The British Journal of General Practice

Viewpoint

Striking off

Once again, the thorny question of patients being struck off by their general practitioner without an explanation is in the headlines. As you know, it is not necessary for GPs to give a reason and when one is given it is usually that 'the relationship has broken down'. In 1997, the RCGP Patient Liaison Group produced guidance for College Members.[1] The recommendations were that:

- the practice policy on removing patients from the list be outlined on the practice leaflet,
- patients should normally be supplied with a reason for their removal, and
- patients who leave the list should be encouraged to give a reason.

In their annual report of 1993, the Association of Community Health Councils reported that three-quarters of CHCs received complaints from patients about being struck off, highlighting the extent of public concern about the problem.

In his letter of of 23 January 1998, the Health Service Commissioner has challenged the situation concerning complaints about striking off, and stated that complaints from patients about being removed from a GP list should no longer be rejected simply on the basis that the practitioner has the right to remove a patient without giving a reason.

A report from the Department of General Practice, University of Edinburgh, in June 1998[2] accepts the right of GPs to remove patients from their list, but not as an unaccountable right. It recommends that GPs give a reason for their decision to Health authorities and Health Boards and that the patient be assured the right to complain.

And now the Patients' Association[3] is currently running a campaign recommending that GPs should be obliged to give a reason for 'striking off' and that if patients feel that the have been unfairly treated then an independent body should be able to help with negotiations.

In the last week I have been contacted by eight journalists, all asking about the quality of the GP–patient relationship, and all raising the issue of GPs being able to remove patients from their lists without giving a reason.

It would appear that the recommendations of 1997 from the College to its members that a reason be given is not being carried out by many general practitioners. Is this situation any longer acceptable? And can the profession be left to regulate itself in this respect?

Patients are now being encouraged to take responsibility for their own health. Patients have access to more and more information about health. Professionals are encouraged to work in partnership with patients and to share information. Relationships between patients and their doctors must be based on trust, respect and openness.

Furthermore, there is increasing anecdotal evidence from patients with chronic conditions, elderly patients on multiple treatment regimes, and patients who do not wish to accept conventional treatments that such patients are becoming apprehensive about their relationship with their general practitioner. There is a feeling of insecurity. 'You can't say too much; they might ask you to leave', said one weary 50-year-old when describing her perception of the quality of care in general practice.

Therefore, can doctors any longer justify removing patients from their lists without an explanation? I believe that in the great majority of circumstances it is no longer acceptable for doctors to remove patients from their lists without a proper explanation. And if the profession does not move quickly and regulate itself in this respect, it is highly possible that legislation will be imposed upon it. Richard Horton comments in his editorial in the *Lancet*[4] that the risk of government interference (in relation to revalidation) is real and stems from repeated failures of the Royal Colleges, the BMA and the GMC to respond to genuine public anxiety, and he quotes Sir Donald Irvine, Chairman of the GMC: 'Ordinary people want more explicit assurances of their professionals'. This sentiment must be taken on board by the profession of general practice.

Patricia Wilkie
Chairman, Patients Liaison Group, RCGP

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The Back Pages...

Anyone not writing epinephrine, lidocaine, cefalexin or sulfadiazine will have the rINN-police descending on their surgeries, for enforced spelling lessons ...

Neville Goodman, page 1889

contents

Physical disability and active learning

The ageing population, and survival at all ages owing to modern medicine, yield an increasing number of disabled people who need help from their general practitioner, and yet doctors generally learn little about how to give this help. Change is afoot,[1] but is slow to reach vocational training. Thus, disabled people lack the help they need from informed general practitioners.

In a rare report, Heyes[2] says that 'hospital training may perpetuate the belief that, if some degree of cure is not possible, then there is "nothing to be done". This sense of futility is very unpleasant, and is almost always wrong; it leads to unease, avoidance, and less than optimal care'. What follows is a sketch of two afternoon meetings, which were arranged following a 1993 report,[3] to show registrars how doctors can help and show that they can learn directly from the experience of disabled patients.

The first meeting was lead by the local Council of Disabled Experts (CODE), who use their own experience to give advice about problems and services. The first speaker lost a leg in a road accident in 1989 and is no longer able to work as a painter and decorator. He described the social model of disability, in which disability is viewed in terms of barriers, both physical and conceptual, in society. The medical model treats disability as an illness, with rehabilitation based on a 'normalized' ideology. This may lead to negative perceptions and stereotypes, and the concept of impairment as a personal tragedy, reinforcing dependency and passivity. The second speaker contracted polio in 1947 and was in a wheelchair; the third became hemiplegic in 1988. They described how they had learned to deal with their disabilities and how others treated them. Written material was provided about key principles: choice, consultation, information, participation, autonomy, and recognition that disability and illness are not synonymous. These important issues were clarified by much useful discussion.

At the second meeting, seven weeks later, five members of the Disability Resource Team (DRT), based at Amersham Hospital, explained their functions both as a team and individually, as co-ordinator, occupational therapist, social worker, clinical psychologist and continence adviser. Because registrars have little or no personal contact with these professionals, the question and answer session which followed was long, important and helpful.

The registrars had been encouraged to learn directly from disabled patients by spending time with them in their homes, but because of the valuable discussion with the DRT members there was time for only two reports from the registrars about their visits:

1. A widow aged 75, with rheumatoid arthritis, sharing a bungalow with her unmarried son in poor circumstances, and with a widowed daughter living nearby. She has a wheelchair, is depressed and probably needs a hip replacement. Discussion covered pain assessment, respite care, psychological help, financial aid, and allowances.

2. A girl aged 13, with a porencephalic cyst and epilepsy. Her parents are divorced and she lives with her mother and younger sister. She is in a wheelchair and attends a special school. Her IQ is uncertain. She is incontinent, needs feeding, cannot speak and has recurrent infections. The needs of carers, team co-ordination and the importance of regular review was discussed.

Was it worthwhile? The registrars certainly found it valuable and saw new perspectives. For example, they gained insight about the many effects of disability on family and relationships, and they appreciated that disabled people are able to learn much about how to deal with their own problems. Frustration over their previous inability to offer help when medical expertise appeared to be powerless was replaced by knowledge of the many available resources and how to use them. They saw that with a disabled person, as with any patient, it is essential to listen carefully, to find out their concerns, to share with them a clear understanding of their problems, and to agree with them what is to be done.

Future sessions could explore both the social and the medical models, and cover the roles of members of DRT, and how teams work. This session should include ways of talking with disabled people, appropriate terminology, and the universal problem of communication. Time should be kept at the end of the first session to review what has been learned and to set aims and objectives for visits.[3] A second session should be devoted entirely to the registrars; it is their opportunity to share what they have learned by spending time in the home of a disabled person, listening to the things that are important to that person, and learning how they cope. Their reports should be directed towards identifying problems and outlining solutions, and they should each be able to tell their stories so that different approaches and outcomes can be compared. One or two of the speakers from the first session would be invited to return to listen but not to talk, unless needed as a resource.

Established practitioners may find it hard to accept that all of this is necessary for doctors. Detailed knowledge is not required, but familiarity with the underlying philosophy, the aspirations of disabled people, and the varieties of help available are needed. Active learning by interaction with disabled people and their helpers also offers practical examples of communication and teamwork, enabling doctors to become more familiar with this important part of modern primary care.

Caroline Houlihan-Burne
John McMullan

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Research Highways and Byways — the NHS, the Internet, and Research

In relation to health professionals, the new NHS IT strategy aims to ensure access to information to support evaluation of care; underpinning clinical governance, planning and research, and aiding continuing professional development.[1] To facilitate this, the government intends to connect all computerized GP practices to the NHSnet by the year 2000. In terms of research, a key resource is the proposed new national electronic library for health — the idea being to deliver a comprehensive collection of clinical reference material via the NHSnet.[2] However, *Information for Health* does not provide all the answers and fails to fully recognize and incorporate the 1990s Internet revolution.[3]

The Internet is part of the worldwide electronic highway intended for information sharing. It is a vast resource similar to having 30 million consultants on your payroll — that you don't have to pay! You can look for answers to any question, send messages across the world in an instant, read books and the latest news or simply while away the hours by 'surfing' through waves of visual information. However, is this source of information as valuable for those primary care professionals interested in research?

There are currently several search engines which are dedicated to healthcare, sites providing such virtual realities as on-line pharmaceutical support with drug databases, and others which simulate doctor–patient interaction. Recently universities have been moving towards utilizing new technologies, and the medical world's first masters degree programme to be fully delivered by multimedia teaching and learning became available in 1996.[4] There are also specific sites, search engines, and discussion lists dedicated to research. This includes the new RCGP Research Pages,[5] which have sprung from an ever-increasing demand for information and the need to facilitate greater research activity and knowledge. The Research Pages have recently gone on-line and already include information and links relating to the following:

- sources of research funding, including RCGP Research Fellowships,
- current issues in research including the MRC Topic Review, The Mant Report, and Culyer Funding,
- an overview of a pilot project to develop a system of accreditation for primary care research in general practice,
- information on the 1998 Research Paper of the Year Award, and
- a comprehensive list of electronic research resources.

Two of the most important developments are yet to come with the provision of Research Intelligence — a database of primary care research, which individuals can not only search, but add their own records — and a UK map providing local information on research training at all levels. These fill some of the current gaps in electronic research resources.

Such a site therefore provides a knowledge base for all primary care professionals with an interest in research, as well as a valuable resource for those health professionals who may simply be 'surfing' the web. It will continue to be developed and updated to provide a service similar to the original aims of the NHS — quality for all and free at the point of service.

Sara Shaw
Yvonne Carter

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We welcome any comments on the RCGP Research Pages. Please contact Sara Shaw at sshaw@rcgp.org.uk or telephone 0171 581 3232 and ask for extension 338.

Reflections on the Network of Community-Oriented Educational Institutions for Health Services Conference October 1998

In New Mexico no one walks. This is not surprising, as petrol is just over one dollar a gallon, and as a consequence it is equally unsurprising that obesity and related illnesses are common, particularly type 2 diabetes.

The Network conference was held in Albuquerque this year. I felt this was a meeting of cultures in many respects, as well as a chance to talk about medical education and community-based teaching. The theme of the conference was 'Partnerships for community health', and there were delegates from over 30 countries and many different health professions.

The cultural aspects were explicit in the demonstrations of local dance. The Indians (whose title appeared to be politically correct this far south) performed for us at dinner. Their demonstration of a traditional ceremony made me uneasy; culture wrapped up and sanitized as entertainment seemed to denigrate a proud tradition. But the nature of that tradition was also open to question when some of us visited Sky City, the oldest continually inhabited site in the United States.

The Acoma people of Sky City are hoping to reinstate their traditional ways. The elders have bought back their lands from the American government (Bill Clinton is referred to ironically as the 'great white father'). But their new lifestyle has also made them prone to diabetes. The old culture heralds a return to non-democratic government by a 12-man council. And yes, no women are allowed to sit on this.

There was much discussion of culture: hospital-based versus community-based; urban versus rural; old versus new. From each continent there were tales of antagonism to moving health professionals' education out of traditional hospital centres; but also reports of students from the newer community-oriented curricula performing as well in summative assessments as those from established prestigious schools. However, there is also a culture, particularly among the medical profession, of graduates expecting high remuneration and good working conditions. One medical student from Kenya praised highly his innovative education based mainly in a poor rural community. He would like to continue to serve that community after qualification, but conditions are harsh, pay poor and incentives few.

Questions arise as from any good educational meeting: what should be retained and what discarded from our traditions of training doctors? How may doctors be attracted to work in less attractive or primary care areas? Change is inevitable: how should it be evaluated and do we reject our favoured projects in the face of overwhelming student, tutor or patient discontent?

Jill Thistlethwaite

Health as human right: one of the world's best kept secrets

Dorothy Logie's article marks the 50th anniversary of the Universal Declaration of Human Rights, 10 December 1998

When we think of human rights, images of torture, abuse, and firing squads come to mind. True, most of the 30 clauses in the Universal Declaration of Human Rights, written by the UN in the aftermath of the Second World War, proclaim civil and legal liberties. But one of the best kept secrets is that health was also defined as a universal human right. Fifty years ago this month the Universal Declaration stated clearly: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, medical care, and necessary social services … Motherhood and childhood are entitled to special care and assistance' (Article 25). The WHO Constitution (1994) went further: '... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, political belief, economic, or social condition'

If health is a human right, how does one deliver it globally? 'By promoting good quality universal primary health care,' said WHO in the Alma Ata Declaration (1978). In this, the world's nations endorsed primary health care as a strategy, but with an over-optimistic time goal of 'Health For All By The Year 2000'. Importantly, it said that health, 'a state of complete physical, mental, and social well-being, and not merely the absence of infirmity, is a fundamental human right and ... the most important social goal whose realization requires action in many other social and economic sectors in addition to the health sector.'[1] The Alma Ata took its lead from the success of community-based health projects in China during the 1960s which had greatly improved that country's health by encouraging low-cost, low-tech medicine, health education and, crucially, community involvement. But the concept had strong socio-economic and political implications, explicitly stating that effective health strategy not only depends on the health sector but also on the underlying determinants of health, such as poverty reduction, and education, and involves strong participation and representation of all users, including the poor.

So the delivery of universal primary care became a radical, if not subversive, concept. Why? Primary care physicians understand basic health needs: they listen to ordinary people: they recognize how economic inequity affects health. (Did you know you were practising revolution?). In 1978, free market policies were being promoted by the major powers. Even Primary Health Care programmes which did not explicitly put social change on their agenda posed a threat to the promotion of the 'market'[2] in health care. Moreover, who wanted to listen to users' voices when health care was being cut?

So throughout the 1980s and 1990s the concept of Health for All was quietly dropped. WHO lost its lead in global health policy and was starved of funds, while the much wealthier and more powerful World Bank took the lead in formulating health policy,[3] culminating in the 1993 World Development Report.[4] At the same time, a global recession with suffocating foreign debt, devastating structural adjustment programmes which make the poor pay for health care, and escalating expenditure on arms all resulted in a massive disinvestment from health spending, especially in poor countries. Poverty increased dramatically, and huge disparities in health opened up within and between countries.[5] Eight hundred million people in 40 developing countries saw their standards of living slashed, their health centres without drugs or doctors, family planning services without staff, and schools without books or teachers.

Instead of 'Health for All' a sanitized edition of 'selective primary health care' was promoted, stripped of the comprehensive perspective. 'Packages' of health care were proposed with a shift from social to technological interventions, like mass immunization programmes and 'top-down' aid programmes. The results were patchy, and many of the gains were transient despite enormous efforts from organizations such as UNICEF in their child survival programmes. Because women's health and education were neglected, any improvement in child survival achieved through programmes like promotion of oral rehydration therapy could be no more than temporary palliation.[2] It is widely recognized that the single most important influence on child survival is the mother's health and level of education.[6]

The health policies of the 1980s and 1990s are now seen to be short-sighted even in economic terms. For example, they tended to exclude preventative policies. It has been estimated that half of all future HIV infections might be prevented with adequately supported preventative programmes.[7]This could not only avert millions of deaths of young adults in their most productive years, and slow down the dangerous spread of global tuberculosis, but also free up health spending and bring economic benefits to affected countries.

As we sit on the edge of a global recession, with more and more countries in the Far East and Latin America tumbling into poverty, there is an urgent need to prevent similar health catastrophes which have caused Africa's health to deteriorate so much in the last 20 years. We know comprehensive primary care works. Zimbabwe in the 1970s, Mozambique and Nicaragua in the 1980s all put in place comprehensive PHC programmes, much in line with the Alma Ata Declaration, and were lauded by WHO for greatly improving health statistics.[8] In

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countries like the UK, with a well-developed PHC, we have much more equitable access to health than the US, where 40 million people have no health insurance and another 20 million have inadequate coverage.[9] Of the 19 major industrial countries, the US has the highest mortality rate for children under the age of five. Afro-American infants born in Chicago or Detroit are more likely to die before their first birthday than infants born in Costa Rica or Chile. Fewer than 10% of children in some inner cities are vaccinated.[10] It is the vulnerable groups, who lack other human rights — the disabled, the marginalized, the ethnic minorities — who are denied health care, emphasizing the indivisibility of human rights.

But the political wheel is turning again. In the UK, we are once more addressing the determinants of ill-health, poverty, education, housing, and environmental policies, and we are starting to involve the comunity: dependency is being discouraged and active participation promoted. At the World Health Organization, Gro Brundtland's new leadership is committed to the delivery of a fairer global distribution of health care. And at the UN, Mary Robinson, the High Commissioner for Human Rights, is determined to emphasize that all rights are indivisible; economic, as well as legal.

The Universal Declaration of Human Rights is just one international legal instrument which health professionals can use to fight for better health. We also have the 1966 International Covenant on Economic, Social and Cultural rights, the 1979 Convention on the Elimination of All Forms of Discrimination Against Women, and the 1989 Convention on the Rights of the Child. In addition to binding international treaties, health and human rights have been addressed in a series of recent global conferences, each with a programme of action: Human Rights (Vienna 1993), Population and Development (Cairo 1994), Social Development (Copenhagen 1995), and Women (Beijing 1995). All these aim to sensitize people to the close connection between health and other human rights and examine the wider societal causes of ill health.

The more people understand what human rights instruments have to say about health, the more we can use them to lever change both locally and globally. Fifty years on from the Universal Declaration, poverty, injustice, inequity, and denial of rights remain widespread. We respond to the floods in Central America with aid but are reluctant to look at the underlying causes of the tragedy, debt, poverty and environmental destruction. In the Alma Ata Declaration we have a blue-print which could help implement one human right: health for all. This anniversary must be a time to translate fine words and altruism into action.

Dorothy Logie

Best Books for Christmas...

Domhnall Mac Auley...
Bridget Jones' Diary by Helen Fielding (Picador, £6.99, 0-3303-3277-5) came with me on holidays and was great company. Not quite Jane Eyre, more general practice than neuro-physiology. Good fun and real life. On the other side of the gender and orientation boundary, Colm Toibln wrote a tragic, yet tender homosexual love story — *The Story of the Night*. A wonderful insight into another world. Recommended by my mother-in-law, I couldn't put it down.

And for those of you who think they might one day give up the day job and write a novel ... too late: Paul Carson, a Dublin GP, got there before you. He wrote an airport blockbuster entitled *Scalpel* (Arrow, £5.99, 0-7493-2447-3) which simply soared up the ratings. A medical thriller with all the excitement of an international bestseller. It didn't win the Booker, but it's a great read and he'll never do another night visit.

Roger Neighbour...
Suffering from skirmish exhaustion? Hypocrisy overload? Could die happy if you never again heard of PCGs, LMCs, MRCGP, Summative Assessment? Then read ***Microcosmographia Academica (University politics, incorporating Microcosmographia academica)*** by Gordon Johnson and F M Cornford (Cambridge University Press, £21.95, 0-521-46919-8), a bang-up-to-date guide to the 'over my dead body' school of decision-making. Sample quote: 'Nothing is ever done until everyone is convinced that it ought to be done, and has been convinced for so long that it is now time to do something else.'

Wish your competence in general practice was at least skin-deep? Bung ***Minor surgery and skin lesions*** by Roger Kneebone and Julia Schofield (Primal Picures, £77.38) in your CD-ROM. The words 'committee', 'resource' and 'can't' do not appear.

But do read ***The Reader by*** Bernhard Schlink (trans. Carol Brown Janeway), (Phoenix, 0-75380-470-0), a piercing novel of the Holocaust, infatuation, atonement and unwitting betrayal. A bit like general practice. The climax made me — literally — cry out, 'Oh no!' My book of the year.

Bruce Charlton...
As the years go by I find myself reading less and less fiction, and increasingly prefer biography. This year it was the turn of Ralph Waldo Emerson — the American 19th-century man of letters. I must have read at least a dozen biographies from the past hundred or so years, but one of the best was ***Emerson Among the Eccentrics*** by Carlos Baker (Penguin, $17.95, 0-14026-029-3). An ideal introduction to the work and times of one of the finest human beings ever to have graced the planet.

On a lighter note, I discovered the world of Dilbert the office cubicle-working everyman of the computer age. The ***Dilbert Future*** by Scott Adams (Boxtree, £12.99, 0-7522-1118-8), moves the comic strip character into the realm of social critique and futurology — very funny and remarkably perceptive.

Choosing a medical volume is easy — ***The Antidepressant Era*** by David Healy (Harvard University Press, £24.95, 0-6740-3957-2) is probably the most intelligent and deeply researched book yet written about the process of therapeutic innovation. Healy has raised our understanding of psychiatry, pharmacology and clinical discovery to a qualitatively higher level. Not just medical book of the year, but of the whole decade...

Michael O'Donnell...
I much enjoyed Edith Wharton's ***The Custom of the Country*** (Everyman's Library, £9.99, 1-8571-5198-4) in this splendid edition: hard back, with paper a pleasure to lay hand upon, all for ten quid. A cracking good tale, superbly told, rewards the reader on every page. Skip Lorna Sage's introduction — clever clogs rather than insightful, and gives the plot away.

Like many of today's best novels, Michael Connelly's ***The Last Coyote*** (Orion, £5.99, 0-7280-944-X) resides on the Crime shelf. Brilliantly plotted; skilfully written; compulsive reading without resort to gratuitous nastiness. My best medical read — Bill Silverman's ***Where's the Evidence?*** (Oxford University Press, $36.50, 0-19-262934-4) is a witty, thoughtful reminder that there's more to medicine than 'performance'. Why three Americans? Coincidence.

Neville Goodman...
First: ***Language is power*** by John Honey (Faber & Faber, 0-5719-0470-2). Is the ignorance of teachers of English, mired in trendy ideas that grammar restricts thought, at least partly to blame for the dire prose of many medical researchers? John Honey is clear that standard English is the key to enlightenment, and his jibes at his detractors add spice and humour.

Second: ***Skin***, by Joanna Briscoe (Phoenix House, £6.99, 0-75380-164-7). A (fictional) writer of erotic novels undergoes plastic surgery. We get descriptions of sexual and surgical encounters: like birch twigs after the sauna, like the flood of relief when a tourniquet is released. The sort of novel (I like a novel to require some effort) that critics describe as a 'tour de force'.

Third: ***Fugitive Pieces*** by Anne Michaels (Bloomsbury, £10.00, 0-7475-3496-9). A winner of prizes, Michaels' novel of the Holocaust also requires effort. Except that, told in flashback through various minds, the thread escaped me at the end, and I felt let down. Could someone who reads it please write and explain?

Tom Gilhooly...
Three books in 1998? ***Born To Rebel*** by Frank Sulloway (Little, Brown, 0-316-88179-1) is quite simply a 'meisterwork'. It is a fascinating and stimulating analysis of birth order, family dynamics, and creative lives. He expounds a theory of human behaviour based on Darwin's theory of evolution in the micro-environment of the family, where the scarce resource is not food but love. He explains how many of our personality traits are defined by our position in the family. First-borns tend to be dominant and make good leaders (and terrorists), middle child-ren are more diplomatic, and the last born tend to be more creative. A rare beast, this book not only reveals unexpected insights to the reader about themselves and their family but also about human behaviour in general.

Emotional Intelligence by Daniel Goleman (Bloomsbury, £7.99, 0-7475-3984-7) is the Bible of emotional learning, and if you have never heard of it then read it and bore your friends into reading it too.

Reading in the Dark by Seamus Deane (Vintage, £6.99, 0-099-74441-4), is a poetic masterpiece. He may well have sold his soul to the devil to write so well, but it will not be so expensive to read and enjoy. One of the

saddest and most moving passages I have ever read is the chapter 'Feet'. And no, it's not about corns.

Michael Smith...
My choice for book of the year is John Banville's ***The Untouchable*** (Picador, £5.99, 0-3303-3932-X***)***; I reckon he's on his way to a Nobel prize, never mind the Booker. Put it on your Christmas list if you've not read it already.

John Gillies...
Simple, dogmatic solutions to complex problems in medicine, politics, and economics are attractive, but don't work. Read Isaiah Berlin to understand why, and how we can and must do better. John Gray's ***Berlin*** (Fontana Modern Masters, £6.99, 0-0068-6244-6) offers a concise introduction to Berlin's writing on freedom, pluralism and history.

Iain Bamforth's difficult and powerful collection of poems ***Open Workings*** (Carcanet Press, 1-85754-257-6), mystified and enlightened me in equal measure. Rural GP, anatomy, and Australia explored as never before. Astonishing imagery.

In developing countries, health expenditure per capita is measured in pennies, not pounds. David Werner's ***Where there is no doctor: a village health care handbook*** (Macmillan, £7.25, 0-3335-1651-6), shows how to provide health care on a minuscule budget. Rationing with starker choices than we care to imagine.

David Haslam...
Because cowards get cancer too by John Diamond (Vermilion, £9.99, 0-0918-1664-5) is not only my medical book of the year — it should be *the* book of the year. A stunning, moving, powerful book written about his own tongue cancer, John Diamond taught me more about cancer and the way that doctors behave than anything I have ever read before. Please read it.

For non-fiction, try ***As If*** by Blake Morrison (Granta Books, £14.99, 1-86207-003-2) — a quite extraordinary analysis of the Jamie Bulger murder. Finally, my fiction choice is ***Wobegon Boy*** (Faber & Faber, 0-57119-489-3) by the marvellous Garrison Keillor. If you enjoyed *Lake Wobegon Days*, you'll love this.

Susan Woldenberg Butler...
Wisdom and Compassion: The Sacred Art of Tibet by Marilyn M Rhie and Robert F Thurman, exp. edn. Principal photography: John Bigelow Taylor, Tibet House, New York, in association with Harry N. Abrams, New York, 1996) is an extremely beautiful book I pick up whenever I want or need to be transported to another world.

In ***A Fortunate Life***, A B Facey (0-1400-7945-9) tells a simple, modest story of his childhood in the Australian bush, his army stint in World War I, and his love for his wife and family. Purportedly, Facey wrote his memoirs at the kitchen table. This Penguin paperback was a real page-turner.

Finally, Henry Laughlin's ***The Neuroses***, (Butterworths), an elegant guide to psychiatric private practice. Beautifully written, with useful guidance on 'combat reactions' and 'prisoner processing' — ideal for Christmas Day...

Tom Fahey...
Being asked to nominate three books that I enjoyed made me realize, with some relief, that I don't read medical textbooks anymore. Though there are lots of books being produced with an 'evidence-based medicine' slant, all saying much the same thing, I did think that bits of ***Evidence-Based Practice***, edited by Chris Silagy and Andrew Haines (BMJ Books, £25.00, 0-7279-1210-0), were very good.

For non-fiction, I couldn't put down the bestseller — ***The Perfect Storm***, by Sebastian Junger (Fourth Estate, £6.99, 1-85702-730-2) which tells the story of the Hallowe'en Gales of 1991 and their impact on the North American fishing fleet.

Lastly, my choice for fiction is ***A Sort of Homecoming*** by Robert Cremins (Sceptre, £10.00, 0-340-71722). Very funny, particularly if you happen to know Dublin.

Robin Downie...
Short stories are ideal for the odd spare moment or last thing at night. Penelope Lively's ***Beyond the Blue Mountains***, (Penguin, £6.99, 0-1402-5693-8) contains 14 stories that are witty, satirical, thought-provoking, and don't turn nasty.

Bernard MacLaverty's ***Grace Notes*** (Vintage Books, £6.99, 0-0997-7861-7) was listed for the Booker Prize in 1997, but was too good to win it, although it was the Saltire Society and *Scotsman* 'Scottish Book of the Year'. The novel concerns the struggle of a young composer to find her identity despite uncomprehending parents in Northern Ireland, an alcoholic partner in Islay, and her depression (wonderfully described) following the birth of her daughter. It is a positive and not unhumorous book.

The title of Mary Warnock's ***An Intelligent Person's Guide to Ethics*** (Gerald Duckworth, £12.95, 0-7156-2841-0) is misleading. No textbook, but the reflections of a widely experienced philosopher and educator. All the chapters are readable and easily accessible to the intelligent person of the title, but those on *Death*, *Birth*, and *Rights* may be of special interest to medical readers.

Paul Hodgkin...
Christmas books need to be pretty special, singing the possibility of change. John Adams' ***Risk*** (UCL Press, £14.95, 1-8572-8067-9) makes the list for prising open medicine's parochial view of risk, exposing our preachy narrowness. The pleasure of watching my pre-existing beliefs fall like nine-pins, combined with the *schadenfreude* of finding that the risk reduction industry has got it so wrong — delicious!

Thomas Lynch has spent a life-time burying people. ***The Undertaking: Life studies from the dismal trade*** (Random House, £9.99, 0-224-04276-9) is about all those black-edged events — death, departure, divorce — which come trailing clouds of transformation. 'Mourning is romance in reverse, and if you love, you grieve, there are no exceptions … if the dead are regarded as a nuisance from whom we seek hurried riddance then life and the living are in for like treatment: McFunerals, McFamilies, McMarriage, McValues.'

And finally ***The Rag and Bone Shop of the Heart: Poems For Men***, edited by Robert Bly, James Hillman, and Michael Meade (Harper Collins, £10.00, 0-0-6092-420-9A), a wonderful anthology reflecting on masculinity and the ineffable joys of living.

Iona Heath...
Two plays this year have provoked me to buy the full text on the way out and go straight home to read. ***The Invention of Love*** by Tom Stoppard (Faber, £6.99, 0-5711-9271-8) describes the discipline of textual criticism in the study of Classics and makes it sound just like general practice; ***Copenhagen*** by Michael Frayn (Methuen, £6.99, 0-413-72490-5) explores the uncertainty at the heart of atomic physics, in a way which is profoundly comforting to a general practitioner in the era of evidence-based medicine.

Finally, William Carlos Williams' ***The Doctor Stories*** (New Directions Books, £9.55, 0-8112-0925-3). He was both a poet and a family doctor and no-one understands better the importance of our patients' struggles to find words for their feelings.

Michael Steel...
I was inspired to pick up ***The Crow Road*** by Iain Banks (Abacus, £7.99, 0-3491-0907-9) because he received an honorary degree from St Andrew's last year and in the eulogy, his sponsor quoted the memorable opening line, 'It was the day my grandmother exploded'. A gripping start to a convoluted tale of dark family secrets, set in the Scottish Highlands — never a dull moment.

Hidden Agendas by John Pilger (Vintage, £8.99, 0-0997-4151-2) is a collection of polemics by a vastly experienced journalist outraged by injustice and hypocrisy, from Myanmar to Merseyside. Many villains but a few heroes and heroines. An eye-opener.

Evolution and Healing: the New Science of Darwinian Medicine by Randolph M Nesse and George C Williams (Wiedenfield and Nicolson, £20.00 0-4608-6140-9) was originally published in the US under the racier title of 'Why we get sick', and is the result of a collaboration between an evolutionary biologist and a clinician. It offers refreshing insights into the evolutionary value of symptoms and diseases. The unusual perspective evokes both applause and scepticism and stimulates argument. Written in a lucid and entertaining style, and not indigestible.

The Insider's Guide to Medical Schools
Edited by Simon Calvert and Ian Urmston
BMJ Books, London, 1998
PB, 152pp, £9.99
(0-7279-1269-0)

When I decided to study medicine, my decision to stay in Scotland partly stemmed from my reluctance to head south. This was owing to a previous university interview which, having made the journey of several hundred miles, I was asked to explain to the panel exactly what a Scottish Higher was.

This book, written by students, seems to be a good idea, giving general advice and a review of British medical schools. The low-down on how to become a medical student contains some sound practical advice — how to fill out UCAS forms, and chill out before the dreaded interview.

The second part of the book is dedicated to choosing the right medical school. The layout of the reviews enables direct comparisons of the schools, where important factors such as the curriculum or the price of a pint can be quickly assessed. All this information can numb the mind a little, although some relief comes at the end of each section in the form of frank personal views. These honest facts have both positive and negative effects on the overall view of the school, and in some cases may contain enough to change a decision.

I'd recommend at least a quick flick through this book. Having decided for sure that you want to study medicine, and if you are then lucky enough to get into medical school, and if you have a choice of schools willing to take you on, then *The Insider's Guide to Medical Schools* will tell you whether you've boobed.

Alison Browning

Getting Research Findings into Practice
Andrew Haines and Anna Donald (eds)
BMJ Books, London, 1998
PB, 190pp, 0-727-912577

In 15 chapters, 38 authors drawn from a range of academic disciplines present potent arguments for ensuring that research findings are transferred to clinical practice. A succinct introduction is followed by a series of chapters outlining sources of information on clinical effectiveness and barriers to evidence-based clinical practice. Throughout the book, a common theme that emerges relates to the inadequacies of current education methods, from undergraduate training to continuing medical education courses, which do not teach skills for accessing new knowledge.

For the general practitioner, evidence-based practice presents a number of dilemmas. General practice is about unorganised illness. Unlike the specialist medical services, which come into play after a selection process has been applied to patients, the GP's surgery is the first port of call for a vast range of undifferentiated problems. The practice of medicine in general practice is not just about technical fixes: it is also about judging what is the right thing to do for a particular person at a particular time. Research evidence is based on populations and the GP has to sift through this overwhelming mass of scientific know-how and decide when the person opposite simply needs compassion and understanding and when they need intervention of a technical kind.

One major omission within the book is any analysis of the problems faced by doctors when patients do not concur with their wishes. We are all too aware of the evidence surrounding the impact of harmful lifestyles on health, yet patients continue to ignore our advice. The outcome of research findings is ultimately in the hands of patients, not doctors, yet this fact is given scant attention. For this, and other reasons, I doubt if the book will appeal greatly to general practitioners and this may be due to the fact that there are few, if any, practising clinicians among the authors.

On reflection, it is difficult to ascertain who the book is aimed at. Perhaps it has important messages for educators who are charged with the responsibility of finding ways and means of helping doctors keep up to date. In the midst of calls for more evidence based medicine, I suspect that the large majority of GPs are remarkably well informed about recent trends in medicine. Pleas for getting research findings into practice cannot be ignored, but have to be matched with an understanding of the culture of general practice where a commitment to whole-person medicine means that GPs cannot necessarily identify or establish strict boundaries to interventions.

John Bain

The Politics of Change in the Health Service
Brian Salter
Macmillan Press, London, 1998
PB £14.99 304pp, 0-333-65641-5

The National Health Service, as one of Britain's great national institutions, consumes a significant proportion of national income and is inevitably political. The election of a new government in May 1997, after a long period of Conservative government, was bound to lead to substantial changes. All health professionals are now working hard to adapt to what appear to be some of the most radical changes in the National Health Service since 1948, perhaps even since 1911.

Brian Salter's *The Politics of Change* in the Health Service is an interesting book and easy to read. He writes from outside the medical profession, but has clearly done a great deal of reading and thinking and his references are good and well chosen. Many of the facts included are a mine of information for all those involved in the organization of the Health Service in its new form.

His political thesis is also of interest. He advances the analysis that all governments since the introduction of the Health Service have systematically raised patient expectation for vote-winning purposes, and he predicts an impending crisis since it seems to him that the likelihood of resources being available to meet such expectation is unlikely.

Another important analysis is his view on the role of the health professions, and in particular what he perceives as a deal between medicine and governments over the years. His view is that if governments provide adequate resources then medicine will be left to determine priorities. He believes that nursing is relatively uninfluential and that the major issues are essentially medical. He suggests that this pattern is likely to change.

Until recently, Professor Rudolf Klein at Bath, and Professor Chris Ham at Birmingham, had established themselves as two of the leading social policy commentators from outside medicine. They now have a rival.

Denis Pereira Gray

Fear and Loathing in Las Vegas
Director: Terry Gilliam
Universal Pictures, Cert 18

Those of you unfamiliar with the output of Dr Hunter S Thompson, as I am, are no doubt puzzled by the immense hype surrounding Terry Gilliam's film adaptation of 'Fear and Loathing in Las Vegas'. The truth is, that anyone who can consume as many narcotics, in as surreal a city as Las Vegas, write a book about it, and *still* be alive today, I think deserves the greatest universal respect — if not a write-up in the medical literature as a case-study in chemical endurance.

From start to finish, this uproariously funny film is a rollercoaster of nauseating camera angles, tracking over nightmarishly patterned hotel lobby carpets and psychedelic casino lounges — Las Vegas, circa 1971, was definitely not a by-word in good taste and elegant living.

Johnny Depp is outstanding as Thompson, who is known under the journalistic alias of Raoul Duke, and is teamed with Benicio Del Toro as the insane Dr Gonzo, Duke's dubious Samoan attorney. This is essentially a plotless bad trip of a movie, in which Duke and Gonzo are sent to Las Vegas, ostensibly as members of the press, to cover first a desert motorbike race, then an attorney's conference on the subject of narcotics. Pursuing a deathwish against the American Dream, they use the opportunity to get through as much LSD, dope, speed, cocaine, mescaline, and just about every other upper, downer, and inside-outer they have stuffed in a briefcase in the boot of their car.

Terry Gilliam's hallmark of creating bizarrely macabre images manifests as Duke's LSD hallucinations — a casino salon full of guests drinking at the bar becomes an orgy of bloodthirsty reptiles; wallpaper and carpet patterns become living tentacles wrapping around people's legs. As the drug-fuelled pair trash their way through a succession of hotel rooms, their adventures reach an increasingly hysterical pitch, teetering between psychosis and a desperate desire to find the ultimate high, while virtually oblivious to the realities of the Vietnam war on their hotel room television set each day.

The machine-gun delivery of the dialogue — which is mostly unintelligible — effectively adds to the atmosphere of personalities out of control; with a film like this there seems little point in the characters making any verbal sense. This is also reflected in Gilliam's direction; normally filled with razor-sharp irony and observation (as in the wonderful 'Brazil' and 'Twelve Monkeys'), here it is the cinematic equivalent of a mortar bomb: crude, but effective. It fails, however, to satisfactorily explain how the optimism of the flower power generation gave way to the path of self-inflicted oblivion chosen by the likes of Duke and Dr Gonzo.

Anyway, who cares? This film is filled with the grooviest music of the era, and is a wonderfully lurid and screamingly funny window on the antics of the lumbering psycho Dr Gonzo and the restlessly paranoid Duke, who hits rock bottom when he wakes up after a particularly heavy night in a half-flooded hotel room, wearing waders and a giant rubber lizard's tail, and with a microphone strapped to his face.

A must for all lovers of tales of excess, this film knocks everything else around for miles into a cocked hat, just for its sheer verve and utter grossness. Enjoy!

Lorraine Schembri

Neville Goodman

There aren't many hormones known to the public by name. Everyone has heard of steroids, though probably for the wrong reasons. Many have heard of insulin; there can't be many people who don't have a diabetic friend or acquaintance. But everyone's heard of adrenaline for the right reasons. Yes, that surge of adrenaline so familiar to every sports fan; adrenaline trips off the tongue of every sports commentator.

Not from 2004 it won't. It's been banned — or more correctly BANned. For those who like abbreviations, which I don't, BAN means British Approved Name. These names are what all good doctors write on their prescription charts to keep the drug companies away. And adrenaline is set to become epinephrine. The instrument responsible for this is directive 92/27/EEC on rINNs. rINNs are Recommended International Non-proprietary names.

Don't ask me why the 'r' in rINN is lower case and R in Recommended is upper case; that's what it says in the latest BNF, which is where (on page x) you can find a list of the changes. These aren't suggested changes; they are required changes. Anyone not writing epinephrine, lidocaine, cefalexin or sulfadiazine will have the rINN-police descending on their surgeries, for enforced spelling lessons.

Notice anything about those International names? Notice the strong EC influence? No, nor do I. But I do notice that they are American spellings. Attempts to rationalize English spelling surface every few years but they are all doomed. After all, how else can you differentiate so, sew, sow and sough? Which service is complimentary service?

These are trivial objections: fiddling with spelling separates language from its history — that's the important matter here. If we lie back and roll over before the Americans, forcing their sulfadiazine upon us, how long will it be before sulphur has to become sulfur? American spellings only became American spellings because of Webster and his dictionary. He was just cussed, and altered some spellings to snub the British.

International names could have become what they say: a few spellings from here, a few from there. Instead, most 'ph' become 'f', many 'th' become 't', and a few 'y' become 'i' — all because that's how it's done in America.

Of course we should have BANs. What I object to is that we are erecting a set of rINNs which are actually rANNs.

Gallstone Grove, tales from tomorrow

Philosopher's past dream of Christmas present?

It was Christmas Eve, and Max Phobius lay awake. As chair of the Clinical Priorities Working Group of the PCG he had to decide which one of the four THRs from his locality scheduled for next week could be funded. The HA Chief Executive had reassured him that it was really quite a simple exercise in distributive justice. Definitely a doctor's province. As he struggled to drift off, Phobius went over the four cases in his mind ...

First there was Mrs Cutout, a 72-year-old with moderate OA of the hip. Reasonably mobile but in some pain, she had been on the waiting list for 23 months.

Then there was Sister Mercy, a veritable angel who had kept the Cottage hospital running single-handed all these years. Fifty-five years old, she had moderately severe OA hip, and will have to stop work unless she is operated on.

Next was Sir Ivor Bentley, a 68-year-old media tycoon on the board of the local NHS Trust. His golf swing is impeded by his gammy hip, and it jolly well ought to be fixed. He will be discharged straight to a private convalescent home, with a welcome saving for your budget.

Finally there was Ratzo 'the Rat' Corleone, a 24-year-old drug dealer who came off his motorbike while trying to evade the police. He had a comminuted hip fracture which was failing to heal, and was in great pain.

As Phobius tossed and turned it seemed that a ghostly form was approaching, crying and moaning towards him through the ether. The spirit spoke ...

'It is I, Emmanuel Kant. In the name of justice I come to plead the case of Mrs Cutout.'

'I didn't know she was a friend of yours', mumbled Phobius.

'She is not, but your duty to each individual is absolute. The slumbering spirit of John Major would remind you that this duty is enshrined in that most deontological of documents, the Patient's Charter, and that each individual has a right to be treated within two years. The Spirit of Kant shouts to your across unfathomable aeons, "Come in Mrs Cutout, your time is up!"'

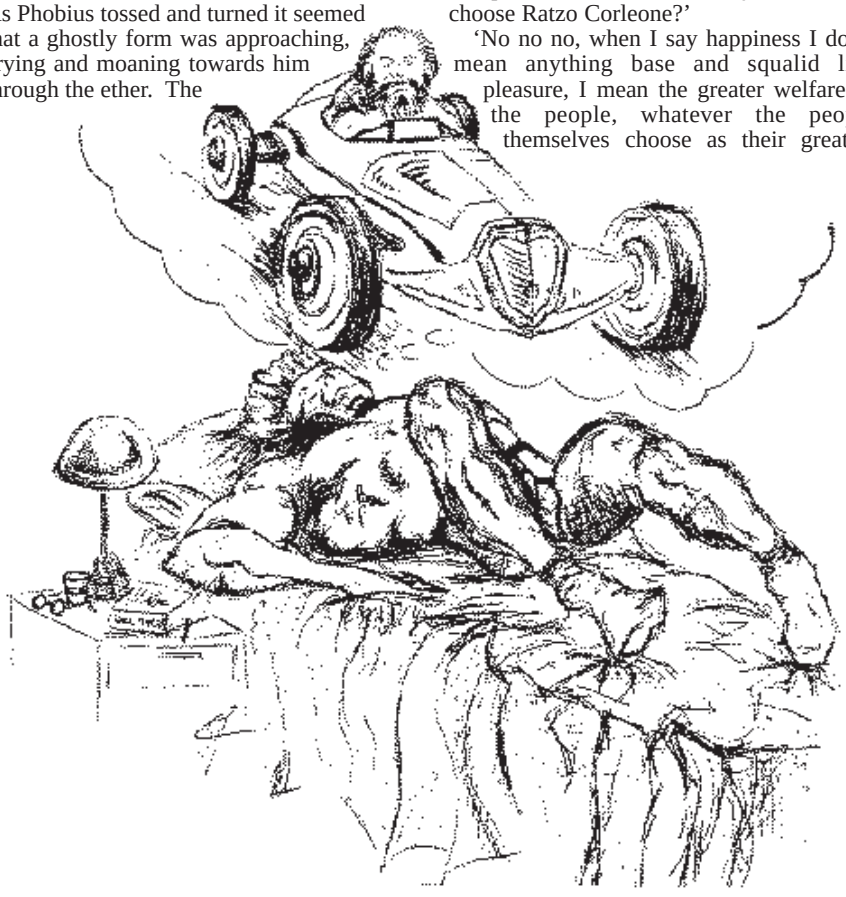
'But what about the others, surely their cases are more urgent that Mrs Cutout's?' If I can only operate on one, how does duty help me decide?...

'But wait, what is this other ghostly form I see materializing before me? It is just a head and straw hat — is it the Cheshire Cat? Is it Jeremy Beadle? Oh no, it's Jeremy Bentham!'

The sprit of Bentham spoke stiffly. 'I will show you a more useful way. In the name of Justice I come to plead the case of Sister Mercy. I preach the Utilitarian maxim of "the greatest happiness of the greatest number". Sister Mercy is a socially valuable member of your team, helping many others. For the happiness of others you must fund her.'

'But what do you mean by happiness?' Phobuis replied. 'If it's a good old poke at the pleasure centre then maybe I should choose Ratzo Corleone?'

'No no no, when I say happiness I don't mean anything base and squalid like pleasure, I mean the greater welfare of the people, whatever the people themselves choose as their greatest



good…'

'Perhaps Sir Ivor, then, he produces those popular TV shows, *The Golden Date*, and *Blind Generation*…'

'No no no,' retorted Bentham, looking glazed. 'I wasn't thinking of anything vulgar that real people want, I was meaning the higher plains of self-development, of human flourishing...'

Phobuis was confused. 'I'm still not clear of your goal — pleasure, what people want, or higher development? By the way, are you saying that if Sister Mercy did nobody else any good it wouldn't be worth operating on her anyway?'

Bentham snorted. 'Come come, let's not get extreme. Next you'll be accusing me of condoning gladiatorial combat if it made the populace settled and happy — whoops, did I just say that?'

'Well,' said Phobius, 'would you?'

Bentham was keeping a stiff upper lip. 'I'm glad you asked me that question. My friend John Stuart Mill says that although it might keep the people settled, as they wouldn't be pursuing their higher development, they wouldn't really be happy would they? I mean not like what educated men like me and John mean by happy. Anyway, I think I can see some Bart's students coming to nick my head again, so I'd better be off. Useful to know you…'

Phobius suddenly caught sight of a further phantasm locking on. 'But wait, I cannot bear it, yet another apparition haunts my fevered dreams. Hang on, this one's driving a Porsche!'

The third Spirit was emerging from a miasma of cigar smoke. 'Well hello. Robert Nozik here. You may not have heard of me, but I'm sure you know my guru Adam Smith, and my dear friend Maggie Thatcher. Let's get real here! In the name of Justice I come to plead the case of Sir Ivor Bentley. When the going gets tough, the tough go shopping, and there's none tougher than Sir Ivor.'

Phobius coughed. 'Do I detect a whiff about your arguments that isn't quite moral?'

Nozik gave a T-Rex smile. 'Money, megastars, megatons — we're talking morals with a capital M. My philosophy is the fairest and freest of them all. Locke showed that society is an artificial construct, depending on a social contact. The greatest moral value is liberty. The deals I do are my business as long as they are in the open market. You have negotiated a deal with Sir Ivor. The other three are relying on the state to pick up the whole bill. Sir Ivor has worked hard for his money. He has a right to buy services freely in the marketplace. No-one has the right to interfere with that freedom.

Phobius wasn't sure. 'Isn't that just the rich and selfish looking after their own interests?'

The Spirit's smile stiffened. 'How dare you suggest my views are selfish? By the way, the charge for this consultation will be three hundred guineas. Thank you, my secretary will give you a receipt.'

'Never trust a Spirit in a Porsche.' muttered Phobius. 'Still, what if he is right? It's a simple philosophy, minimal interference, maximum freedom of the individual. At least I won't be troubled by anyone coming to plead for Ratzo Corleone.'

'But no — surely not — who is this bearded apparition, hot-footing it from Highgate Cemetery?'

'Yes, it is I, the Spirit of Karl Marx. In the name of Justice I come to plead for Ratzo Corleone.'

Phobius was shocked. 'I didn't know that Communists were into drug trafficking?'

'All right, all right,' replied Marx, 'don't get bolshie. I didn't know how the last hundred and fifty years were going to turn out. Lenin maybe, but Stalin was no follower of mine. Ice picks and ICBMs — nothing to do with me.'

'But why are you pleading for Ratzo Corleone?' Phobius asked.

'Well it was either me or Jesus. And you know that joke, "What's the slowest thing on four legs — two Christians trying to get through a door", well I beat him to it.'

Phobius looked uneasy. It is always uncomfortable to mix our deepest beliefs with work. 'Do you mean you and Jesus share a common view on ethics?'

Marx gave a half-embarrassed smile. 'Well, yes and no. I shared some of his ideas about the value of ordinary people. But I was more of the intellectual revolutionary. He just went around practising what he preached, telling quirky stories and ended up dying for the sin of the world, whatever that means. Still, apart from that we had one or two things in common. Jesus told us to love our neighbours as ourselves, and as I always say — '

'To each according to his needs, from each according to his ability" Phobius interjected.

Marx was one impressed ghost. 'Very good. Ratzo Corleone is a selfish criminal. Lenin would have had him shot. Stalin would have had his village shot. But he is the one out of the four who has the greatest need, and can only get better if you fix him. Anyway, I see the red dawn rising, and must return to the land of shades. Farewell, farewell …'

Phobius turned and mused to no-one in particular. 'So, if there are no simple answers to distributive justice how do I decide? Didn't Childress say that if resources are not available to offer an expensive treatment to all who need it, then the most just response is to treat none of them? Well, it might be ethics but it sure ain't show business. Definitely the biggest turkey on my plate this Christmas.'

David Misselbrook

our contributors

John Bain is professor of general practice at Dundee
Alison Browning is a medical student at Glasgow, presently engaged in an intercalated degree in immunology
Denis Pereira Gray is President of the RCGP, but still sees more patients than he has Ceremonial Dinners. Though only just.
Caroline Houlihan-Burne is a GP registrar at Penn in Buckinghamshire
Dorothy Logie's essay, 'Poverty and Health: debt relief could help achieve human rights objectives', will appear imminently in the *Health and Human Rights Journa*l of Harvard School of Public Health in a special issue celebrating the 50th anniversary of the Universal Declaration of Human Rights.
John McMullan was a GP in Chesham from 1967 until 1991
David Misselbrook is a GP in Catford, and an associate adviser
Lorraine Schembri is the dynamic new Senior Assistant Editor at the *BJGP*. She spends most of her time at the cinema.
Pieter Veenhuijsen is a GP in Pukekohe, 50 kilometres south of Auckland, New Zealand. According to the *Mobil New Zealand Travel Guide*, Pukekohe ('the hill where the kohehohe tree grows', no less) is 'synonymous with vegetables', which seems a trifle unfair
Patricia Wilkie is chairman of the RCGP Patients Liaison Group

Christmas Books...
Susan Woldenberg Butler is a freelance writer who lives in Tasmania; **Bruce Charlton** recently announced that antidepressants should be available in sweetie shops, a fast-track to *You and Yours*; **Robin Downie** is professor of moral philosophy at Glasgow University; **Tom Fahey** is senior lecturer in Bristol and a member of the *BJGP* Editorial Board; **Tom Gilhooly** is a GP in Glasgow and is Lanarkshire's Drugs Czar - he prescribes methadone on an industrial scale; unlike **John Gillies** who works quietly amidst the sheep in the Scottish Borders. **Neville Goodman** is a consultant anaesthetist in Bristol and a freelance medical editor; **David Haslam**, as music critic of the *East Anglian Evening News*, scrounged lots of free records; **Iona Heath** is a vice-chairman of the College and chairs the Inequality in Health working party; **Paul Hodgkin** is an academic GP in Sheffield and an authority on cyberpunk fiction; **Domhnall Mac Auley** is editor of the *British Journal of Sports Medicine*; **'**Jolly' **Roger Neighbour** is the energetic and tastefully clad chairman of the RCGP Examination Board; **Michael O'Donnell** is an acerbic columnist for *Medical Monitor* and a lifelong admirer of the RCGP; **Michael Smith** is moving from general practice to psychiatry, and, by way of preparation, spent most of 1998 on a beach in Australia; **Michael Steel** is a professor of medicine at St Andrews

Alan Munro

Leadership, a tale of claret and waistcoats

Long ago, I was a regional adviser's honorary henchman. One of the delights of this hobby was prescribing games with the trainees. They would make carbon copies of their prescriptions for a while, as did I. We then met to chew over the figures. This was fun in itself, but for me there were also delicious, illicit glimpses of the entrails of other practices at a time when doctors assumed a sacred right to privacy in their consulting rooms.

A letter of complaint duly materialized from a scandalized trainer. Being a sensitive youth, I was upset, though in retrospect it's hard to see why. The boss, I thought at the time, dealt with the whole matter rather too lightly. A few months later she announced, with the air of someone about to impart a particularly juicy morsel of professional gossip, that she had met the trainer in question at a Health Board reception. 'I marched up to him, tripped slightly, and poured my red wine down his waistcoat.' This is the kind of leadership that inspires not so much loyalty as external devotion.

One purpose of the prescribing game was to show trainees that they were signing away with their prescription pads a hefty wad of tax payers' money, and that they each did so very differently, from one another. We wondered, with prescribing costs rising faster than was in the long term sustainable, how long we would be allowed to prescribe as we liked. Now we have prescription charges, black-listed medicines, prescribing advisers, and indicative budgets.

Similarly, nowadays, the service generally has the appearance of being unsustainable. If we do not control demand, it will be done by others by the introduction of charges. That very proposition surfaced recently at the Labour Party conference. It seems inescapable that if we want the privilege of working in a system which is free at the moment of illness, we must tackle the problem of demand.

There may be other reasons to do so. Years ago, Ivan Illich invited us to consider whether the level of medical activity prevalent even then might be less than an embellishment of the lives of patients. He saw medicine contributing to the realization of something like Huxley's *Brave New World*. Written in 1932, Huxley's vision seems creepily prophetic now. Today's reader needs little imagination; the Central London Hatchery is technically believable. Soma, the population pacifier, is a next-generation SSRI. The Park Lane Hospital for the Dying is your local hospice with a glossier brochure. Huxley's brave new life is medicalized, controlled, predictable, strangled. Is ours?

We have not yet had the debate which Illich and Huxley set up. If our work guides society towards one or another future, are we bound to think about that, or can we take refuge legitimately in the supremacy of the consumer? If we want to preserve access to GPs on the basis of something approximating to need rather than ability to pay, are we not obliged to adopt sustainable practices? Young docs need to get stuck into these questions. Old docs need to set up the necessary structures and to insist that the philosophizing is professionally valued. That is, they must provide leadership.

Schizophrenia

He comes like a thief in the night
and takes away your precious son,
who you love so much.
And while the doctors tell you what to do,
be supportive and not too demanding,
he turns him into a sluggish shell
and laughs his last cruel laugh.

Pieter Veenhuijsen