)/(1-CER)	= 93/73	= 1.27

By the same calculation, the experimental and control event rates for VIIIth nerve damage from streptomycin are 64% and 0% respectively. The absolute risk *increase* is therefore 64% and the number needed to *harm* (NNH) for this adverse event is **1.6** – i.e. on average less than two patients need to receive streptomycin to produce one additional case of VIIIth nerve damage.

Box 3: Numbers needed to treat (NNTs) for some common conditions in general

Condition	Intervention/comparison	Outcome	NNT (+ 95% confidence interval where available)
Head lice	Permethrin vs placebo	Eradication	1.1 (1.0-1.2)
Acute soft tissue injury	Topical NSAIDs	> 50% pain relief	2+
Neuropathic pain	Antidepressant vs placebo	> 50% pain relief	2.5
Childhood asthma	Nurse-led education vs usual care over 4 weeks	Avoidance of hospital readmission	6.1 (3.8-15)
Acute otitis media	Antibiotics vs placebo	Absence of presenting signs at 7 days	7
Hypercholester-olaemia	Statin drugs vs placebo over 5 years	Secondary prevention of vascular event	11 (10-13)
Hypercholester-olaemia	Statin drugs vs placebo over 5 years	Primary prevention of vascular event	35 (24-63)
Shingles	Acyclovir vs placebo in acute stage	Prevention of post-herpetic neuralgia	No benefit
Simple sore throat	Antibiotics vs no treatment	Time till symptom free	No benefit

** A number of references to randomized trials prior to the MRC streptomycin trial exist in the literature. Indeed, a suggestion that sick individuals might be allocated to comparable groups to test the effectiveness of different treatments on mortality rates is found in the Bible (Daniel 1: 12-16). Fletcher's famous trial comparing a diet of brown rice vs white rice in beri-beri in inpatients whose allocation was determined by day of the week was published in 1907[a]. But Bradford Hill was probably the first to recognise the importance of, and ensure, concealment of allocation in the randomization process.*

miscellany

Senescence and Society

Do the waning powers of an elderly person represent no more than a loss of neurons, myocytes and immunity, or are they the result of a two-way process of estrangement from the environment? To what extent do the drastically reduced demands made of the aged contribute to their decline? Is society's response to increasing impairment an adjustment to the new and immutable realities or is it also a casual factor? I had occasion to ponder these questions recently as I watched a patient regress into total dependency when his caretakers' main purpose became to prevent injury from unguarded or unanticipated movements. The outcome was a kind of disuse atrophy pertaining to activities of daily living: stiffening of joints, loss of coordination and curtailment of sensory input, all of which appeared to worsen the predicament of very advanced age.

As social animals, human beings require intercourse with others in order to test themselves and to receive nurturing provided by feelings of affection and approval: "The joy of being observed ran so deep that ... the real pain of old age, bereavement, outliving one's friends, was the absence of scrutiny – the horror of living an unobserved life."[1] When Shakespeare spoke of our biographies as being enacted on a stage where "... one man in his time plays many parts",[2] he must have had this need for an audience in mind. The many parts are our interactions with people, for each of whom we are someone else.

The giving up-given complex[3] is apposite to the questions raised above. It was formulated to explain why certain people with stable chronic illness can take a sudden turn for the worse without their physical circumstances seeming to warrant it. Although, in general, the giving up seems to precede being given up, the possibility that the reverse order also applies on occasion must be given consideration. Thus, society, for its own convenience, might give up on an elderly person and determine his or her fate.

A woman of 86, living with her daughter and the daughter's young family, is a accustomed to drying the dinner dishes. Her eyesight is failing and she has a tremor but, somehow, she manages to get the job done every night. As long as this is the case, she feels part of the household, contributing to the general welfare. One evening, she drops an expensive disk and it is then decided that she "is no longer capable" of performing the chore because she cannot see the edge of the draining board and her hands shake. Her ecological niche was, for most part, made up of small services rendered and received. Once she could no longer be of use to others, she lost it and the price was exemption from the give and take defining human society. While the exemption was "justified" from the point of view of functional status, it had a dynamic of its own with a potential for accelerating decline.

A chief ingredient of a person's sense of self is the way people react to him or her. Children with attention deficit or hyperactivity disorder, organically impaired to a minimal degree, often have "secondary" psychological manifestations stemming from the impatience, anger and exasperation their behaviour invokes.[4] The elderly, too, respond to the manner in which they are handled. When their useful activities are restricted, even if the idea is to protect them from harm, they may experience resentment and a sense of hurt.

Illich maintains that senescence is not a disease and, therefore, has no cure.[5] Nevertheless, it is continually being medicalised as evidenced by things ranging from the speciality of geriatrics to a preoccupation with ethical implications of health expenditure incurring during a person's last year.[6] While it is certainly true that there are medical problems the prevalence of which rises with age, such as changes in renal and hepatic function and their consequences for polypharmacy, also frequent among the elderly, none is truly specific to this time of life. neither is the concept of terminal care which can apply to providing support for the family of a child with an advance malignancy as well as to Alzheimer's disease in an octogenarian.

Rabbi Eliezer Ben Hyrcanus once said: "Repent one day before your death."[7] His pupils, taken aback, questioned whether a person has advance knowledge of his or her impending demise. Rabbi Eliezer replied: "Then repent every day, for you may die tomorrow". Since the last year of life is nearly always diagnosed in retrospect, it behoves those who deal with the elderly to re-evaluate their attitudes and policies on a daily basis, thus ensuring that the harm done by society's responses will not exceed what nature brings about in promoting decline.

Joseph Herman

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Lifts – Up and Down

The lift at 14 Princes Gate is something of an institution. Built some time in the early 1900s it is a notable feature of the College, famed because the younger Kennedy children used to play in it. Now, its distinctive appearance provides a talking point for visitors to the College.

Sadly, the lift no longer conforms to modern safety and fire standards. Its rather eccentric behaviour over recent months has indicated that it is time to modernize the lift completely. Planning permission and listed building consent have been sought from Westminster City Council and English Heritage, and Axis Elevators Ltd have been appointed to carry out the necessary work. This will include:

- A new, more substantial steel framework for the lift car;
- A flat area on top of the car enclosure to support a maintenance engineer;
- A new car enclosure built from steel panels; and
- Side opening automatic doors on the car and at the landings.

Thirty years ago, the maintenance contract for the lift cost just £53.15.0d. This time round, the work will cost considerably more!

Perhaps the most important thing for College members, staff and visitors to know is that the work will begin in August 1998 and will continue for roughly 12 weeks. So it's time to start using the stairs and get fit for the summer!

A short history of socialized medicine... 10

NHI to NHS – Social Medicine between the wars

As National Health Insurance (NHI) dawned in 1913, surgeries were besieged by patients seeking registration and free medicine. Panel incomes (and drug costs!) were higher than expected, pay being mostly by capitation. Local funding pools were derived from "Approved Societies" (insurance and friendly societies) and included a floating sixpence – a possible bonus from drug-budget savings. Guidelines on prescribing followed, and local panel committees were empowered to investigate abuses. In 1922, drug costs reached some £1 337 300, and local pricing bureaux started collecting data. Patients in Leeds were prescribed an average of 4.5 prescriptions annually, compared with 3.1 in Bradford. Chemists were authorized to substitute generics and the first national formulary appeared in 1929. General practitioners, including one who ordered 520 lbs of cod-liver oil and malt for 179 patients, were interviewed by Regional Medical Officers (RMOs). However, of 1885 practitioners investigated in 1930, only 13 were punished.

NHI also covered sickness benefit and lax certification, attributed by the Approved Societies to malingering and doctor's anxiety to recruit new patients, was a bigger problem. Under pressure from the societies, the 1931 economic crisis forced the Ministry of Health to get tough, seeking to make an example of a Dr MacQuilan, 71% of whose Aberoycham patients were declared fit by RMOs (his locality averaging 51%). The doctor admitted he had given the patients the benefit of doubt, but when a fine of £10 was proposed, he demanded to be told which patients did not deserve a certificate and the Ministry had to climb down!

The 1920 Dawson Report, commissioned by Health Minister, Dr Christopher Addison, recommended development of GP delivery of health services by building health centres and expanding preventative work. A 1930 BMA scheme contained further proposals including specialist, dental, laboratory and nursing in the insurance model, but there were competitors – local authority medical services were in their heyday and public health doctors preferred a salaried service with GPs under their control. All was not roses with the NHI – the Approved Societies had failed to expand to include dependants and specialist treatment, using their profits instead to attract members (mostly from friendly societies) through dental and optical benefits. Capitation narrowed the range of GP procedures, as out-patient clinics converted from competitors to specialist referral agencies – nonetheless medical advisory boards considered D&C, treatment of leg fractures, incision and drainage of breast, neck and ischio-rectal abscesses and drainage of advanced hepatic ascites, all part of GP care!

As the war loomed hospitals were forced into the Emergency Medical Service, demonstrating a non-insurance model of health care. Commissioned to design a comprehensive post-war social insurance scheme to tackle his five evil giants, Beveridge included a treatment service in his report which was circulated to all troops in 1942. The subsequent NHS GP service expanded to include dependants, but utilized the insurance structures (minus the Approved Societies!) and the Lloyd George envelopes established by NHI 35 years earlier.

Jim Ford

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the 80s

Let me begin with a caveat. This will be a partial history, partial, in the sense of brief and therefore incomplete; partial, also, in the sense of partisan. I was, like most of my readers, a bit player in this drama.

Margaret Thatcher became prime minister in 1979 and quit office in 1990. Thatcher governed with a Big Idea – the virtue of the liberal market. The last time the country had been governed by idealism rather than pragmatism, was uvin the latter 1940s. Then, the Big Idea of Atlee's post-war Government was socialism. The outstanding and lasting legacy of that socialism was to be the NHS. From the point of view of health care, the lasting legacy of Thatcher's market idealism was to be the notion of illness and care as commodity, the primacy of efficiency, and the subsequent expression of this in the attitudes implied, for example, by the values of quality adjusted life years (QUALYS).

By the start of the 1980s, the now familiar problems of escalating costs, stimulated consumerism, lengthening waiting lists and media shroud waving, challenged Government. The following seems to have been their analysis, and consequent political bind:

- The public exhibits a growing and endless appetite for medical "goods"and expectations will rise;
- Demographic and bio-technology forecasts suggest an exponential escalation in activity and cost;
- The NHS is bedevilled by "provider capture" – the clinicians command the use of limited resources, driven only by their untrammelled belief in what is clinically achievable, or desirable, or, at any rate, interesting;
- As a matter of party political belief, public expenditure is not to be expanded or supported by further taxation; and
- It will prove politically impossible to dismantle the NHS (even though as the biggest of the nationalized industries, it must have seemed a very tempting prize to a radical Conservative Government hungry for privatization).

The liberal market changes proposed for the NHS in *Working for Patients*,[1] and the mysteriously contrasted but contemporaneous command economics of the New Contract for general practice, were not to appear until the end of that decade. But clues of what was to come were there throughout the 1980s. For general practitioners, the opening of the decade was a time of great hope. David Morrell called them the "happy years".[2] General practice had come of age in the university and the medical profession (it was the career of choice for the majority, including the most promising, of medical students), and its literature burgeoned.

This was the decade which included John Horder's[3] and Godfrey Fowler's[4] advocacy for health promotion and preventive medicine; the fruition of Paul Freeling's[5] work in the Nuffield courses; David Pendleton's original deconstruction of the consultation;[6] the publication of *What Sort of Doctor*?[7] (an attempt to define closely the desired characteristics of the general practitioner and the means of auditing them); Julian Tudor Hart's[8] public health agenda for general practice ("the fusion of epidemiology with primary care"); and, crucially, the College's *Quality Initiative*, devised and led by Donald Irvine.[9]

It was these ideas, many emanating from College working parties, or endorsed by the College, that informed Kenneth Clarke's Green Paper in 1986.[10] It advocated distinguishing those doctors whose performance was significantly above the average, and rewarding them with a "good practice" allowance. Denis Pereira Gray, Alan Maynard and I immediately published a series of three essays in the *BMJ*,[11] examining the possible links between contract and quality. We were largely in support of the Green Paper proposals and urged that they be explored by the profession. The profession, including the College, thought otherwise. The last of these articles ended with the prophesy that, in the absence of a positive response from doctors, Government would eventually administer much more drastic medicine.

From the moment when, two years later, in the course of an interview on BBC TV's *Panorama*, Margaret Thatcher suddenly conjured up her own review of the service, there followed a furore of new thinking - not least in think-tanks on the political right, and among civil servants in the Department of Health. The College leadership was widely accused of secret involvement, and collusion, with ministers. This simply did not happen.

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The accusation was based on the unsurprising fact that the opinions of a number of general practitioner activists and academics had long been canvassed informally by civil servants and others. I was one of those invited to engage in such discussions. In 1984 I had taken part in a small think-tank, under the leadership of Lord Vaizey, in which we were enjoined to think imaginatively about how the NHS might be improved and reconfigured at the end of its first half century. Among the twenty participants were a number of leading health economists, the Chief Medical Officer, and the Accountant General of the DHSS. Our assumptions (certainly mine) included both a total commitment to the principles of the NHS, and an acceptance of the necessity for radical change.

The essay which I contributed to the subsequent publication set out an "experimental model" of what I called a franchise for primary care "budget holding". More audacious still, Alan Maynard, a fellow think-tank member, suggested that this model could be extended to include the purchase of some elements of secondary care. This was to be a carefully evaluated experiment. I wrote "In order to provide minimal arrangements for such experiment, it may be necessary to establish something analogous to the present "enterprise zones", for the National Health Service.[12] These tentative ideas, designed only to provoke discussion, were totally ignored. As one very senior civil servant put it to me at the time, "It's too late now for experiments. The Government wants action".

In terms of the development of general practice theory, of teaching, research and morale, most of the 1980s may well be recalled in Morrell's nostalgic phrase: "the happy years". Throughout most of the decade, the doctors I met on the MSD Foundation Leadership courses, in all regions of the UK, were inspirational in their energy, innovation and commitment. But the decade that had begun so brightly for general practice was to end in tears. Whatever criticism and blame for this may properly be ascribed to the Government and Department of Health, in medico-political terms I believe that the profession sleep-walked through 10 years of missed political opportunity.

Perhaps this is too harsh a judgement, and I should qualify it. The BMA and the GMSC are democratically elected representative bodies, and can claim that in failing to engage seriously with the Governments various radical proposals, they were faithfully expressing the will of the vast majority of their electorate. It has also been put to me with some force that by the time of the publication of *Working for Patients*, and the *New Contract*, the Government was in no mood to listen to the profession, and that the only political response possible was obdurate opposition.

Could the College have played a more constructive part? Its determination to show solidarity with the GMSC, and with the majority of doctors, may have appeared responsive and responsible at the time, but was, I believe, an unfortunate mis-reading of its academic role. In its anxiety to "hold the line", I believe that the College failed to engage the Government in intellectually tough discussion of its emerging policies. This meant that crucial insights and evidence from general practice research, and above all from general practice values, went by default.

The irony of the events of the 1980s was that, at the close of the decade, general practice found itself in a world of escalating responsibilities, and minute accountability for clinical, public health and managerial performance, which College leaders and working parties had largely invented, but which the College played almost no part in shaping.

If I am critical of others, I am much more critical of myself. In the 1980s I made some significant mistakes. Among the ideas I explored or canvassed, some were to bear some fruit. Others were to prove morally hazardous in the execution. The conflict between patient advocacy and distributive justice was more problematic than I had predicted. Competition in health care proved, in the end, to offer only a mirage of progress: the cost in lost cooperation was great; too easily fraternal competition for quality could be transformed into commercial competition for price. Yet the lessons from the mistakes of the 1980s carried within them, could they but be learned, the seeds of a better time ahead.

Marshall Marinker

Willie Fulton

Readers may have heard of the death of Willie Fulton, who died aged 81 in early June.Willie contributed the first in our series *NHS 50*, published in the May *Journal*. I had asked, late as usual, for the piece one lunchtime in early April. Six hours later he appeared, elegantly besuited, on my doorstep with the typewritten manuscript. Editors dream of such behaviour.

When I arrived on the West of Scotland faculty board in 1990, a callow youth of 30-something, Willie Fulton was the faculty's provost. He was renowned above all for an encyclopaedic knowledge of the Red Book. He could probably have recited it verbatim and correctly punctuated. But in the last 10 years I learned, as many have done before me, that his skills extended well beyond the dry jargon of medical politics. He was committed utterly to the NHS and to general practice. He was a founder member of the College, a visionary proponent of postgraduate education, and for decades the secretary of Glasgow LMC.

He was a truly great man, and will be sadly missed. He is survived by his wife Elsie Gordon, also a GP, and a plethora of children and grandchildren.

Alec Logan

digest

Has general practice lost its way...?

General Practice under the National Health Service, 1948-1997
Eds **Irvine Loudon, John Horden and Charles Webster**
Clarendon Press, London, 1998
HB 329pp £45 (0 19 820675 5)

The photograph on the cover of this important record of the first 50 years of NHS General Practice shows a baby at the centre of a traditional consultation looking straight out at us, as though asking an important question. The question may be the one posed in many of the distinguished contributions inside: in spite of the phenomenal progress recorded since the Collings Report of 1950, has general practice lost its way?

The story of these two great, parallel adventures, General Practice and the NHS, is told here in a series of contrasting essays, bound together by David Morrell's fine introduction and John Horder's equally fine conclusion. On first acquaintance the book looks serious, as indeed it should, but wherever it is opened the reader's interest is immediately engaged. The eye falls first on the tables and charts, for example the one showing the astonishing changes in the pattern of diseases in the UK between 1950 and the mid-1990s.

This collection alone will be an invaluable resource on library shelves. The Chronology chart is fascinating too, though oddly patchy; 1990 appears much less eventful than I remember. This perhaps reflects the broad, historical perspective of the editors, resulting in five references to Kenneth Robinson in the index, quite rightly, while the more recent Kenneth does not appear at all.

Few readers perhaps will read the book straight through, but those who do will find some fascinating juxtapositions. Nick Bosanquet and Chris Salisbury on "The Practice" for example ("Soon there would be links with hospital pathology for results to be downloaded directly into patient's electronic notes.") immediately preceding Marshall Marinker's remarkable essay, " 'What is Wrong' and 'How We Know It' " ("Subtly but radically these shifts of emphasis redirected what Foucault described as the doctor's 'gaze', that is to say, the assumptions about what is to be looked at, and looked for.") Venn diagrams of these two views of practice would not overlap at all, but both views are certainly needed to make the picture.

It is almost inevitable that a book of this kind is a chronicle of great men and women written by great men and women (though neither inevitable nor fair that here all of them are white). But the great achievement of general practice has been a myriad of unrecorded deeds by unknown doctors. In this we may find a clue to the "prevailing ambivalence of the general practice community towards its academic wing" which John Howie so correctly decries in his chapter on the massive accomplishments of general practice research. To "the general practice community" this book may seem to be something of an "Authorized Version". Almost, "General Practice from the Outside". Not really what it felt like at the time. This is no trivial complaint if we want to go on motivating a new generation who do not have a wilderness to tame.

Some of the most significant changes receive little or no attention; the growth of large partnerships, the arrival of women (welcome, of course, welcome), deputizing services, the management revolution, the imposed change from "service" ethos to "market" ethos, pressures to undermine the confidentiality of medical records. As for the usurping of clinical freedom, it is left to Ian Tait and Susanna Graham-Jones to quote the wise words of Bacon: "the price tag of clinical freedom for the generalist is worth the expense".

But the triumph of the book is that it does address the central question; the question which the baby on the cover appears to be asking. Horder puts it clearly in his closing words (but it appears in many voices throughout), "Erosion of the tradition of personal care is now a real danger, and its preservation is one of the great challenges we face in these times of uncertainty and confusion over the future direction of the NHS and of general practice within it."

Yes, we have made incredible strides, general practice and the NHS are amongst the achievements of which this country has most right to be proud. But Tait and Graham Jones, again, highlight the paradox, "However, in terms of the things patients value most in their general practitioners the picture (of progress) was far less clear."

James Willis

Rehabilitation of the physically disabled adult Second Edition

Eds **C John Goodwill**, **M Anne Chamberlain**, **Chris Evans**

Stanley Thomas (Publishers Ltd) 811pp (07487 3183 0)

When present disability limits choice and threatens independence and this should concern family doctors greatly.

In the UK one person in eight has some form of disability.[1] Thus a GP with an average list of 2000 patients will be looking after 250 patients who can be described as disabled and who will present a wide range of needs.

Rehabilitation is aimed at restoring the right of choice to the individual and according to WHO includes "all means aimed at reducing the impact of disabling and handicapping conditions and at enabling disabled people to achieve optimal social integration".

Rehabilitation is a recently developed speciality only really emerging in the 1980. Thankfully since then progress has been rapid. Yet it does not figure prominently in the undergraduate or postgraduate learning programme which is a serious omission considering the prevalence of disability in the population.

When talking to people with a disability and their carers one of the most frequent remarks they make concerns the lack of knowledge of professionals about the range of services available for disabled people. There is obviously a knowledge gap which is precisely why the emergence of a second edition of this valuable book should be warmly welcomed.

The editions have called upon the knowledge and experiences of 68 contributors and the result is a highly comprehensive publication which is divided into nine parts dealing successfully with Setting the scene, Muscular skilled disability, Energy restricting disability, Sensory and communication disability, Neurological disability, Common medical problems, Care and therapy, Equipment and Living at home in the community.

In spite of the multi-authorship the book reads well and in this is tribute to very skilful editing. In contains a wealth of information which should be of tremendous value to all charged with the care of disabled people, it should certainly be in every practice library and consulted frequently.

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Colin Waine

The MRCGP Examination – A guide for candidates and teachers Third Edition

Richard Moore

RCGP, 1998

PB 218pp £21.50 (£19.35 members) (0 85084 7 218)

The *MRCGP Guide* has reached its third edition within only five years, testament to breathless change to the exam itself. The new edition does help registrars, and especially their trainers, keep up.

It is, however, more than a simple exam guide; it makes several important points about the role of the College in determining quality, the meaning of membership, how we value ourselves as a profession and the future of general practice. In his editor's comments, Professor Denis Pereira Gray, discusses the origin and development of the exam and makes several cogent and well argued points in its favour and also looks forward to when it may become a mandatory entry point to the profession. Overall the changes do appear to make sense; the four-hour video has been quickly and commendably dropped and has been replaced by a requirement for a tape of 15 consultations, or in exceptional circumstances simulated surgery. The PEQ has been abandoned as it generated a lot of work but had been found to be of little practical use in assessment. The written papers have also been redesigned to test the "application of knowledge rather than the mere possession of it".

The exam now follows a modular pattern, but all parts must now be passed in their own right – as elegantly stated by Roger Neighbour, clumsy interpersonal skills should not be overlooked because the doctor happens to be a world expert on pityriasis rosea. Other changes are that the MCQ of the MRCGP can be passed and used to gain exemption from that component of summative assessment, in theory commendable, though surely unlikely that registrars would restrict themselves to this path – obviously you can practice having passed summative assessment but not the MRCGP.

The exam revisits a familiar problem for GPs in that it is not change that disturbs us, more the pace of change. It is argued that this represents evolution, not revolution, and was necessary to reflect the increasing complexity of our work. We are reminded that general practice is now the leading speciality in assessment as well as education.

All laudable, but the process seems more Maoist than Darwinian, and here you have to examine the role of summative assessment. The authors seem unclear whether this has been a welcome catalyst for change, or an unexpected spanner in the works, with adverse effects on training. A number of problems are identified; there is considerable duplication of work and many registrars have the impression that they are white rats in an educational laboratory, viewing the assessment process as a series of hoops to jump through. There is a danger of turning the registrar year into a test of stress management rather than an enjoyable period of professional and personal development, with time for reflection and genuine evaluation.

All this makes the move to an 18-month period of training even more necessary, and is it too naive to assume that it is not beyond the guardians of the College exam and architects of summative assessment to construct a more user-friendly unified assessment package.

Niall Cameron

AUDGP 5-a-side football tournament
Thursday, 9 July (17.15-18.15), Heriot Watt indoor pitches

If anyone attending the AUDGP annual scientific meeting in Edinburgh would like to drag themselves away from the televisual spectacle of Scotland preparing for the World Cup final in the early part of the second evening of the AUDGP conference please let me know. I have reserved a five-a-side indoor playing area and will organise a tournament depending upon the number of individuals or teams who wish to play. Departments may enter entire teams but are advised that attempts to win the prestigious and newly historic trophy may beconfounded by the regulation that all teams must be stratified by ageand sex to ensure representativeness. I can assure everyone who wishes a ticket to spectate that they will not need a French passport to qualify.

Frank Sullivan,Tayside Centre for General Practice
(Tel: 01382 632771; Fax: 01382 633839;
Email: *f.m.sullivan@dundee.ac.uk*)

The Doctor, The Detective, and Arthur Conan Doyle
Martin Booth *Hodder and Stoughton* HB, 371pp, £20.00 (0 340648997 X)

"A man cannot spin a character out of his own consciousness and make it really life-like unless he has some possibilities of that character within him". Conan Doyle was Sherlock Holmes – or was he? Holmes was Conan Doyle – or was he? Does it matter? The above quotation, from Conan Doyle himself, gives some sort of answer but – in any event – most of us rest content that he created the greatest of all fictional detectives, and are happy to remain forever in his debt for having done so.

There was, though, far more to him than his writing, as Martin Booth's thoroughly researched biography shows. Conan Doyle embodied all the certainty and superiority of the Victorian and Edwardian era, living by the strictest moral code; a devoted family man; a sportsman; a patriot; a fighter against injustice – a model of the rectitude of his time whose life became, in a real sense, a panorama of that time. He played cricket with WG Grace. He met and greatly admired Oscar Wilde. He knew HG Wells. He shared interests in cricket and spiritualism with JM Barrie (they collaborated on an operetta for D'Oyly Carte, and Conan Doyle helped care for him when Barrie's chronic bronchitis worsened).

Paternal depression and alcoholism shadowed his Edinburgh childhood, while his remarkable mother held the family together as they drifted in near poverty from one neighbourhood to another. She inculcated in him a lifelong habit of omnivorous reading; she taught him French; she encouraged him to write stories, and she arranged sufficient family help for him to go to boarding school and hence back to Edinburgh, where, at her prompting, he read medicine. He found both curriculum and teachers uninspiring, with the great exception of Joseph Bell, the surgeon who became the model for Sherlock Homes and who, like Holmes, would observe where others merely saw, and listen where others merely heard.

His gave up medicine, aware that he lacked the competitive edge necessary for success, while realizing that he might be able to earn his living as a writer. His reading had led him, unimpressed, into an exploration of detective fiction. His own first effort in the genre, *A Study in Scarlet* was his first Sherlock Holmes story; he sold it for £25, relinquishing all rights in his anxiety for publication. Holmes was not, though, the first scientific fictional detective. Poe – to whom Conan Doyle would always pay generous tribute – had written similar stories 40 years previously, featuring the detective Auguste Dupin. Holmes and Dupin were alike: eccentric, arrogant, each supported by a prosaic and loyal partner. It was Holmes, though, who developed as a character – human, flawed, conceited, consistently and intolerably right. His incredible stamina, his mastery of disguise, his violin playing, and (most intriguingly) his cocaine addiction, all served to flesh out the printed page. And, as he developed, so did his follower, Watson – the one a mysterious, aloof genius; the other a brave and loyal henchman.

After *A Study in Scarlet* Conan Doyle began work on his great historical novels, *Micah Clarke* and *The White Company*, both hugely successful, together with the creation of Brigadier Gerard and Professor Challenger. But the public demanded more Holmes and the second Holmes story, *The Sign of Four* followed, with, at last commensuate income.

It was Conan Doyle's luck that the advent of Sherlock Homes coincided with the development of the popular magazine – notably *The Strand*, in which 12 of the Holmes stories were published. *The Strand* was responsible for the lasting image of Holmes, in Sidney Paget's illustrations – the piercing eyes, the hawk-like profile, the pipe and the deerstalker hat. The success of the stories frustrated Conan Doyle's desire for recognition as a historical novelist, and so Holmes had to die, in that titanic struggle at the Reichenbach Falls. (His creator commented: "a worthy tomb for poor Sherlock, even though I buried my bank account with him.") Eventually, of course, Holmes had to return, in *The Strand* of course, to an ecstatic welcome with crowds blocking the streets in the rush to obtain copies.

Conan Doyle's concern with honesty and fair play involved him in attempts to correct major miscarriages of justice. He exposed the criminal exploitation of the native workforce in the Congo Free State, publishing *The Crime in the Congo* – typically at his own expense – and spoke all over the country, doing his best to overcome international political inertia. In addition to his writing, he involved himself in politics, divorce law reform, and in fights for religious freedom and tolerance.

Martin Booth's book describes this complex life in great detail. The prose is occasionally a little dull with, equally occasionally – odd errors in style and proof-reading; but overall, a fascinating portrait, of a fascinating man.

At the end, though, it is the Sherlock Holmes stories which are central to everything and which, as Booth comments, made Conan Doyle the first "Blockbuster Novelist". And it is for these that we most remember him; the creator of that wonderful world of fogbound Victorian London, where, at 221B Baker Street, a middle-aged man is woken out of his fireside doze by the urgent summons, "Come, Watson! the game's afoot!".

Michael Lasserson

Gallstone Grove, tales from tomorrow

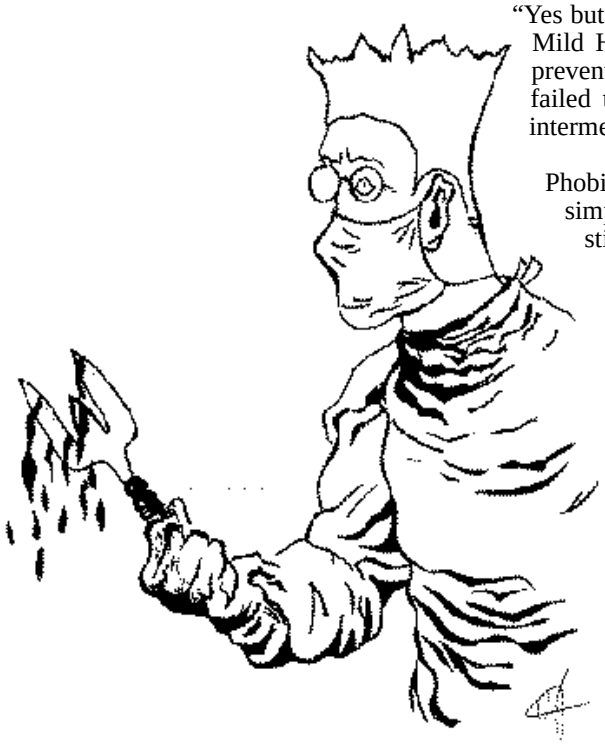
Episode 6: It's logic Jim, but not as we know it...

All the diagnostic signs were there. Insatiable cravings for gardening tokens, obsessive anxiety as to whether the new Fremontodendron was the evergreen hybrid. Let's face it, Phobius was at that awkward phase between recognition hunger and frank middle age. What he needed was a break, and he was planning a sabbatical with attitude.

Phobius was working his last week, and in a playful mood. The new registrar, Jim Fixit, was working out much better than his last. Three months in the post and still not stuck off. Phobius felt it was time to introduce him to the heady joys of evidence-based medicine. Phobius had read a historical feature in the ever popular *Scandinavian Journal of Irreproducible Results*. The author had analysed the absurd fashion of bloodletting in pre-scientific medicine. Having taken into account the incidence of secondary polycythaemia in the days of untreated COAD, and the acute benefit to be obtained in LVF (with all those dodgy post-rheumatic valves around) he estimated a number needed to treat of 50. While it was by and large harmless (most blood donors seem to survive) the evidence clearly showed disbenefit to be more likely than benefit. He thought it would be instructive for Jim to compare this article with the evidence for a common modern management protocol.

This was timely, as Jim had been reflecting on his consultation with Mrs Mansard-Roof, a new mild hypertensive: "She came into my surgery thinking of herself as well, but by the time she left she seemed somehow to have become ill. She said that since her last visit she had tried to forget about her blood pressure, but that now she kept on worrying that she might have a stroke. I haven't seen a patient so worried since the MRI scanner got stuck on its spin cycle."

"Well" replied Max, "you have simply alerted her to reality. We have science, we have evidence, we have 'NO MORE ANGST' decision support software. The world of general practice is rich with indeterminacy, which we can only tame if we apply Bayesian logic. We never know what an individual outcome will be, but we must take all factors into account to give the greatest probability of benefit. Coming to terms with disease is never easy. One has to expect a loss reaction."



"Yes but I thought mild hypertension wasn't a disease but a risk factor. The MRC Mild Hypertension Trial showed you have to treat 850 patients for a year to prevent one stroke; 20% stopped due to side effects, and the treatment mostly failed to prevent strokes anyway. I have made my patient feel ill to treat an intermediate outcome which gives her only a marginal benefit."

Phobius couldn't help feeling that this evidence stuff didn't make tutorials any simpler. What on earth were registrars coming to these days? Much better to stick to the NO-MORE-ANGST protocols. Jim hadn't quite finished...

"Also Stoate found that screening well people can have a negative effect on their General Health Questionnaire score. And what about Jachuck's finding that a label of hypertension can have profound negative effects on the spouse? The evidence shows that I do more people harm than good by treating mild hypertension, and that the harm is not trivial. Evidence bends easily enough to fashion. Why do I give out antihypertensives with an NNT of 850 per year. And yet rubbish bloodletting with an NNT of 50 per episode?"

"What an excellent question" replied Phobius, desperately seizing the initiative before Jim could demonstrate the superiority of Morris Dancing over streptokinase in acute MI. "Can I suggest you seek to clarify the point as a project, while I am pursuing my own researches into the beneficial effects of flavinoids and phenolic substances produced by the traditional fermentation processes advocated around Bordeaux."

Yes, it was time for a Sabbatical. After all, evidence bends not just to fashion but to taste. And as Phobius' previous Registrar always said, a cat in a bag troubles no man.

David Misselbrook

Dr Phobius *et al* are now on extended summer leave. They may re-appear at Christmas. In the meantime an exclusive range of Phobius casual wear may become available if anyone is interested.

80 sites on the Net

I would like to inform readers that I have collected (after a great deal of surfing) 80 UK General Practice Internet Web sites. The collection is growing daily. When I first started the collection two years ago there were only four websites. The collection shows the fort or home page of each of these sites as an image. Each picture can be "clicked on" and acts as a hyperlink to that site. There is also a brief description of each General Practice Site for background information.

This unique collection of sites is an invaluable resource for any GP who is intending to create a General Practice Website for themselves. This the largest and most up to date collection in the world. There is a free password for security reasons to access this page (similar to most accredited authentic medical sites such as *epulse*, *Medline*).

By publicizing the site I hope to generate further submissions to the collection and keep it up to date. The site is completely free and will remain so.

The following URL gains access to the site:
http://www.internet-gp.com/gp.htm
Any practitioners wishing to contact me about these sites are welcome to write to me, telephone me, e-mail me, fax or complete the forms which are available at the above Internet address.

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30 years on the Pill

In May the RCGP celebrated the 30th anniversary of its unique and world-renowned study into the safety and effects of the oral contraceptive pill on women's health.

The RCGP Oral Contraception Study was set up in May 1968, recruiting 1400 GPs and 47 000 volunteer women throughout the UK, half of whom were using oral contraceptives, the other half had never done so. Over three decades the study, which has become one of the largest detailed investigations into the pill worldwide, has highlighted many important and significant links and risk-factors between the oral contraceptive and a variety of medical conditions.

It was among the first to show that the risk of cardiovascular disease among pill users is concentrated mainly in users who smoke, especially in older women. The study was also the first to demonstrate a link between risk of hypertension or arterial disease and the progestogen content of the pill. The study also confirmed many beneficial effects of the pill, including a lowering risk of ovarian and endometrial cancer. Recent studies carried out have indicated that there is no evidence of a persisting or emerging latent risk of disease in former users.

The wealth of information gathered over the years has also enabled researchers to examine other issues relating to women's health, including the long-term cardiovascular effects of pre-eclampsia, the characteristics of HRT users and the determinants of stroke in young women.

The study, which is led by Professor Philip Hannaford, Director of the RCGP Primary Care Centre for Research and Epidemiology at the Department of General Practice and Primary Care in Aberdeen, has become a world leader in its findings which have influenced clinical practice across the globe and has developed into a valuable source of information about the factors influencing the health of women living in Britain both today and those over the past 30 years.

One hundred million woman around the world are currently using oral contraceptives.

general practice archives

'It is clear that general practitioners, at the close of the 20th century, still operated much as their predecessors had done. Most serious illness was managed in hospital, and although they bitterly resented the suggestion, they had been unable to disprove Lord Moran's quip that they were the doctors who had fallen off the ladder'.

A fictitious conclusion from a mid-21st century analysis of our work, but one which may be arrived at from an examination of the archives we are currently leaving behind. The danger highlighted nine years ago of "reaching the absurd position that records from general practice in the second half of this century are scarcer than those of the 18th and 19th centuries", has not receded in any way. The principal record of our activities, patient's records, are destroyed after their death. (This is not inevitable. Permission can be obtained from health authorities and boards for their retention by GPs.) The other items of documentation that is part of the GPs contract since 1990, practice annual reports, are not routinely retained so as to be available to future researchers and their obligatory content reveals little about the nature, scope, quality and outcome of the services provided.

The wealth of academic papers about general practice, which have burgeoned from virtually nowhere in the last three decades, are not a substitute for records from actual practices, and the more the better. Although almost anything could be of value to a future researcher, historians appreciate records that are comprehensive, continuous and which may be placed in context. That does not mean everything should be saved. Besides annual reports, many practices have been carrying out audits of varying aspects of their work in the last few years. Registrars and visiting medical students typically carry out small studies, and practice meetings are often minuted. Campaigns to save cottage hospitals often generate correspondence, and there are doubtless other sources of interest too.

Those considering depositing records may contact county record offices, but these may be uncertain about access to confidential information from which it may be possible to identify individuals. The Wellcome Contemporary Medical Archives Centre is experienced in these problems and is willing to advise potential depositors. Access is usually allowed to *bona fide* scholars provided nothing is published that could identify patients.

Before destroying by intention or neglect the records of their work GPs should consider the purpose of leaving good records of their endeavours to future generations. A glance at any journal of 10 years ago is to re-enter a world we have probably left forever. Ensuring that there survives sufficient evidence for others to appreciate the variety, quality and struggles of general practice in the closing years of this millennium is merely to do our colleagues and ourselves justice.

John Holdon
Julia Sheppard

Blair Smith

Apollo

Apollo's essential domains included poetry and medicine and he was the deity by whom Hippocrates' graduating students swore an eponymous and poetic oath. This same oath is sworn by today's graduands, with modern variations: the language has been pedestrianized, secularity conferred, and the clause concerning abortifacients removed. The British Medical Association, on behalf of the World Medical Association, has famously and lengthily considered a radical re-write of the Hippocratic oath, to reflect the modern face of medical advances and ethics (and preserve the essential mystique and exclusiveness of entry into the profession). Proposals at a recent Annual Representatives' Meeting ranged from its abandonment to its detailed expansion, and the signed consent of Hippocrates to any modification was called for. Suggestions that the format should return to poetry, in order to preserve the aesthetic appeal of the original, have resulted in a flurry of variously calibred proposals in the lay press.

Forming an intellectual bridge between ancient and modern society, and as part of his successful attempt to monopolize the founding of Western philosophy, Plato had much to say about those of Apollo's domains under the current discussion; he feared political reprisal in neither. His *Republic* was written in response to a perceived deficiency in the contemporary morality. In this argument he claims that poetry is generally an unsuitable subject of study for the elite of society, threatening as it did the moral and intellectual development of its readers or listeners. He condemned the inevitable encouragement of passion, the appeal to inferior parts of the intellect, and the distancing effect from truth and reality conferred by poetry. He found no place for beauty in the education of his elite. "If you admit the entertaining Muse of lyric and epic poetry, then instead of law and the shared acceptance of reason as the best guide, the kings of your community will be pleasure and pain".

Poetry in the ancient and illiterate age was the main medium for teaching history, language, religion and ethics. It was epic, elaborate and explicit, and Plato viewed it in these senses as an equivalent of our *Neighbours*. He was aware of "an ancient quarrel between poetry and philosophy", the latter being equivalent in many ways to our modern science and, in Plato's view, superior to and incompatible with the former.

Poetry today is (or should be) something different, attempting to capture essences in a minimum of carefully chosen words. Good poetry generally leaves something unsaid, requiring the reader or listener to fill the gaps. According to Don Paterson, poet and former writer-in-residence at Dundee University where, as with Hippocrates, medical students featured heavily among his charges, "a good poem leaves the world a more mysterious place". Poetry, like science, has advanced beyond the recognition of our forefathers. There is a similar role today for the romance and rhymes of Tennyson as for the physiology and pathology of the four humors.

If the request for a poetic graduand oath is to be fulfilled, we must choose between a self-defeating return to an ancient style, with the danger of distorting moral development, or a modern subjective style which is open to the varying interpretation of the swearer.

Poetry has many roles in medicine and society. The required acceptance of harsh professional accountability is prosaic, and should be celebrated thus. Apollo has heard enough swearing.

Source
Plato. *Republic*, tr Waterfield R.. Oxford: Oxford University Press, 1993.

web site of the month

BJ,
You know you said you were interested in practice computers, well I may have just found some mates for you...
http://www.schin.ncl.ac.uk/phcsg/phcsg_home.htm and they are having a conference in September. The PHCSG of the BCS (Primary Health Care Specialist Group) is an organization which appears to specialize in the production of acronyms) (as well as primary care computers). They have all sorts of members from dentists to GPs to opticians to nurses and NUG managers! (I know what a manager is but what's a NUG? – a snug without seats?)
However, the thing that really foxed me was what is an "informatician"? Is this some sort of new doctor who is an expert in cyborg technology and can surgically add, upgrade and remove laptops? Or is an "informatician" a sort of bureaucratic mix-up where the hospital thinks that you have given consent to donate your pancreas to medical science when you are not even dead yet?
Answers on an e-mail to **Rob.Wilson@ncl.ac.uk**

our contributors

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Blair Smith is, amongst many distinctions, on the Editorial Board of this very *Journal*...

... whereas **Liam Farrell** is not.

All our contributors can be contacted via the Journal office.

Liam Farrell

The highlight of my life

Being granted a column in *The British Journal of General Practice* has undoubtedly been the highlight of my life. The College of GPs has always felt to me like a big warm polygamous family, all snuggled up in bed together in front of a huge roaring fire on a cold winter's night with icicles hanging by the wall and Dick the shepherd blowing his nail, scaring the daylights out of each other with really spooky ghost stories, drinking hot cocoa and waiting for Santa to come and leave presents and fellowships and knighthoods for everyone; like having 20 000 psychic *doppelgangers*, and every one of them an unabashed party animal.

For a while I was estranged, a lost sheep; I thought the College was boring, man. And now, awarded the privilege of writing for the *Journal*, the prodigal son returns, crestfallen and apologetic, humbled and bumbled; I have returned from the wilderness, where it was bloody cold, I can tell you, and you had to kill what you ate. I am chastened and no longer a virgin, but at heart still one of the boys, like the Arsenal back four. It's like the mother ship is calling me home, the mythical farrow with 200 000 nipples, and the fatted calf is beginning to realise that all the extra grub it was getting had a downside and not on account of us liking it particularly, or it being handsome and sweet-smelling.

"Wait till mom hears about this", it used to say to itself, a trifle smugly, as it received yet another portion of juicy silage while the other poor calves were being turfed out into the field. "Don't worry", it would call to them condescendingly, "The cold weather will harden you up – hey you, mind how you're swinging that."

But there is yet room for improvement, and I think we do need to become more clubby. The bar in Princes Gate, for example, should be a mandatory port of call for all out-of-towner GPs up for the weekend, somewhere we'd always be sure of meeting someone of like mind to while away a few pleasant hours in repartie and saucy badinage. For a big city can be a lonely place, especially to those of us reared on the hiss of wind through the reeds and the rich, intoxicating smell of newly mown hay.

Maybe a regular music session would help draw the punters in. I'd be prepared to do my bit; I play in a modestly successful folk group, successful because we appeal at all times to the lowest common denominator of culture and civility, and never ever appear to place virtuosity and egotism before jollification and diversion.

Or maybe a Happy Hour for pina coladas and strawberry daqueries, or pitchers of beer and barbecued ribs at half price during big matches on the big screen TV. We could raid fellow institutions, draw moustaches on the portraits of the Great and the Good, or smuggle a herd of undipped sheep into their libraries. (Have you ever seen the ticks hopping around on those things?) Soon a friendly rivalry would develop and we would spend many happy hours thinking up further devilment while at the same time being on our guard against retaliation.

I know, I know, we are a serious academic body, but all work and no play makes Jack a dull Fellow.