The British Journal of General Practice

Viewpoint

Medical Publication Ethics

I have recently been brought face-to-face with publication ethics by three events. The first concerns a family I have cared for as a general practitioner for nearly 14 years (Box 1). The second involves discovering some of my own work to have been extensively plagiarized (Box 2).

The third episode arises from a workshop I recently facilitated for the European Association of Science Editors, which addressed possible content areas of a code of publication ethics for medical and scientific journals.[1] In this context, a 'code', the workshop accepted, could refer to a digest of rules and regulations or something a little vaguer, such as a collection of broad principles addressing areas of moral concern. 'Ethical' was taken to mean knowing where agreed duties lie in regard to situations frequently arising in the course of editing science journals in which questions of right and wrong loom large.

To judge by the burgeoning literature on the subject, a rapidly growing corpus of ethical issues is taxing the minds of editors the world over,[2,3] covering such matters as:

- how to limit potential damage from the intensifying pressures to publish;
- how to guarantee patient confidentiality and consent to disclosure of information;
- how to measure (and possibly improve) the validity of peer review procedures and, given the complex collaborative nature of much medical research, how to develop appropriate criteria for authorship and contributorship; and
- how journals can best ensure reviewers' and authors' conflicts of interests are properly disclosed, and that research misconduct (including plagiarism) is reported to an appropriate authority, once detected.

Is it not time to open a debate, in the pages of this journal, about the ethical complexities that now surround medical publication? My particular experiences indicate that matters of publication ethics touch not only the relatively abstract worlds of editors, academics, and colleges, but those of patients, practitioners, authors, and contributors too.

Brian Hurwitz

References

1. *BMJ*/EASE. Workshop for editors of Journals. Paris Berthier, 22–23 October 1998.
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3. Williamson A, White C (eds) Annual Report of the Committee on Publication Ethics 1998. London: BMJ Books, 1998.

Box 1

The mother of a 16-year-old patient consulted recently and recounted how she had recognized a picture of her daughter as a baby in a book about the paranormal. The mother had immediately recognized the distinctive features of her daughter's port wine stain in the photograph, together with her own hands (she had been holding her baby aged only 3 days old when the picture had been taken).

The stain, and the multiple laser treatments it has required, have caused considerable suffering to the girl and her family over the years. The picture appeared in a chapter concerning body marks which allegedly supply clues to the causes and modes of dying sustained in previous lives. Port wine stains, the book asserted, appear in the reincarnations of people who have died violently, particularly in those who have been burned to death.

The mother was stunned. So was I!

Her child had been born in a central London hospital; and she had agreed to a photographic record being made by an official hospital photographer, but had never thought about the matter again. The mother had assumed the photograph would be used for teaching and educational purposes only, and had not given consent for the image to be published.

I wrote to the relevant hospital photography unit and received a reply from the custodians of something called the National Medical Slide Bank, a national collection of medical images donated by departments of medical photography throughout the UK. The custodian apologized for a breach of the ethical code that now regulates the release of medical images to third parties, which requires that identity must in no way be revealed. This particular picture has now been re-classified as 'not for loan

Box 2

Last year, I was sent the manuscript of a talk which had been delivered to a large gathering of doctors, concerning a topic which I also have researched and written about. The entire argument developed in the manuscript, which had been handed out at the meeting, was a cut-and-paste rendition of two papers I had published previously in medical journals. Some 70% of the manuscript consisted of verbatim liftings from these articles, reproduced without acknowledgement or citation, and without any indication that they were, in fact, quotations.

I wrote a letter of complaint to the author, enclosing a parallel text. Eventually, I received a letter of apology, and then thought nothing more about the matter until I was subsequently sent another manuscript of a talk delivered by the same lecturer to another group of doctors, on a similar subject. The first paragraph of this second talk was a verbatim, unacknowledged transcript of a paragraph I had written in a BMJ editorial some years ago.

The Back Pages...

'One thing you can say for the old, pre-reformation NHS, is that every atom of its fabric shimmered with care ... '

James Willis, 'Time To Count The Spoons', page 86

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news

The RCGP Careers Support Forum's Great Careers Debate

In October, the RCGP's Careers Support Forum demonstrated the College's continuing, if unsung, commitment to working for its members. The Great Careers Debate aimed to address the issues surrounding falling recruitment and retention in general practice. Over 80 delegates attended representing GPs at all stages in their careers, from registrars to those approaching retirement, and from retainer scheme doctors to senior educationalists.

Dr Roger Chapman, Chair of the General Practitioners Committee's medical workforce subcommittee, opened the meeting with an outline of the history behind the current recruitment crisis. The Medical Practices Committee's current estimate of 1000 principal vacancies demonstrates the severity of the problem, however the situation is likely to become worse as many overseas GPs currently working in the inner cities approach retirement, and an insufficient number of young GPs are willing to replace them. A recent BMA report shows that only 20% of young doctors wanted to enter general practice, when the discipline needs about 50%.

Shaun O'Connell, a principal in Leeds and a founding member of the National Association of Non-Principals, discussed the lack of exposure of medical students and junior house officers to general practice. The content and length of GP training was inadequate, however he emphasized the importance of the new ability of house officers to spend four months of their pre-registration year in general practice, and for GP registrars to spend 18 months in practice. He also called for more formal posts at the end of training to help newly qualified non-principals, and for schemes to support young principals.

Amanda Kirby spoke enthusiastically about portfolio careers, arguing that most GPs have a portfolio career. This should not be regarded as 'opting out', but recognized rather as a way of enabling doctors to maintain their enthusiasm and 'stay in' general practice. Jamie Harrison spoke about the development of the County Durham Careers Start salaried posts and how they had enabled newly qualified GPs to remain in full-time posts providing continuity of care. Such schemes encourage doctors to look for and remain in principal posts within the locality. Many delegates were enthusiastic about the opportunities that such posts bring, and felt that similar posts needed to be developed across the country.

Maureen Baker welcomed recent changes to the doctors' retainer scheme. She also described her work in establishing the first re-entry course for general practice to be run in the UK, and outlined current initiatives to aid returners to general practice.

Workshops in the second half of the morning explored further the topics that speakers had addressed. In the Early Career Planning workshop, delegates discussed the value of making a career plan that included a six-monthly operational plan and a five to ten-yearly strategic plan. The Portfolio Careers workshop discussed potential ways of working with a GP's qualifications, the difficulties of working as a locum, and how continuity of care for patients is best provided. The Salaried Doctors workshop highlighted the lack of information about such posts. The workshop agreed that a salaried service should not replace the independent contractor model but that the two models of provision of service should exist.

In the afternoon, Ruth Chambers, Professor of Health Commissioning at Staffordshire University, highlighted the benefits of adopting flexible working patterns. Showing that trends in working patterns were moving towards increasing flexibility, Professor Chambers discussed the barriers to flexible working and emphasized the need for ongoing medical careers counselling. She argued that job satisfaction is more important than job security and that flexibility enhances standards and protects against stress. She concluded that the 'New NHS' had to accept increasing flexibility for much of its workforce and wondered if the day's debate should have been inclusive for all primary care careers.

Dr Sarah Jarvis and Dr Andy Rose vigorously argued that 'There is Life after 50'. They looked at alternatives to traditional models of full-time working, and tactics to prevent 'burnout' and maintain enthusiasm throughout a professional career. Continued career planning and a modicum of outside interests help to keep enthusiasm for general practice alive. The subsequent workshop was welcomed as an opportunity for delegates to share problems and seek solutions. Common themes were 'getting stuck' and personal and partnership conflicts. Solutions centred on the provision of information and support, and planning for retirement.

Mrs Deborah Mellor chaired an NHSE-led workshop entitled 'Working Lives'. More philosophically than in other workshops, she addressed the real reasons for the recruitment crisis. Her group felt that more GP training should be based in the community, but also believed that young doctors had different aspirations from their predecessors and did not accept that work dominated the lives of older generations.

By the end of the day, many delegates were commenting that they had appreciated just coming and hearing that others had similar difficulties to themselves. There was a strong resolve to 'talk up' general practice, as it was far from 'all bad'. Delegates wanted better access to career planning, better information on flexible career options, and more support for women GPs who wished to return to general practice after a career break. Dr Baker asserted the College's interest in working for all GPs to address such issues. The Careers Support Forum plans to address these issues in its forthcoming publication on careers in General Practice.

Shaun O'Connell

WONCA Europe 1999 Mallorca

The preliminary programme and call for abstracts is now available for the next European Society of General Practice/Family Medicine (WONCA Region Europe) meeting in Mallorca, May 19–22 1999. The meeting will take a different format this year: it is the first open meeting of the European Network Organizations, which look at education (EURACT), research (EGPRW), and quality (EQUiP) issues across Europe. It is being organized by the Spanish Society of Family and Community Medicine (semFYC).

If you or any doctors you work with require further information, leaflets are available from the RCGP International office, or from the conference secretariat (e-mail congresos@semfyc.es). These are being circulated to faculties and members of Council this week.

The deadline for submission of abstracts is 15 January 1999. The meeting is intended to be smaller and the venue has limited capacity. **Registration to attend the conference cannot be guaranteed after 17 March**.

Do let us know if you need any further information on extension 302 or 205.

International Department

Seeking Ultimate Career Satisfaction? — Write Now!

Where DID it all go wrong?
How on earth did I end up here?
I never thought it would be like this!
How can I refuse?
I feel trapped!

Many of us, in varying degrees of despair or frustration, or occasionally elation, have asked ourselves these or similar questions at some point in our careers. Hopefully most of us, with some hard work, deep thought, and considerate support from colleagues, friends, spouses and families have struggled through to some resolution, with or without some professional help. Unfortunately, the disproportionately high rates of alcoholism, drug addiction, and suicide within the medical profession — not to mention partnership and marital breakdown — suggest that this is not always the case.

Sources of career difficulties
Increasing concerns about the GP workforce, service changes, alterations in societal, cultural, and family priorities have all put pressures on the traditional perception of the male-dominated career structure of general practice — a perception, which is based on a now half-century-old philosophy. Dr Finlay has a lot to answer for!

Over the last ten years, much attention has been paid to the problems suffered by specific interest groups within the profession — women doctors, ethnic minorities, academic GPs, part-time GP registrars, retainers, assistants, and most recently that peculiar hybrid (which is showing remarkable vigour) the non-principal. But in many ways all of this attempted pigeonholing of doctors' problems misses the point. These variations on the theme of the traditional GP career are not problem-creating but are, instead, all attempts at finding solutions to some fundamental underlying difficulties, which may occur in anyone's life, and which are not even peculiar to doctors. Some of these solutions, such as the new GP retainer scheme, are now becoming quite sophisticated.

Why, then, do so many people encounter such difficulties? The answer is twofold. First, we need to go back to basics to appreciate that no matter which path our career is taking us along, the reasons that may cause us to become unstuck, or feel trapped, are all depressingly similar. Disagreements with colleagues are allowed to fester, marriages founder, people close to us become sick, or die, financial crises hit, the knack of saying 'No!' continually evades us, governments change, and with them goalposts; and through it all, for some maddening reason, small children keep turning up with varying degrees of unexpectedness. Which brings us to the second part of the answer. We are all human, and no matter how professional or Dr Finlayesque we attempt to be as GPs, we are not islands, and from time to time we need a bit of propping up.

Anonymous personal contributions
We've all been there to some extent. The RCGP's Careers Support Forum is now inviting you to share in these columns — entirely anonymously — your blackest moments, your shattered dreams, the lowest points of your career and personal life, and how they have been interwoven. But we need to hear about your salvation too, whatever form it may have taken.

Over the next few months we would hope to publish short extracts from your letters or e-mails that illustrate common threads of dilemmas which are occurring in GPs' lives and how these have been resolved. We cannot provide 'agony aunt'-style replies to individual letters, but this will be your column, your chance to get some things off your chest in a public, but anonymous way. However, if it is to work, we do need YOUR contribution, no matter how short.

Our aims are, first, to permit others to see reflected not only their own current distress, but also potentially positive resolutions to their own situations. Secondly, we want to try to establish a truly anecdotal evidence base of the problems UK GPs have encountered in their careers, and how successful they have been in working through them. This evidence base should then be of immeasurable value to those doctors experiencing problems in their own careers, and the colleagues who advise them.

Keith Donaldson and Maureen Baker

Managing Emergencies in Primary Care

In recognition of the importance of this subject, the College hosted a conference in November on the management of emergencies in primary care.

Lesley Hallam, a Research Fellow at the National R&D Centre, looked at the importance of managing demand through public education, 'gate keeping', and reducing accessibility. Financial penalties were likely to be ineffective or unacceptable. She concluded that decisions must be made regarding whose interest were paramount — the patients, the providers, or the Government?

Jeremy Dale, Professor of Primary Care at Warwick University, stressed that emergencies included social as well as clinical problems. He described the current system as being fragmented, with poor communication and duplication. He identified skill-mix, professional development, and the use of IM&T as important considerations.

Paul Jenkins described his work as Central Project Manager for NHS Direct. He spoke about the provision of this initiative, that aims to provide a confidential, reliable source of advice to patients and to improve their access to information. Competent staff, user-friendly decision support systems, access to high quality, updated information, and cost-effective use of other health professionals are to be the hallmarks of the service.

Dr Cattie Moss, former Medical Vice-chairman of the Patients Liaison Group, questioned the role of partnership with patients in the emergency situation, but concluded that it should frequently be possible, even so, to involve them or their families in choices of care.

Dr Jim Cox, Medical Adviser to Cumbria Ambulance Trust, examined the interface with the ambulance service and changes in relationships now that paramedics have taken over many of the traditional roles of GPs.

Working Groups were led in the morning by Dr Mark Reynolds, Chairman of the National Association of GP Co-operatives, who looked at the work of the Association, and Heather Maughan, Discharge Planning Co-ordinator at SWLPCO, who examined the role of early planned discharge into the Community.

In the afternoon, working groups were lead by Dr Ed Glucksman, Consultant in Accident and Emergency at King's College Hospital, who examined the input of GPs in A&E departments. Dr David Lloyd described the work of Harmoni, the largest Co-operative in the country; and Dr Sam Everington discussed the work of the Tower Hamlets Emergency Doctor Service in the East End of London.

A full report on the conference can be found on the College website, at http://www.rcgp.org.uk.

six doctors in literature

Six Doctors in Literature

Number 1: Dr Bero from *Madmen and Specialists*, by Wole Soyinka

The majority of practising clinicians in literature are sympathetic characters. Most medical 'monsters' tend to be of the 'mad scientist' type, as exemplified by Victor Frankenstein.

However, Wole Soyinka presents a truly terrifying example of what the ordinary doctor may become when divorced from ethical practice.

Soyinka's play, first performed in 1971, is set against the aftermath of the Nigerian civil war. The action takes place in and around the home surgery of Dr Bero as he returns from the conflict to his village.

Dr Bero's sister has looked after his practice while he has been away, with the aid of two old women, using traditional herbal cures. She believes he has been practising medicine at the front line. Dr Bero's father has disappeared after running away to the war in a confused state.

Before we meet Dr Bero, a terrifying chorus of cripples and beggars suggest that Dr Bero has not solely been involved in good works while he was away. They act out an apparent scene of torture, conducted by 'the Specialist':

> *Aaafaa:* ...*(points a 'needle' held low, at* GOYI*)* ... Think not that I hurt you but that the Truth hurts. We are all seekers after truth. I am a Specialist in truth. Now we shall push it up all the way, all the way? Or shall we have all the truth, all the truth.*(Another push. GOYI screams, then his head slumps.)*

The torturer depicted is clearly adept at all forms of torture, both physical and psychological.

When Bero appears, it transpires that he has imprisoned his father in the surgery, after smuggling him back to the village with the aid of the beggars. He is contemptuous of his sister and castigates her for accepting help from the old herbalists. He identifies his new nature to her:

> *Bero:* You are everything once you go out there. In an emergency…The Head of the Intelligence Section died rather suddenly. Natural causes.
> *Sister Bero:* And that's the new vocation?
> *Bero:* None other sister, none other…
> *Sister Bero:* But you have… given that up now. You are back to your real work. Your practice.
> *Bero:* Practice? Yes, I intend to maintain that side of my practice. A laboratory is important. Everything helps. Control, sister, control. Power comes from bending Nature to your will. The Specialist they called me… You analyse, you diagnose, you — *(he aims an imaginary gun)* — prescribe.

There are complicated levels of political and social satire in this play, many specific to the situation in Nigeria at the time the play was set. However, it becomes clear that both Bero and his father have indulged in thoughts and actions that have overturned traditional values. One expression of this is their apparent espousal of cannibalism. This is an apt metaphor for the fratricide of civil war. Bero's reductionist justification for the practice illustrates how scientific method can become truly monstrous when divorced from morality:

> *Bero:* ... What is one flesh from another? So I tried it again, just to be sure of myself. It was the first step to power you understand. Power in its purest sense. The end of inhibitions. The conquest of the weakness of your too human flesh with all its sentiment.

Dr. Bero's imprisonment of his father in his surgery can be interpreted in several ways. It may be an attempt at reconciliation or a cynical way of removing a relative threatening to embarrass Bero before the new regime. More disturbingly, it may be a prelude to the torture and murder of his own father.

> *Bero's Father:* I am the last proof of the human in you. The last shadow. Shadows are tough things to be rid of. How does one prove he was never born of man? Of course you could kill me…

The play ends with Bero shooting his father. The 'last proof' of his humanity has gone. The old women herbalists then burn his surgery. Despite their efforts, Bero remains — one of the most frightening depictions of evil in modern fiction.

Dr Bero has used his clinical prowess to become a torturer. His communication skills justify the unthinkable. It is worth remembering that physicians around the world are frequently involved in cases of torture reported to human rights organizations.

We are a profession that manipulates other humans both physically and mentally, in the most profound ways. Dr. Bero shows what we may become without ethical guidance for our skills. There can be few more dangerous people than a doctor without morals.

Wayne Lewis

Text used: *Madmen and Specialists,* from *Six Plays* by Wole Soyinka. London: Methuen, 1984. Thanks to PE Lewis for help in identifying the text.

essay

A Need To Know

How much information do pregnant women want during their antenatal care? We doctors believe they want to know about the normal course of pregnancy, the reasons why we test their blood pressure and urine at clinic visits, and what an ultrasound scan is capable of showing. We counsel them about the rationale behind the triple test, and discuss the birth plan and place of delivery. They may go to antenatal classes and talk about labour, what is normal, and what might go wrong.

And yes, there should be some time to think about a less than perfect outcome: the possibility of a forceps, vacuum, or Caesarean delivery. Most pregnancies and labours proceed normally and naturally. There are a small number that do not.

Three years ago Caroline's baby died seven hours after birth. She had been worried early on in the pregnancy when she was told her eighteen-week scan showed an abnormality that suggested the fetus might have cystic fibrosis. At thirty-four weeks gestation she and her partner were informed that everything was fine. At thirty-six weeks the baby was born and named Ingrid. Soon afterwards, the girl developed breathing problems and was taken to the special care baby unit, where she died later that day.

Caroline believes that expectant mothers should be told about the possibility of perinatal death, so that they are prepared to make choices and have some idea of what to do after such a tragic event. She and her partner were offered choices while their baby was dying. She remembers being uncertain about what to do. They were in a sitting room; the baby was in the room next door. They were given the choice of seeing her if they liked, or staying on their own. She would have liked to have been gently guided into being with the child. She had the impression that the nursing staff were frightened of her grief and that the professionals were also unable to cope with their own feelings.

Before the ventilator was switched off, the couple was asked whether they wanted to be present at that time. Caroline said no, because of the impersonal nature of the machines. But she felt there was a misunderstanding, as they were then left alone for longer than expected while the baby was dressed in hospital clothes. The baby was given to her to hold. She asked if Ingrid was dead. No one would say. She was told that Ingrid's pulse had stopped.

There is a photograph of her daughter, Ingrid, which was taken after she died. The Polaroid is dark; Caroline did not want to be on the pictures herself at that time, but now she wishes that someone had suggested: 'it would be lovely to have a photo of you with the baby'. In her grief, she was unable to project ahead and see the comfort such a photograph would bring in later years.

In hindsight, she understands her feelings and knows that she could have made different choices. She was unprepared for her baby's death, and suggests that women should be prepared for these choices. The possibility of death could be discussed in antenatal classes; in a group setting the discussion could be less intense. Perhaps this preparation would prevent the feelings of failure a mother experiences when her pregnancy ends in loss. The baby's short life is to be celebrated, not suppressed: medical and nursing staff should recommend the parents hold the child, there should be access to a good camera, and midwives and doctors need to be trained to deal with death.

While the family doctor and midwives called at the house the day Caroline went home, they appeared to avoid mentioning the death. Perhaps they were embarrassed by bereavement. If only the doctors could have said they were sorry, exposed their own feelings, not with any sense of blame but with empathy and understanding.

Caroline is grateful for the special midwife who seemed to understand, and her obstetrician who called on her at home. On balance, she feels that the staff in the hospital were human and caring. Two of the nurses attended Ingrid's funeral, and on her birthday there were flowers from them on the grave. However, she does think that the changes she proposes will improve circumstances for other families coping with death.

She declined a post mortem, and while there are unanswered questions about the exact cause of death, the reason why does not haunt her. The official cause of death was pulmonary hypoplasia.

In Caroline's words:

Few would readily admit that to think about a birth is also to consider a death, or that planning the birth of a baby may involve a set of counter choices concerning the death of that child at or near birth. Those of us who have had a baby die see that clearly. Sadly, we find that people are reluctant to learn from us though we have in our hands knowledge that lies at the very essence of parenthood.

I believe that this has much to do with the current notions of a modern lifestyle in which we have choices about the directions of our life and think that doctors can cure all evils. The idea of fatalities, particularly of babies, threatens all that. It simply shouldn't happen, but it does. As parents of those babies we are given the message to fade into the background and keep away from pregnant women, the very people who might need our help in the not too distant future.

When your baby dies there are choices to be made. If you are denied access during antenatal care to consider those choices you are left powerless at the most critical moment of your life. You have to live with the consequences. When you learn that your newborn baby has hours to live or that your baby has died before delivery, you need advice on how to handle the situation so that you don't regret making the wrong decisions for the rest of your life.

We have come a long way since the time when dead babies were whipped away from the mother before they were seen. Now we are thrust fully into the drama of the situation yet, bizarrely, given little preparation for the choices we might need to make. Tackling these issues in antenatal classes would be a start.

As a GP involved in obstetric care, I am not sure how to tackle the issues raised so eloquently by Caroline in her piece above, and when I talked to her at length. At what point in pregnancy do we raise the possibility of death, and do we acknowledge that all our antenatal care and screening tests cannot rule out completely any abnor-malities or loss?

Jill Thistlethwaite, Caroline Bath

Sylvia Chapman

Dr Sylvia Chapman, a New Zealand doctor, was leading a relief team in Greece in the aftermath of World War II when financial support was withdrawn. Rather than be repatriated, she decided to settle in the UK.

Despite working as an obstetrician, she regarded herself primarily as a general practitioner. She agreed with the views expressed in the national and medical press that there was a need for a College of General Practitioners to enhance standards. In 1952, she sent a donation to the Steering Committee fund and offered voluntary secretarial support. John Hunt accepted the offer and introduced her to the Provisional Council in December 1952. Within weeks, she was dealing with hundreds of membership applications arriving daily.

After the election of the first Council, a full-time secretary was employed, and Sylvia was asked to act as Registrar to the overseas membership. It is unclear how this transformed into being Honorary Registrar, but she attended Council meetings as such and was frequently thanked for her work. She instigated the College's representation on the Churches' Council for Healing in 1959 and created the memorial roll of fellows, members, and associates still held in Princes Gate. She resigned in 1961, and was elected an honorary fellow at the following AGM.

Sylvia Gytha de Lancy Chapman was born in Dunedin, New Zealand on November 27 1896, the youngest of five children. Her father, who became the first New Zealand-born Supreme Court Judge, was persuaded to allow her to attend one of the new style girls' boarding schools, where the emphasis was on languages, history and elocution. Mathematics was taught on request. Of a class of ten, Sylvia was the only one to stay the course!

A favourite brother was a doctor (Otago, Cambridge, and London Hospital) and possibly influenced her choice of career. Sylvia matriculated in 1915 (the year her brother was killed at Ypres), and graduated MB ChB from Otago University in 1921. She worked for a couple of years at Cook Hospital, Gisborne, before coming to Europe for further study. She acquired the Irish Midwifery diplomas in 1924, then acceptable qualifications for senior appointments.

Back in New Zealand, she set up practice in Wellington, sharing consulting rooms with Agnes Bennett, the Medical Superintendent of St Helen's Hospital. This institution was one of a small number where comprehensive midwifery training was given. Sylvia worked as Dr Bennett's deputy and succeeded her when she retired. She examined for the New Zealand Nurses and Midwives Board 1936–1946.

The high infant and maternal mortality rates were a national preoccupation in the 1920s, and Sylvia was part of the network of professional and well-connected women campaigning to improve matters. She wrote her MD thesis on 'Blood cell morphology in the new-born' (1934), was awarded a Silver Jubilee medal (1935), and sat as a Government nominee on the McMillan commission on Abortion and Maternal Mortality (1937). A year later, she was the first woman to be appointed to the University of New Zealand Senate.

Sylvia was the youngest ever International President of the YWCA and, as a representative of this organization, was involved in many humanitarian activities. She was particularly concerned for the welfare of a group of Polish child refugees who had been settled in New Zealand. It was through the Council of Organisation for Relief Service Overseas (CORSO), which she helped set up in 1945, that she went to Greece.

After her retirement she moved with a friend to Bexhill. She died there on 1 September 1995, of old age.

Helen Sapper

digest

Handbook for Non-Principals in General Practice
Shaun O'Connell (ed) Limited Edition Press
PB, 273pp, ISBN 1 859 88039 8

The contribution non-principals (GP locums, retainers, deputies, and assistants) make to the everyday running of general practice has been overlooked for too long. Their information needs are at least as great as those of their GP principal colleagues, but their access to information is limited by their exclusion from regular mailings of British National Formularies, clinical updating services, GP newspapers, and postgraduate educational events. This handbook brings together the essential information GP non-principals need to safeguard their employment rights and responsibilities, negotiate fair payments for work done, be aware of continuing medical educational opportunities, and contact details of local non-principal groups. The book demonstrates the strength of commitment of GP non-principals in general, by the extent of collaborations involved in writing and producing the book, guided by the main author and editor Shaun O'Connell. The book was commissioned by the National Association of Non-Principals (NANP), supported by an educational grant from the NHSE, printed as a service to the medical profession by the Medical Defence Union, and written by the co-operative efforts of many — more than 50 individuals or organizations are acknowledged contributors. No non-principal should be without this book. Come to that, GP principals need their own individualized version, too.

Ruth Chambers

Rural Health Care
Jim Cox and Iain Mungall (eds)
Radcliffe Medical Press, 1998
PB, £22.50, 180pp, 1 85775 2678

This is the first textbook on rural health care published in the UK. It is largely the work of members of the RCGP rural practice group, with additional chapters contributed by other GPs, a veterinary surgeon, and a practice nurse. As the title suggests, it is not only a clinical textbook, but also covers educational, organizational and managerial issues.

The largest and most comprehensive chapter is on rural diseases. This offers a really useful and practical summary of diagnosis and management of common conditions, and less common ones such as Lyme disease, adder bites and organophosphate poisoning. Short, pithy clinical anecdotes show that the information is borne of experience, not just reading.

I learnt a lot from the chapter on animal diseases, and now understand why one of my farming friends refers to his blackface flock as 'beasts wandering around a hillside looking for various ways to die'. Besides engendering a greater understanding of zoonoses, it is a good idea for us to be better informed about the problems that our farming patients and veterinary colleagues face. The glossary at the end of this chapter has cleared up some long-standing mysteries for me, such as the meanings of 'staggers' and 'teasers'.

There are short chapters on dispensing, communication (including the potential of the NHSnet and telemedicine), teamwork, and the thorny issue of access to care. Rural research and rural poverty, important issues for the next few years, are also addressed. Continuing professional development is well covered in a comprehensive well-referenced chapter, and the increasing importance of multidisciplinary learning and working is acknowledged in several contributions. Dilemmas in the range and quality of service provision in community hospitals are well explored in a thoughtful article, and the section on provision of medical services in remote areas through the inducement practitioner and associate schemes gives a useful overview, with examples of how these complex schemes work. I wondered whether a chapter on the many new initiatives in undergraduate and postgraduate training for rural practice might be a useful addition, perhaps to the second edition.

This book covers a great deal in 180 well laid out pages, an indication of good unobtrusive editing. It has a symbolic as well as a practical importance, in that it illustrates the growing confidence of rural medicine as a discipline. It should be read and discussed by all involved in the provision and planning of rural health services, by educators of nurses and doctors at undergraduate and postgraduate levels, and by medical and nursing students. An essential addition to practice libraries in rural surgeries.

John Gillies

The Reader
Bernhard Schlink (tr. Carol Janeway)
Vin Books, 1998
PB, £6.99, 224 pp, 0 6797 8130 7

This short novel, by a German writer born at the very end of the war, begins, in the affluence of post-war western Germany, as the study of an obsession, and evolves into the study of a crime. The title refers to the criminal's central secret as well as the true role of the narrator, a role which is his teenager's passport into an obsessive relationship with an older woman — he from a middle-class intellectual family, she untutored and menial. Of him, she knows everything; of her, he knows little other than her name. The obsession simmers on long after she ends the relationship, its memory destroying all others — including his marriage.

It is, above all, a novel — understated, bleak and terrifying — of the Holocaust. The woman is identified, in a single thunderclap sentence, as a war criminal who, at her trial, exhibits a perverse readiness to accept her guilt and her sentence. It is the narrator, now a law student present as an observer at the trial, where he sees her for the first time in years, who has to reconcile his obsession with this dreadful new knowledge. It is this knowledge which leads him to recognize it as the complicity not only of his family — passive spectators at the tragedy — but of an entire generation. It is this knowledge which haunts him for the rest of his life, as he struggles to balance condemnation with understanding, and with the realization that her behaviour at the trial is the clue to her secret — that which drove her to become a cog in an extermination machine.

During her imprisonment, he attempts a rehabilitation (anonymously, by post) evolving over the years into a dialogue. Their prison meeting just before her release brings him, as an emotional cripple drained by this obsession still colouring his life, face to face with an old, haggard, fat, grey, woman, for whom, suddenly, he can feel very little. The obsession now centres on the past rather than the present, and it is her suicide just before she is to leave prison that, very slowly, over many years, allows his own release into some sort of emotional quietus.

It is the huge strength of this novel that it brings us all into the anguish of this debate, forcing confrontation with the issues of guilt and understanding — and the absolute limits of forgiveness.

Michael Lasserson

Opium and the People:
Opiate use and policy in 19th and early 20th centry Britain
Virginia Berridge
NYU Press, 1998
PB £20 370pp ISBN 1 853 43414 0

This book is already an established 'classic' for addiction studies and is on the reading list for most further education on the subject. It is not difficult to see why, as this is an exhaustive and detailed account of the place of opium in Victorian Britain which helps to understand contemporary attitudes to the drug.

A fascinating subject, the author retains attention by lacing the text with rich detail of nineteenth century Britain and the circumstances surrounding the use of the drug. The heavy use of opium in the Fenlands of eastern England was so marked that it would have been hard to find a pub which did not adulterate its beer with the drug. While this reflected the local taste for the drug, any unsuspecting strangers would be rendered unconscious by the adulterated brew; not for nothing is this drug labelled 'narcotic'.

The development of the purer drug morphine (named after Morpheus, the god of sleep) at the beginning of the nineteenth century, led to many therapeutic advances and, indirectly, to the establishment of the medical profession. Until then, we had been of tradesman standing and it was during this century that both the medical and pharmaceutical professions became fully established, and as this developed the widespread use of opium, especially as an 'infant soother', came under scrutiny. This culminated in the 1868 Pharmacy Act, where the sale of opium-containing medicines came under control, resulting in a significant improvement in the infant mortality rate.

The author manages to avoid intruding on the story but tries to maintain a balance between the medicalization of opiate addiction and the social circumstances that led to its use. The fact that opium was freely available in Britain at this time and was widely used does not convince this reader that legalization of heroin would be a good idea. The drug was used, as it is today, to cover over the problems that the individual and society was suffering: a symptomatic treatment for complex and difficult problems, but not an answer.

This edition has a brief update of the current situation and twentieth century drug policy, but it is the nineteenth century story that makes this such a valuable book which I can recommend to anyone with even a passing interest in the subject.

Tom Gilhooly

Fellowship
The Committee on Fellowship will meet in May 1999. Please give some thought to whom you would like to put forward for fellowship. Nomination forms are available from the Clerk to the Committee on Fellowship, RCGP, 14 Princes Gate, London SW7 1PU, 0171 581 3232, extension 233. Please note that enquiries about Fellowship by Assessment should be made to the Vale of Trent Faculty, Department of General Practice, Queen's Medical School, Nottingham, Notts NG23 2UH, 01602 970 9391.

uk council, the agm ... 20 November 1998

Motions at AGM
A motion to amend Ordinance 3 to permit the introduction of a system of Membership by Assessment of Performance was passed *nem. con*.

Amendments to Byelaw 2 in connection with the subscription rates were passed at the Meeting, as was a motion from the Honorary Treasurer to re-appoint Messrs Buzzacotts to be College Auditors. The January Meeting of Council will set the actual subscription rate for 1999–2000.

Officers
The following members of Council were elected to hold office in 1998-99:
Mike Pringle *Vale of Trent*
Chairman
Scott Brown *Northern Ireland*
Paul Davis *NE London*
Vice-Chairmen
Tony Mathie *Mersey*
Honorary Treasurer
Bill Reith NE Scotland
Honorary Secretary

New members and observers to UK Council for 1998–1999 are as follows:
Dominic Faux *Midland*
Rob Mortimer *SW Wales*
Gordon MacKinnon *NW England*
Alan Warsap *Severn*
Val Wass *South London*
Tina Ambury, Richard Fieldhouse *National Ballot*
Judy Gilley *GPC Observer (ii)*
Joanne Currie *GP Registrar*
Sean Hilton *AUDGP Observer*

Chairmen of Networks and Examination Board, 1998–1999:
David Haslam *East Anglia*
—Assessment and the Examination Board
Lindsay Smith *Severn*
—Clinical and Quality
George Shirriffs *NE Scotland*
—Education
Yvonne Carter *NE London*
—Research
Maureen Baker *Vale of Trent*
—Services

Chairmen of Committees of Council, 1998–1999:
Philip Evans *Overseas, East Anglia*
–International Committee
Iona Heath *N & W London*
—Committee on Medical Ethics

Annual Report of Chairman of Council
Chairman John Toby presented his third and last annual report as Chairman of Council to the meeting. An edited version will be published in the *Journal*.

FIRST MEETING OF 1998 COUNCIL

The Meaning of Membership of the College and Revalidation
Council considered a paper on the Meaning of Membership and its implications. The paper seeks to recognize present concerns within society about professional self-regulation and the need for professional organizations to set out explicitly the responsibilities and expectations of their members.

In the course of a wide-ranging discussion, Council noted the rapidly changing circumstances in which general practice and the College are operating. There is a clear need to inform the public what medical qualifications mean and how they are linked to standards of practice.

Other medical royal colleges are having similar discussions. The General Medical Council at its meeting on 4 November 1998 agreed to the principle that ‘specialists and general practitioners must be able to demonstrate on a regular basis that they are keeping themselves up-to-date and remain fit to practise in their chosen field.’ The Government, in its recent White Papers, has shown a particular interest in medical professional standards and will introduce proposed legislation early next year to Parliament on clinical governance.

Council, in acknowledging that the College has worked since its foundation to promote high standards of care for general medical practice, recognizes the need for patients to be confident of the quality of care from their general practitioners, reaffirmed that continuing membership of the College indicates commitment to encouraging and fostering high standards of general medical practice for patients, supported the decision of the GMC that all doctors should demonstrate on a regular basis that they are keeping themselves up-to-date and remain fit to practise, decided that membership of the College will be linked increasingly to an explicit demonstration of satisfactory standards of care for patients; and will continue its work towards establishing a comprehensive framework in which general practitioners can demonstrate, on a continuing and regular basis, the quality of care for their patients.

A summary of a paper from Scottish Council of what our members expect from the College was warmly welcomed, and will form part of the review of strategy over the next three years.

Membership by Assessment of Performance
Bill Reith reported to Council that the Annual General Meeting passed *nem. con.* the resolution proposing the amendment to Ordinance 3, to permit the introduction of a system of Membership by Assessment of Performance (MAP). The change needs to be approved by the Privy Council and negotiations with them have already begun. Iona Heath, the Chairman of the MAP Working Group, informed Council of the continuing progress of the system, the pilots presently being conducted, and the aim to have a system operating by April 1999. Iona thanked all the people who had worked so hard to get this important and significant initiative underway.

Accredited Professional Development
Mike Pringle and George Shirriffs introduced a paper on Accredited Professional Development. This proposes a voluntary system for general practitioners in which they can demonstrate explicitly their commitment to lifelong learning through keeping up-to-date, communicating effectively, improving care, and adhering to professional values. The system will include an assessment of personal and professional learning needs, the principle of peer review; and the flexibility to accommodate the wide range of general practitioners; will aim to be supportive of general practitioners, enhancing their professional self esteem. Council noted that the intention is for the system to be independent, although it was accepted that the system may form part of programmes for clinical governance in Primary Care Groups, and their Scottish and Welsh equivalents, and for revalidation for continuing registration with the GMC, referred to above in paragraph 10.

It is intended to invite faculties and other appropriate bodies to bid to undertake the next stage of the work and to bring a report to Council within a year.

Good Medical Practice
David Haslam introduced a paper which sets out links between the GMC’s *Good Medical Practice* and *Maintaining Good Medical Practice*, and various College initiatives on quality issues. The GMC documents clearly state that practices should be able to show that they are maintaining a good standard of medical care and are protecting patients from poor practice. There are implications, therefore, for individual doctors, practices, Primary Care Groups, and the College. Council noted that the College has a number of initiatives which provide quality markers for medical care, including the Examination itself and Fellowship by Assessment. A number are due to become fully operational in the near future, including Membership by Assessment of Performance, Practice Accreditation, and the Quality Practice Award. Council was pleased to note that the

College's Patients' Liaison Group plays an increasing role in the continued refinement and development of these initiatives and projects. Council agreed that the College should produce a statement on what is good medical practice in general practice with appropriate patient input.

Quality Markers
Council generally welcomed a paper from Mike Pringle on the principles behind quality markers in general practice. The paper expands on the markers set out in the paper 'Recognising Quality of Care in General Practice', and lists eight principles, including measurability, comprehensiveness, validation through peer review, recognition of the diversity of general practice, and promotion of public confidence and professional self esteem. Council suggested that the principles should have patient input where appropriate and should be applicable throughout the United Kingdom wherever possible. Mike will work on a revised paper and bring it to January Council.

Research Strategy
Council warmly endorsed a comprehensive Strategy Plan for Research for 1998–2003 from Yvonne Carter. This sets out key objectives: raising the College's profile in research and development; raising the profile of research and development in general practice; developing the infrastructure of general practice for research and development; helping to achieve an evidence-based culture in primary care; ensuring the national research and development agenda reflects the concerns of general practice; and developing and fostering links with other organizations to further strategic goals.

Contracting out to Faculties
Council approved a draft Policy Statement on Contracting out to Faculties, and agreed it should also be applicable to outside bodies who carry out work for the College. It sets out a system for how faculties can carry out work of various types for the College. The process will establish the tasks to be carried out, the timescale, the budget, and reporting and reviewing.

Chairmanship of Council
John Toby gave his last annual report as Chairman of Council at the AGM on Friday. At Council, Denis gave a warm tribute to John and thanked him on behalf of Council and College members for all his hard work and achievements. In response, John thanked everyone involved in his chairmanship and, in giving his full support to his successor, wished Mike well over the next three years. Council welcomed Mike's personal strategy for his term of office.

Date, Time, and Place of Next Meeting
RCGP, Princes Gate, Friday 29 January, 1999 at 10.00am.

Ryan Prince

A Day at the RCGP Annual General Meeting ... a registrar's viewpoint

Having been shocked and dismayed to have failed the DRCOG exam a month ago, I vowed that I would never sit another examination again. If MB ChB was good enough for all those jovial, golf-playing, successful GPs out there who you seemed to bump into at just about every watering-hole in the region, that would do me fine also!

My tutor during my time as an SHO in Obstetrics some time ago had told me what the DRCOG was all about. Apparently he even used to examine for it. He said that he had quite frankly been told that he was not to fail anybody unless they were absolutely appalling, as it would be 'rude' to do so, each doctor having shown an interest in the exam and given a few quid to the College. So when I managed to fail the exam by 1%, I thought that I was appalling too, or was simply not meant to gain any further accolades in life. There was no way that I was going to waste any more money and sit the MRCGP!

I sheepishly told my trainer of my impending slide into academic anonymity, and as a fellow of the RCGP he said, 'OK, fair enough', which was not exactly the reply I was expecting!

A few days later he said, quite casually, 'Oh, the RCGP annual general meeting is next week, would you like to come?' I thought 'What's in it for me?', which he quickly pre-empted by saying that, of course, being the fine establishment that it was, there would be lashings of nice things to eat and a bottle or so of wine floating about afterwards. Not only that, but being the sound fellow he is he would even buy my train ticket into the bargain.

After morning surgery, we finally got to London courtesy of Virgin Trains. The last mile to the College was jogged due to the aforementioned time constraints; as a committed 15-stone semi-professional television critic, this put me in a great frame of mind to start with.

However, this soon changed as I entered the hall where the AGM was to be held. Everybody was extremely friendly and seemed genuinely pleased to see and talk to a new Registrar. The people involved with the Royal College were committed to the improvement of patient care. I was inspiring to see what some of these GPs who were receiving awards had done with their lives, including charity work abroad, and research that had altered the way we practise and that we all take for granted. It made me realize that being a GP is not just about seeing patients and picking up our pay cheques. Each one of us should really have an obligation to try to do something, no matter how small, to audit the care that we provide and keep improving the way we work.

The College did not forget the existence of Registrars (which would be easy enough to do, considering that we appear to be an endangered species at present), with an award for the best marks at the MRCGP, and the Roche award for the best audit project undertaken. In addition, the James Mackenzie lecture on quality and efficiency as a GP — a topic that I suspected would make for quite a dry delivery — was most amusing and stimulating.

After the business part of the day, including a very sensible decision to allow mature GPs membership of the College by assessment, the fun part of the day started, which turned out to be a really good party with a buffet and excellent wine. After a few minutes the President of the College announced that this was an opportunity to speak to whoever we wished. I seized the opportunity and spoke with the President who, like everybody else there was very friendly and unassuming, and told me that he would look forward to seeing me round the place in future.

To me, the College is no longer just an address at Princes Gate, or a body who want to rip me off to the tune of hundreds of pounds to sit yet another postgraduate exam. It is somewhere where all GPs can find identity with like-minded people. I will now be sitting the exam and paying my annual subscription (apparently, it's all tax deductable!). I will look forward to the next time I can go down there for a damn good party, and perhaps even to learn something!

our contributors

Caroline Bath is a teacher in Yorkshire

Ruth Chambers is a GP non-principal, and is Professor of Health Commissioning at Staffordshire University

Tom *Henrik Larsson* **Gilhooly** combines high academe with fervent support for a Glasgow football team. His favourite drug is methadone

John Gillies is a GP in the Scottish Borders

Brian Hurwitz is senior lecturer at the Department of Primary Health Care & General Practice, Imperial College School of Medicine at St Mary's, Norfolk Place, London W2 1PG.

Michael Lasserson remains in Surrey

Wayne Lewis was photographed in one of the comics recently, displaying a most fetching line in knitwear. He practises in the darker parts of Wales

Shaun O'Connell is an editor of the *Non-Principal's Handbook*, and works as a GP in the north of England. He is a member of UK Council

Ryan Prince is a GP registrar in Hampton-in-Arden, very central England

Helen Sapper practised in west London for 'too many years', and is now semi-retired. She became intrigued by female members of the College in its early years while studying for her Diploma in the History of Medicine, Society of Apothecaries

Jill Thistlethwaite is a GP in Hebden Bridge, West Yorkshire, and a senior lecturer in general practice at Leeds University

James *Paradox of Progress* **Willis** is standing back from real life for six months in order to help people understand why you can't understand real life when you stand back from it. He will be generously funded by the postgraduate medical establishment if there is any justice in this world

All our contributors can be contacted via the Journal office

James Willis

Time to count the spoons

The louder he talked of his honour, the faster we counted our spoons.
R W Emerson, American poet and philosopher

The more we talk about 'communication' in the health service, the less we seem to communicate. The more we talk about 'trust' in the health service, the less we find we are trusted. The more we talk about 'care' in the health service — about being members of a caring profession, about 'packaging' care for consumption, about measuring the quality of care — the more the following sort of thing seems to happen. I wonder if there is a connection.

It concerns two close friends. The sort of people we care about — you know, without being told to, or without feeling the need to write it on a placard. I met him years ago through amateur dramatics and his wife turned out to be my wife's new colleague at school. We have all just been in a production of Schiller's 'Mary Stuart' together. He was Paulet, I was Melville, and my wife was Queen Elizabeth I of England, no less.

One of the many sub-plots in our lives during the later rehearsals and the week of the show was the story of their visits to his old aunt, who was dying, as it turned out, in a London teaching hospital. It became clear that they were extremely unhappy about the care she was receiving, and desperately searching for ways they could take her away. And when I asked them what they meant (feeling to some extent responsible) they said that the person handing out meals in the ward did so wearing a personal stereo and headphones.

Somehow it makes it a thousand times worse when you hear this sort of story to know that the authorities who ought to have been making sure it didn't happen think the answer to the problem (if indeed they see it as a problem) lies in inventing better slogans. One thing you can say for the old, pre-reformation NHS, is that every atom of its fabric shimmered with care. Another is that no-one inside it would have dreamt of saying so. There is something particularly nauseating about seeing lovely, innocent, vital words like 'care' and 'trust' being prostituted in an ad-man's lexicon. 'Trusssssssssssss......t me', say the reptile-smiling teeth, coils ready to tighten. Like Mowgli, we find we don't.

A patient came to see me the other day wearing a particularly nice, individually-designed jersey. When I admired it she said, yes, she was very fond of it, but her teenaged daughters kept making fun of her for wearing it because it didn't have a fashionable label. Children who have grown up judging each other by the brand name on their trainers can hardly be blamed if they can't recognize good design when they see it. But surely we should worry when hospitals can't recognize care. And when they don't know that you can't measure care in inches, or cubic feet, or least of all in money. Or that the very act of measuring it is apt to destroy it.

Saying this sort of thing is not without its dangers. Like amateur dramatics, in the modern world it's not the coolest thing to do. You might almost say that in the modern NHS the last thing it is wise to do is show you really care.

But I don't, as they say, give a damn about that. As Queen Elizabeth I of England, who always shares these thoughts with me, would be the first to admit, it was Mary Stuart who emerged the moral victor. At least, that is, to Schiller's German eyes. Elizabeth — cold, steely, unbending — had all the power, but Mary Stuart — warm, passionate, vital — comforted by Melville in a touching scene at the last, emerged, even though headless, in the right.