The British Journal of General Practice

Viewpoint

No Sex, Please — We're British General Practitioners!

It's spring, and sex is in the air. Once again, we seem to have discovered that Britain has the worst teenage pregnancy rate in Europe.[1] Coupled with a high termination rate, the conclusion seems obvious: 'Something has got to be done'. I've been in practice for 16 years, and it seems that the call has gone out in nearly every one.

The trouble is that Britain has not shaken off the legacy of its hybrid religious past. The other European countries fall into two types: the southern Catholics and the northern Protestants. Each has a distinct approach to the problem of sexuality; the Catholics favouring individual and family control, with a very rigid code, and the Protestants favouring a collective approach to education, and a much more laid back attitude.

Both northern and southern Europeans believe in the rampant sexuality of teenagers. Southerners repress, and northerners accept. The British take neither approach, and hope the problem will go away. We seem to fall between two stools. The moment someone starts giving the morning-after pill in schools, the media start to scream about encouraging underage sex.

The British medical profession is similarly ambivalent about sex. The British medical student is expected to lose all his inhibitions about bowels and waterworks, but is not taught how to take a sexual history. We produce some excellent books about the GP's role in sexual problems,[2,3] and how we can tackle them. However, natural British reticence and embarrassment prevents us from putting these good ideas into practice.

I think that we now have an opportunity to change things. The Viagra debate has made doctors think about the place of sexual activity in the 'health' that we promote. We have become very uncomfortable with the idea that there are 'worthy' and 'unworthy' types of impotence. It has made us look at the other areas where rationing is common — fertility treatment, vasectomy, sterilization, and family planning clinics. I know that varicose-vein operations and tonsillectomies have been cut too, but there does seem to be a tendency for sexual health to be seen as an easy target when money is short.

I would like us to be able to deal with sexual problems with the same degree of comfort and skill that we bring to birth and death. This may be unattainable for many older doctors, but surely we can change things for the new generation. Medical school education is changing, and we can encourage the introduction of education in sexual history taking, sexual problems, and sexually transmitted diseases. Vocational training schemes are already teaching in some of these areas, and can be encouraged to go further. The content of the MRCGP exam should give adequate coverage to these problems.

Above all, I would like us to stop being embarrassed about sex. It is an essential human activity, as normal as eating. Maybe we will soon be able to write explicitly about sex in a medical journal, without putting a warning on the cover.

Catti Moss

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2. Tomlinson J (ed). ABC of Sexual Health. [Series in *BMJ* (1998–1999)] **317-318**.
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The Back Pages...

It may seem perverse to speak of listening at the present time, when there are so many pressures on our time and resources. But to a mind trained in attention, intuitions come timelessly; and between doctor and patient, as Michael and Enid Balint taught, healing moments occur in a flash ...

Ian McWhinney reassesses Michael Balint, page 418

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In the Cuddly Lion's Den — The MRCGP Course at Princes Gate

For those attending a week's course held in February in preparation for MRCGP, it was an introduction to the College for many, and a revisit for an embittered few.

Forty-eight anxious delegates (mostly registrars) met on the first day for some ready contact with the occupants of the perceived Ivory Tower. When they emerged — the boys from South Wales — Doctors Joshi, Dare, Davies, and Morgan, the scene was immediately set and the atmosphere became relaxed, with murmurs of "Ooh, aren't they cuddly?" coming from the (mainly female) delegates.

The aim of the week was to take away the mystery of the examination by meeting the examiners, who provided guidance on 'hot topics' and problem areas (this inevitably included the Critical Reading questions). The small group work provided an intimate atmosphere in which to expose weaknesses — particularly in regard to performance on video — and to build confidence. The mock examinations, including the viva, enabled us to compare ourselves with our peers. From these comparisons, decisions were made on whether we were 'May', 'October', or 'No sitting of the exam' candidates!

The course organizers fostered a tremendous feeling of peer support among the delegates. They themselves were shining examples of well informed, enthusiastic, approachable GPs, to whom we could aspire. In addition, the course content was thorough, relevant and well targetted.

John Toby, former Chairman of the RCGP, was invited along as guest speaker at the end of the course dinner, and he delivered a warm and encouraging speech to the fledgeling GPs. It was a great opportunity to let one's hair down after a demanding five days.

It was, all in all, £550 well spent (how much?!). Most of us came away from the course yearning to aspire to more than just those five magic letters after our names, and to get through the 500-plus references we had been given before May. We also wanted to be part of the College, in the sense of upholding its principles and beliefs, and maybe hoping, in some small way, to prepare for whatever the future holds for it.

This article first appeared in the March issue of the East Anglian Faculty Newsletter.

The next MRCGP course will be held 7–11 September

Karen Blades

New Honorary Secretary for Council

Dr Maureen Baker FRCGP was voted Assistant Honorary Secretary of the RCGP at the Council meeting on 27 March and will replace Dr Bill Reith FRCGP as Honorary Secretary in November.

Dr Baker has been Vice-Chair of her Faculty, the Vale of Trent, since 1992 and has been a member of the College Council since 1994. She has been actively involved in developing Membership by Assessment of Performance (MAP) and is a member of the College's Inequalities in Health Working Group.

Maureen Baker practices in Lincoln and is Associate Advisor in General Practice at the University of Nottingham. She has numerous publications to her credit including *GPs will have a key role in the new NHS* (1998), and more recently, *Flexible work is the key to retaining GPs* (1999).

Of her election to the position of Assistant Honorary Secretary she commented:

"I am delighted to have been elected as Assistant Honorary Secretary and look forward to learning from Bill Reith, who has been a great asset to the College over the last five years. General practice is facing many changes at present and in my new role as Assistant Honorary Secretary I intend to take on the challenges facing our profession."

Founder member honoured for shingles research

Dr Robert Edgar Hope-Simpson, a founder member of the College, recently received the VZV Research Foundation Scientific Achievement Award for a research paper he produced 34 years ago.

His paper, entitled *The nature of herpes zoster: a long term study and a new hypothesis*, has long been viewed as the definitive paper on varicella-zoster virus (VZV) research. He refined the theory that shingles is caused by a reactivation of dormant varicella virus, and he hypothesized that the increased incidence and severity of shingles in older people is the result of declining VZV immunity.

The Examination for Membership and Summative Assessment — Update

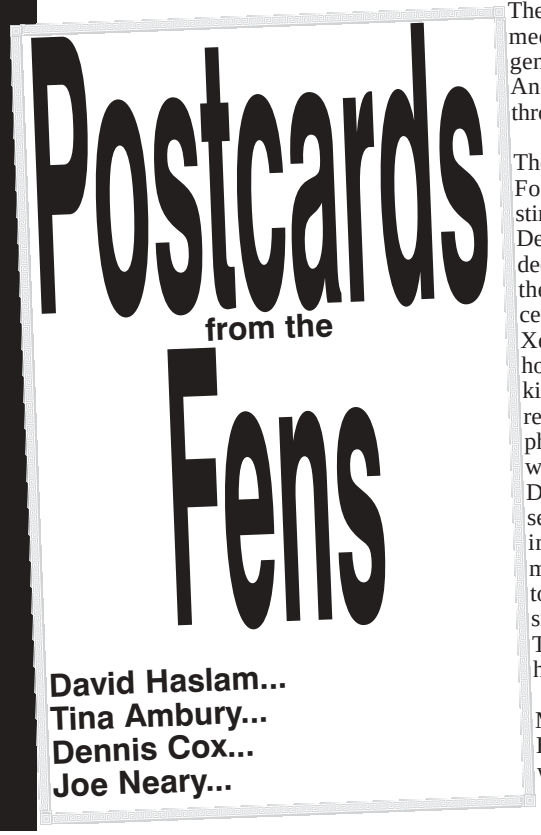
At March UK Council, the Chairman of Council, Professor Mike Pringle, reported on the progress made on the acceptance of the Examination for Membership by the Joint Committee on Postgraduate Training for General Practice (JCPTGP) as evidence of satisfying the requirements of summative assessment. A Working Group comprising the College, JCPTGP, and the Conference of Advisers in General Practice, Universities of the United Kingdom (UKCRA) has been examining possible methods for resolving the current competing demands of the two separate assessment procedures for GP registrars. The JCPTGP has already agreed in principle that a pass in the Examination for Membership should be taken as evidence that a candidate possesses the competencies tested by summative assessment and as set out in the VT Regulations. The Summative Assessment Advisory Group of the Joint Committee will now decide whether to recommend to the Joint Committee that it considers the examination to be technically and academically sound. If it does so, then the Joint Committee will be asked to approve formally that a pass in the examination would satisfy the requirements of summative assessment.

Under the proposals of the Advisory Group, registrars would opt to be assessed through the examination or the UKCRA summative assessment package. In order to make this possible, there would need to be some re-timing of the MRCGP written papers and the development of a common MRCGP/UKCRA log book for the video. Whichever assessment is chosen, registrars would need to submit an audit project and a trainer's report before satisfying summative assessment.

Council debated various complex associated issues: the control of the content and standard of the examination; the need to monitor standards; the importance of maintaining confidence in the examination; the need to support registrars as potential future members of the College during their vocational training; and possible future developments such as the setting up of a Generalist Register and a reconstituted JCPTGP. Council voted by a large majority to go ahead with the application to the JCPTGP for approval of the examination as a whole as satisfying the requirements of summative assessment. Council asked the Examination Board to submit a paper to Council on continuing developments in the examination.

Bill Reith

“Behold, where surly winter flies ...”



It could have been a terrible omen. Three days before the conference, the organizer’s car was stolen. On the back seat lay the signs to direct visitors around the geographically tricky conference centre. Two days before the conference, the keynote speaker was sadly taken ill. The unpredictable seemed to be happening with predictable ease. And then the delegates arrived.

Read the medical press, and your image of general practice would be one of despair, cynicism, and exhaustion. But when Arthur Hibble opened the conference, he said that the overall aim was to celebrate general practice, “the best job in the world”. And nobody argued, or jeered, or sneered.

So there were jokes — my favourite compared fundholding to Jurassic Park: one’s an experiment that went wrong and resulted in our being taken over by monsters, and the other was a film by Steven Spielberg.

The academic programme resembled digital television on an unusually good night. You thought you’d chosen what you wanted to see, only to find that you’d missed something equally good.

On the social front, there were delegates and their partners exploring the delights of Cambridge. Scott Brown went a-punting, and did not fall in. Paul Sackin removed his educationalist hat and provided us with a wonderful array of art, music, and culture. There was Ian Banks, at an RCGP meeting of all places, getting genuinely enthusiastic applause. And there were no pigs flying through the Cambridge skies.

There was much food for thought. Food for delegates was less stimulating, at least at lunchtimes. Delegates passed along a table of deep fat fried nibbles, only to find themselves opposite a pharmaceutical company stand marketing Xenical, complete with a hologram demonstrating what a kilogramme of subcutaneous fat really looks like. Overhearing the pharmaceutical company reps, it was clear they were very happy. Doctors who, in academic sessions, would stress the vital importance of evidence-based medicine, would seemingly listen to anything in exchange for a smart pen and a free calculator. They know who they are — I have their names ...

My personal highlights? Iona Heath’s extraordinary and wonderful Pickles Lecture, which was greeted with a spontaneous and sincere standing ovation, and Gillie Bolton’s workshop on the therapeutic power of writing. It was deeply moving, and so many emotions were displayed and shared that we agreed it had to be totally confidential. I can tell you no more. You missed something remarkable ...

David Haslam

I’m becoming a veteran of spring meetings — this was my sixth one — and at least I got there on time this year. Mind you, I could have missed the opening keynote address, as there wasn’t one. Unfortunately, the keynote speaker was absent due to ill-health, and her ‘stand-in’ treated delegates to a somewhat garbled ‘rough guide’ to the conference programme. Not the most auspicious of starts. Thankfully, this was not a sign of things to come and the weekend’s academic programme was excellent.

Helen Smith, Director of WReN (Wessex Research Network) outlined how the network operates. Her small audience contained at least two professors from other areas and I suspect they were looking for tips to avoid reinventing wheels in their own patches. The discussion certainly suggested that both academic and service general practice can coexist in a mutually beneficial way. Joe Neary and his co-presenter, Audrey Bradford (Chief Executive of the Fenland PCG), tackled the future of the primary care workforce and outlined their experiences in studying how the ‘joined-up’ provision of services might be achieved.

Plans for small group work were abandoned in favour of a passionate debate about the imposition of cost-driven change in primary care. At its heart was the assertion that patient choice must be the focus for any future change.

One of the highlights of the conference for me was a moving display of photographs taken *in situ* by Paul Schatzberger — each with a poem by Gillie Bolton. It was scandalous that this exhibition of the very essence of general practice was relegated to a passage away from the main conference. Shame. But the last word must be about Iona Heath’s pinnacle Pickles Lecture on the last day — wow! I felt humble and exhilarated at the same time.

Tina Ambury

‘Virtue Ethics and the Bristol Case’: there was standing room only at this presentation given by Peter Toon — Head of RCGP Publications, and the Reverend Jeremy Caddick — Dean of Emmanuel College Cambridge. We listended to how we had been looking at cases like this in the wrong way for at least 300 years and that the last person who had got it right was Aristotle. In our support of liberalism and the importance

of the individual, we had managed to forget the significance of good character. We should treat our patients well; not just because we have a contract with them, but because we are doctors and treating patients well is one of the things which defines the character of a doctor.

Likewise, when doctors *do* fail, we should think of them as sinners rather than criminals. Jeremy Caddick helped us understand why the case of the Bristol paediatric heart surgeons had affected us so deeply. We were asked to think about them in terms of Greek mythology — the tragic and fallen heroes of our age.

The argument was then explored and developed by members of an audience which included GPs from Bristol and a member of the GMC who had screened the case — as usual there wasn't enough time to give the subject justice. If you want to know more about virtue ethics, then read Peter Toon's occasional paper, which is scheduled for publication this month by the College (see page 417 for details).

Dennis Cox

Can you imagine how challenging it is to 'let go' and beat a drum to a formless body of sound? I can tell you, the experience was unforgettable. Standing intently at a drum and cymbal, I tried not to feel too foolish as I listened to the rhythmic sounds around me, and started tentatively to join in. This was a music therapy session which formed one of the events at this year's college symposium in Cambridge, and which must rank as the second highlight of the conference for me.

The themes of the symposium were art and science in the service of general practice. If the organizers' intent was a demonstration of how far eclecticism could be pushed in the cause of general practice, then they emerged triumphant. The opportunities of bringing a wide range of disciplines from the outer reaches of Cambridge academia were fully realized.

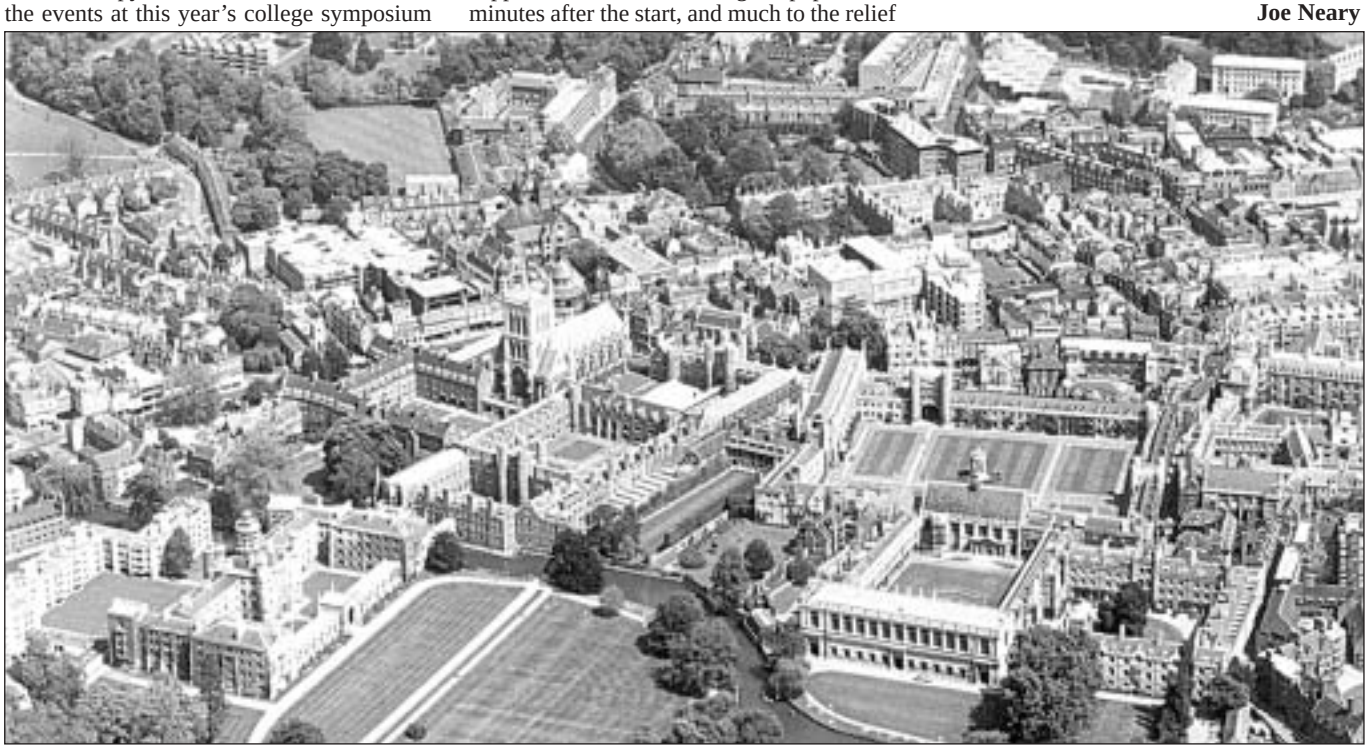
Contributions to the main programme included reviews of classical Athens, philosophy, and art in the service of transplantation. This last item was an illustrated reflection of a life's work in surgery and art by Professor Sir Roy Calne. Give the man his due: he faced up to a full house of GPs and showed us his paintings that illustrated his stories of success and failure; death and survival. I wondered about his painting of patients. Did their survival in his art somehow represent success beyond the unforgiving statistics of surgical mortality?

An embarrassment of riches. I heard many complain of the difficulty in deciding what to leave out of their weekend's plans, the result of compressing material for two weeks of study into 36 hours. I found some of the venues rather difficult to locate. In particular, I remember arriving panting at a small room in Churchill College where I was supposed to be delivering a paper two minutes after the start, and much to the relief of the session chair, Simon Griffin.

The highlight of the conference was beyond doubt Iona Heath's shining Pickles lecture. I cannot remember standing in a unanimous ovation to an academic lecture before. Even less can I remember being reduced to tears by one. Iona gave a masterly display of eclecticism. Such was her perception that she seemed to pluck my own half-formed thoughts from the outer boundaries of my speculative reflection and give them a beautiful and clear articulation. She spoke of paradoxes ranging from wave-particle duality, through the tensions between personal and population perspectives, the condensation of experience into thought, to the distinction between moral autonomy and physical heteronomy. I have to admit that she lost me at times. But for most of the time I felt as though my mind was being stretched and laid bare. Only by appreciating that real life simultaneously contains both sides of mutually exclusive theories can we hope to come close to nature as it is. Huge 'theories of everything', in their pretension to explain all of life's experience in a single grand narrative, are a vanity. They merely illustrate our unease when confronted with a reality which refuses to be constrained within such convenient generalities. This is the stuff of general practice.

Her words resounded into my consultations this week. I tried to listen more. There can be no higher accolade. She even managed to overshadow my music therapy.

Joe Neary



Cambridge University Collection of Air Photographs: copyright reserved

Primary Care Research – The Truth

Much has been written of late about the necessity for encouraging research in primary care[1] and, with the advent of Culyer, more funding is being directed towards primary care research. While I applaud this, I would like to put the view from the coalface, that of trying to do research in primary care.

Research in primary care is different. Having a background of more than 20 years in clinical research, I thought that I knew all there was to know about running a research project. Before beginning on my current project, on the management of dyspepsia in primary care, I heard Professor David Mant speak on the difficulties of trying to do research in primary care.[2] His talk seemed rather disheartening and I must admit I did think that he was overly cynical. Professor Mant, I apologize. You were right, I was wrong. While I would not wish to discourage the enthusiastic primary care researcher in any way, I would like to outline what I consider to be the minimum requirements for even having an outside chance of doing good, ground-breaking research.

First of all, you need an enthusiastic researcher, preferably with the temperament of a labrador — keen, eager, but of a placid nature. This researcher should either be entirely without family commitments, or have a partner with the disposition of a saint. It is very hard for a partner to look enthusiastic about the statistical significance of your results when your supper is in the dog and your kids have cried themselves to sleep. I am lucky in my current project because, although I do not conform to the ideal, the GP in charge of the project fits the above criteria admirably, as does his partner.

Time is probably the most important factor to consider when research is proposed. How is one to fit research into the daily rounds of crammed waiting rooms, irate patients and sleepless nights? Are you really sure that you're going to feel like research after this? There are two ways of addressing this: either you do the research yourself and employ extra help to cover your day job or you pay someone to do the research for you. Both ways have their advantages and disadvantages and only the researcher can decide which is the right way for him. Research can be a break from the nitty-gritty of practice but, when a research study is underway, it can be pretty tedious too. In my current project, the GP researcher chose to employ me to do the study, while he continues in his practice. This has the advantage for him that he is free from the day-to-day grind of doing the research, but continues to oversee it. However, it also means that he is remote from the project and can therefore lose his sense of ownership, unless meetings, etc. are carefully scheduled to be outside practice hours.

The research question should be very carefully considered. A good researcher will probably come up with several possible questions every day. The good research question should take the broad view but ask the small question; that is, be of sufficient relevance to be worth doing, but be formulated to address the population, intervention and outcome. In designing the question, it is worth considering at the outset what one will do with the answer. It is not worth spending years researching a problem that is fascinating but will be of little general relevance and unable to be published. It is also important to be absolutely sure that your proposed research is original, by exhaustively searching the published literature.

One of the most frequently quoted truisms in research funding is: 'To him that hath, shall be given', meaning here that most research grants go to those who have already had them. At first reading, this would seem to be unfair, for how could a new researcher ever hope to get started on the research path? However, the system is not as partisan as it would appear.

No craft can be learned from a textbook and the best learning takes place under the eye of a master. It is important that the researcher should have ownership of a project, in order to sustain him through the hard days ahead, but before attempting to pursue a research question off one's own bat, one should have had some practical training in research. By this I mean one should have actually done some research in collaboration with other, more experienced researchers, not just attended a few seminars on research methods. Thus, the best way to learn the craft of research is under the eye of an

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2. Department of Health. *R&D in primary care (National Working Group Report.)* London: HMSO, 1997.
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4. Federation of Primary Care Research Networks, c/o Trent Focus Group, Department of General Practice, Medical School, Queen's Medical Centre, University of Nottingham, Nottingham, NG7 2UH.

experienced researcher. This can prove a big problem for the career GP who will not have had the opportunity for supervised research that his hospital-based colleague may have had, and this may affect his ability to attract funding as he will not have a portfolio of research papers to his name. Also, single-handed research is a lonely job. The best research is done in centres of excellence where your knotty problem can be chewed over in the coffee room by like-minded colleagues. The primary care researcher has a real problem here. Where can he get the support he needs to do good research? Being associated with an academic institution can help, but the linkage that most provide is little more than just a name to enhance the letterhead. The researcher must be actively insinuated into the research culture of the institution and both the researcher and the institution should give and receive an equal measure of support and benefit.

Obtaining funding for research is an area in which you should seek advice from an expert. Preparation of grant proposals is not something to be undertaken by the amateur and many areas are well served by Research and Development Support Units or University Research Offices. Get help, and do not be too disheartened if your first attempts are unsuccessful. Remember local charities and patient support charities as a source of funding. There is increasing support for networks of researchers in primary care and you will probably find that there is one near you. Information about networks can be obtained from the Federation of Primary Care Research Networks.[3]

Research is often best practised as a team and the drawing together of a good team is the most important part of the research process. No-one should be under pressure to do research without being wholly committed to the project. Motivation is hard enough when you truly believe that what you are doing is worthwhile.

It goes without saying that every team should have a leader and that the team should be compatible. In primary care, the team is almost always multi-professional, including members of the primary health care team as well as the necessary academic disciplines relevant to the project, such as statisticians, psychologists, or health economists. Do not be inhibited by the presence of academics on the team. While you do not have their strengths, neither do they have yours. How many statisticians regularly dream up projects to inform their practice? Nonetheless, neither should academics be treated like technicians: "Twenty-three in each group, you say? Thanks, goodbye". Remember that there will be differences in work culture and that tolerance is necessary if the team is going to gel.

In primary care research it is almost always necessary to recruit patients from the practices of others. This can lead to all sorts of potential difficulties. How would you feel about a colleague who does not want to recruit patients to your study, but you have recruited for him for years? In my current project, where no financial inducement is involved, only about 5% of GPs recruit with any enthusiasm, either for the sheer love of research or because they were best man at my wedding; 10–15% occasionally recruit a patient, when they have time and remember about the study; 70% say they recruit but never recruit a patient, and 10% said from the outset that they were not interested and gave no further bother. Researchers in other primary care projects have indicated that their figures are similar and that monetary inducements will only encourage slight movements from group to group.

Having achieved a research grant, a mentor is essential and should be chosen with care. I define a mentor as a person, outside the study team, whom one feels has sufficient experience to provide wise counsel and support during the course of the project. The most productive mentorship usually begins by chance and develops by mutual consent. No-one should try to fulfil this role for an unwilling mentee. The relationship requires mutual understanding and respect.

Finally, if you have a burning idea for a research project then I would encourage you to have a go. The time has never been better for primary care research and if you don't try, you'll never know whether you could have done it. Above all else, you will learn a tremendous amount and you won't be bored!

Lisa Vickers

Six Doctors in Literature

Number 5: the doctor from *King Lear*, by William Shakespeare

King Lear is Shakespeare's tragic masterpiece on madness. Here, we meet the dysfunctional family from hell. King Lear and his three daughters spend their time in the play sliding towards self-induced disaster. The final scene sees the whole family die in a conclusion of unparalleled bleakness. It is fitting that such a play should contain one of Shakespeare's few doctors.

Cordelia, the daughter who truly loves Lear, symbolizes the healing power of human love. She attempts to bring help to the King, who has gone mad through despair at his foolishness, and his betrayal by Goneril and Regan (his other daughters). The doctor appears with Cordelia as she tries to rescue her father, emphasizing her association with healing. As they search for Lear she appeals to the doctor:

Cordelia: What can man's wisdom
In the restoring his bereaved sense?
He that helps him, take all my outward worth.

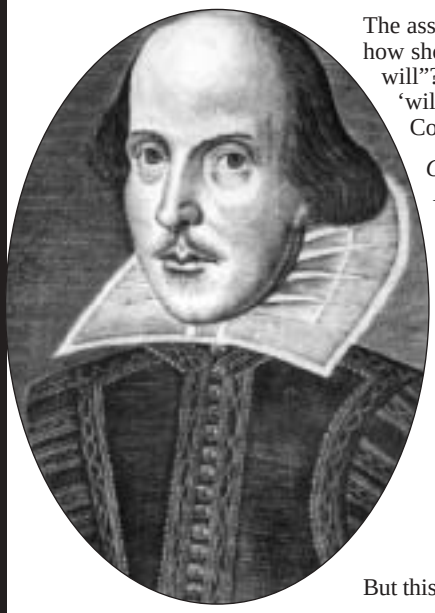
This is ironic, as Cordelia was unable to show her 'outward worth' to Lear when he looked for compliments from his daughters. This lead to her banishment. Her worth is proved to be inward, as it is she, not her emollient siblings, who cares for Lear now. The Doctor replies:

Doctor: There is means, madam.
Our foster nurse of nature is repose,
The which he lacks; that to provoke in him
Are many simples operative, whose power
Will close the eyes of anguish.

The doctor is claiming he can provide a quick and simple cure, by returning to Lear the 'repose' of nature. But hasn't Lear been experiencing the full force of 'nature' as he endured the storm on the heath in his madness? This cure doesn't sound so sure.

The doctor reappears when Lear is found:

Cordelia: How does the King?
Doctor: Madam, sleeps still.
Cordelia: Oh you kind Gods,
Cure this great breach in his abused nature!
Th'untuned and jarring senses O wind up
Of this child-changed father.
Doctor: So please your majesty,
That we may wake the king. He hath slept long.
Cordelia: Be governed by your knowledge and proceed
I'the sway of your own will.



The association of Cordelia with the doctor is clear from the running together of their lines. But how should we take Cordelia's request that the doctor wake the King: "I'the sway of your own will"? The doctor must wake Lear now so he can be reconciled with Cordelia. The doctor's 'will' is totally subservient to the dramatic logic of the plot. Similarly, when Lear wakes, Cordelia asks the doctor:

Cordelia: He wakes! Speak to him.
Doctor: Madam, do you; 'tis fittest.

As if the doctor could reply otherwise. It is this reconciliation that we have been waiting for, not the doctor's views. This is the original 'walk-on part' for the medic. We learn nothing about him. He is there for plot and character development only. He is gloriously two-dimensional while surrounded by some of Shakespeare's most psychologically complex characters.

We bid farewell to the doctor as he gives the ultimate in impossible advice. Referring to Lear, he exhorts Cordelia to:

Be comforted, good madam. The great rage,
You see, is killed in him; and yet it is danger
To make him even o'er the time he has lost.
Desire him to go in; trouble him no more
Till further settling.

But this is King Lear! He can't be "troubled no more!" Set an achievable goal, for Goodness sake!

Lear's doctor should remind us that we too only have 'walk on parts' in the great tragedies of our patients' lives. Lear's doctor would have seen the King as 'his' patient. The King is in return barely aware of his existence. Truly:

The oldest hath borne most; we that are young
Shall never see so much nor live so long.

Wayne Lewis

Text used:
New Penguin Shakespeare

RCGP Publications — “the times they are a’changin’ ...”

Publications are one of the most visible faces of the RCGP. This *Journal* and the *Occasional Papers* are a forum for the presentation of new ideas and research evidence. I am now responsible for the other publications, and their main purpose is to provide GPs with up-to-date ideas and information in a clear, simple, and organized form that they can use in practice. In the past, this has largely meant publishing textbooks and reference books, as well as reports on policy and RCGP projects. This is valuable and will continue. However, there are now new challenges in general practice and new ways of publishing.

Traditionally, we sat down and read a book; a rather passive activity. When not being read they made a warm and comforting contribution to the furnishings. For many books, bought in hope that merely owning them would provide wisdom, the latter was their only function. But the interaction between readers, books, and practice can be much more active. We intend to work towards making our publications aids for active distance learning.

Like it or not, we now have to face clinical governance. Although overshadowed by other reforms at present, the pressure for continuous professional development based in practices and related to patient needs will not go away. Very soon, revalidation will be a reality, and GPs will need tools for these tasks. To help us cope, Ruth Chambers’ *What Stress in Primary Care!* is a personal stress management plan for individual use; the first of our active learning books. Soon to be published are a series of workbooks for the increasing number of GPs involved in research alone or in networks. We intend to accompany future books on clinical and management topics with practical learning plans for practices to use, and will seek to get this learning accredited under PGEA or whatever future systems there might be.

To most of us, publishing means books, and books mean paper. Five hundred years ago, the printing press suddenly made books widely available at a fraction of the cost of tedious copying by hand. Now they are mostly prepared on computers. The Internet makes it possible to publish text and pictures even more widely, without transport and paper costs. So far, the College website, like those of most organizations, has been used to advertise services and provide information. But the World Wide Web provides opportunities far beyond this. Text and pictures can be downloaded straight into the practice computer, saving shelf space. Learning can be interactive, both with prepared materials and with other doctors, in the next street or on the other side of the world. We will be exploring all these options to find ways to make College publications really useful to doctors and for patient care.

Peter Toon

Fifty Years On: The Legacy of Michael Balint*

**Based on an address delivered to the International Balint Society on 10 September 1998, in Oxford, England.*

It is fifty years since Michael Balint and his GP co-investigators started to explore the doctor–patient relationship in general practice. I entered general practice in 1954 and, like so many of my contemporaries, I found myself in an unfamiliar world for which I was ill-prepared. I can still remember the excitement with which I read *The Doctor, His Patient and the Illness*[1] when it was first published. For me, it threw light on some dark places. The book has become a classic and some of its aphorisms have entered the language of general practice, but I suspect that it is now rarely read. The book came out of the general practice of the 1950s. Fifty years later, the context has changed and now, as we approach the end of the century, it seems a good time to assess the relevance of Balint's ideas for modern medicine.

Re-reading the book after an interval of many years, I was struck by how well Balint's key ideas have stood the test of time. For Balint, the doctor's ability to listen was of central importance, and gaining this ability involved a process of personal development. Listening, wrote Balint, 'is a new skill, necessitating a considerable, though limited, change in the doctor's personality. While discovering in himself an ability to listen to things in his patient that are barely spoken because the patient himself is only dimly aware of them, the doctor will start listening to the same kind of language in himself'.[1] In the group, Balint was described as a model listener: 'He listened to everything that went on — to the preamble, to the story as it unfolded without interruption, to the asides, to the unconsidered remarks, and to the jokes. But he did more than listen to the words … he also took in everything that went on in the here-and-now of the session — the silences, the glances, the atmosphere'.[2]

Balint not only proposed a new task for medicine ('deep' diagnosis) but also developed, together with his GP colleagues, a group method — the Balint group — for bringing about the necessary personal change in the physician. The aim of the Balint seminar was 'to reveal a GP's emotional reaction to the patient, acknowledge his counter-transference, and work with it in the service of his professional endeavours'.[2] Although the focus was not on the doctor's personal life, Balint acknowledged that the doctor could benefit in his or her own personal development. Balint was a psychoanalyst as well as a physician, and the ideas generated in his first group were a coming together of insights from psychoanalysis and general practice. Psychoanalysis now has many critics. As a way of producing personal change it has proved disappointing. Its underestimation of human possibilities, and heavy emphasis of sexual repression, now seem perverse. Petty squabbles about technique have invited ridicule, not least from Balint himself. Yet analytical psychology has helped us to appreciate the importance of unconscious motivation in human behaviour, and the role of defence mechanisms in the avoidance of disturbing emotions. The emotions, beliefs, and assumptions that the clinician brings to the doctor–patient relationship have great potential both for good and for harm. Balint remarked that doctors were often quite unaware of how much their own perspective determined their behaviour, even when this seemed obvious to the other members of the group. The personal change he spoke of was the dawning of self-knowledge in the physician. It was this self-knowledge that made the doctor's teaching — what Balint called the 'apostolic function' — a therapeutic influence tailored to the patient's needs, rather than an automatic expression of the doctor's own unexamined beliefs. All this is comprehended by the rather clumsy term 'counter-transference'. We must learn, said Balint, how to use 'the drug doctor' with full understanding of its therapeutic power, and its potential for harm.

In Western culture we have tended to distrust the emotions and to neglect this aspect of human development.[3,4] Now there are signs of change. We seem to be awakening to the importance of the emotions in human cognition,[5] human judgement,[6] moral development,[7] and interpersonal relationships.

The emotions in clinical practice

There are good reasons for clinicians to pay attention to the emotions. Serious illness evokes powerful emotions: fear of death or disability, grief at our losses, and anger at our fate, or at those we feel have failed us. If we recover, there is little to compare with the feeling of joy and self-renewal. Sometimes, the emotions are displaced and projected on to the physician or on to family and friends. In physicians, the daily encounter with suffering can also evoke strong emotions: helplessness is the face of incurable illness, fear of discussing questions that frighten us, guilt at our failures, anger at our patients' demands, and sadness at the suffering of someone who has become a friend. If we fail to acknowledge and deal with our disturbing emotions, they may be acted out in avoidance of the patient, emotional distancing, exclusive concentration on the technical aspects of care, and even cruelty. Lack of emotional insight can disturb or destroy the relationship between doctor and patient, adding to the patient's sufferings and often leaving the doctor with a sense of failure. Attention to the emotions

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Acknowledgements

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essay

is also good clinical practice. Emotions, beliefs, and relationships are important factors in the outcome of illness.

The clinical method that has dominated modern medicine, however, does not specify attention to the emotions. As long ago as 1926, F G Crookshank,[8] writing on the theory of diagnosis, noted that the handbooks of clinical diagnosis, which appeared in the early 1900s, 'give excellent schemes for the physical examination of the patient while strangely ignoring, almost completely, the psychical (sic)'. Attention to the emotions was not expected in any clinical discipline except psychiatry and, in psychiatry, attention was directed more to the emotions of patients than to those of psychiatrists. The idea that physicians should examine their own emotions would probably not have been taken very seriously. The teaching with regard to the doctor–patient relationship was 'don't get involved'. In one respect, fear of the emotions was well founded. To be involved at the level of one's unexamined emotions is potentially harmful. But what the teaching did not say was that involvement is necessary if one is going to be a healer as well as a competent technician. There are right and wrong ways of being involved and the teaching gave no guidance about finding the right way. The teaching was also profoundly mistaken in suggesting that one can encounter suffering and not in some way be affected. Our emotional response may be repressed, but this exacts a heavy price, for repressed emotion may be acted out in ways that are destructive of relationships. There is no such thing as non-involvement and only self-knowledge can protect us from the pitfalls of involvement at the level of our egocentric emotions. Without self-knowledge, moral growth is likely to have shallow roots.

A balanced medical education, aiming to produce competent and compassionate physicians, would nurture its students and teach them to attend to the emotions in an atmosphere of openness. Judged by these standards, modern medical education is falling short. The most prevalent change in students as they progress through the medical school appears to be from idealism to cynicism. Mental illness is common in students and house staff. For many students, clinical education is a humiliating experience; many have regrets about their choice of career, and recent graduates are reported to have little capacity for self-reflection.[9] How can an experience which so many students find soul-destroying prepare them for a daily encounter with suffering? It seems more designed to harden the protective shell which distances them from their patients. There is surely no reason why an intellectually rigorous education should be emotionally stunting.

Balint's influence in modern medicine

If Balint's legacy is identified only with the Balint group, we might consider his influence to be waning, but we would be wrong. His ideas have influenced us beyond any particular application of them. His footprints can be seen in our attention to the consultation and doctor-patient communication, and in such developments as the bio-psychosocial model of illness and the patient-centred clinical method.[10] The essence of the patient-centred method is that the doctor attends to the patient's beliefs and emotions in every case, as well as categorizing the patient's illness. The doctor then seeks a common ground of understanding with the patient, a basis for what Balint called the 'mutual investment company'. The essential skill of the method is the doctor's ability to listen in the way Balint described. It is not simply a matter of learning interview techniques. Balint observed that some physicians become passive listeners when they apply techniques without going through a personal change. Listening is at the same time a skill, a state of mind, and a way of being a physician. When we are in this state of mind, we can listen to our patients with total attention. Listening with attention does not mean that we are unresponsive. Without the intrusion of distracting thoughts and emotions, we can respond to suffering with authentic feelings and acts of compassion. As clinicians, too, we heighten our awareness of the patient's bodily symptoms. As we listen to the patient we are also attending to our own beliefs, assumptions, and emotions, filtering our response to the patient for any bias in favour of ourselves.[7] The key is to so internalize self-reflection that it becomes second nature, a subsidiary awareness that does not intrude as we focus our attention on the patient.

Towards emotional development

Perhaps the most portentous change of recent times is our dawning awareness that the world's great wisdom traditions, including our own, have practices for controlling the disturbing and egoistic emotions in the furtherance of spiritual growth. The rediscovery by the West of Asian philosophy and psychology has been called 'a second Renaissance in the cultural history of the West',[5] providing something which has almost ceased to exist in the West as a living tradition: 'a dependable and sustained practice' for reliably producing emotional and spiritual growth.[11] This is where medicine and the ancient wisdom traditions converge. The ability to focus the attention is central to both, and control of the egoistic emotions is the key to the openness of a compassionate clinician.

Jean Vanier, the founder of L'Arche, a network of communities for the intellectually disabled, describes the healing relationship as one of accompaniment, 'the heart of all human growth'.[12] A healer is one who 'walks with us', not judging us or telling us what to do, but revealing what is most valuable in us and pointing towards the meaning of our inner pain. It would be difficult to better this as a description of the doctor–patient relationship at its best. Could it not also be a model for the relationship between clinical teacher and student? The healer is a receiver as well as a giver, and we can all, at different times, be one or the other. Perhaps, in time, affective education will be integrated seamlessly with clinical teaching, making the Balint group, and courses in ethics and interviewing, almost superfluous.

It may seem perverse to speak of listening at the present time, when there are so many pressures on our time and resources. But to a mind trained in attention, intuitions come timelessly; and between doctor and patient, as Michael and Enid Balint taught, healing moments occur in a flash.[13]

Ian R McWhinney

Michael Balint ***(for full bibliographic details on Michael Balint visit http://www.psychematters.com/bibliographies/balint.htm)***

The 'Two Cultures' Debate
Chair: **Melvyn Bragg**
Radio 4, 13 March 1999

Although the 'Nos' sounded louder over the radio the chairman said there were a lot more 'Ayes', so the 'Ayes' had it. Numbers count in a Radio Four debate, as elsewhere, and 'Forty years after C P Snow's famous lecture, Britain (it was decided) is still a nation of two cultures'.

Melvyn Bragg had allowed time for a little pondering of votes by telling listeners about the Eduardo Paolozzi statue that the participants had passed as they had come into the new English Library. It was based on William Blake's image of Isaac Newton, and both works apparently showed the great scientist seated, surrounded by the glories of nature, but oblivious to them, concentrating on 'reducing the Universe to mathematical dimensions'. Bragg hoped that this deliberate fusion of two British geniuses, Blake and Newton, one from each side of the great divide, might promote a 'fruitful kind of ambiguity', which sounded to me a bit like general practice.

But although the motion was carried, I thought the basic dichotomy under discussion was false. It isn't as simple as Art versus Science. It may have been that simple 40 years ago, but it certainly isn't now. Lewis Wolpert made his point vigorously that the scientific method and scientific knowledge are *different*, but repeated too often that science is hard, grim stuff and should not be approached for enjoyment. 'Any idea that anyone has about the nature of the world which fits with common sense would be scientifically false', he insisted.

Gillian Beere, English Professor at Cambridge, countered, rightly, that *all* new ideas are contrary to common sense, that's what makes them new, and that *all* disciplines require intellectual rigor.

Simon Jenkins said science teaching, for all its spurious domination of the national curriculum, was 'fact-based, rote-learned, and dull' and that if he was a scientist he would long for people to teach his subject as a subject of wonder. Wolpert was incandescent — how can a public that only sees science in terms of wonder and understands nothing, ever make rational judgements?

Then Susan Greenfield, with her authority as classical scholar turned scientist turned popularizer of science, showed how wonder can be a legitimate entry-point to the public understanding of science, which is indeed so vital. 'Knowing how the machine works' is going to become more and more important, of that there is no doubt.

But Art versus Science is too simple. Different scientists know almost as little about each other's specialties as anyone else does. Pure science versus applied science is another bitter divide. Then there is the whole contemporary question of rationality versus irrationality. And since, with the solitary exception of a schoolteacher, every single speaker and questioner in the debate was either a familiar name or the holder of a senior position, the divide between what the Americans unctuously call 'celebrities' and ordinary people was perhaps the biggest divide of all.

The only thing I couldn't understand was why they didn't have a GP there to tell them how to bridge all these divides. Yes, we are artists. Yes, we are scientists. Yes, we are Susan Greenfield's touchy-feely, people-people *par excellence*. Yes, we are also her dysfunctional nerds. I couldn't help feeling how important it was that we show the world how much we have to contribute to this debate in the short time left before we are abolished.

I am not suggesting there are no divisions and we are all one homogenous soup of uniformity. But nor do I think that we are anything remotely as simple as *Two Cultures*. And I do think this 'fruitful kind of ambiguity' is very like general practice.

James Willis

Narrative Based Medicine
Edited by T Greenhalgh and B Hurwitz
BMJ Books, London 1998
PB, 286pp, £21.99, 0 7279 1223 2

Greenhalgh and Hurwitz have assembled an excellent collection of articles on narrative and discourse in medicine. The authors of the 25 essays come from a wide range of medical backgrounds and from disciplines beyond clinical practice, including anthropology, history, and sociology. There are also stories from patients. Some of the collected articles are reprinted extracts from elsewhere, including classics such as Donald Bateman's 'The good bleed guide' and Marshall Marinker's 'Sirens, stray dogs, and the narrative of Hilda Thomson'. The majority of the collection consists of new articles that are also, in the main, as stimulating and well written as the essays that have been published before. John Launer on 'Narrative and mental health in primary care' and Jane Macnaughton's 'Anecdote in clinical practice' are two thought-provoking examples, which give

some idea of the scope of the publication in which general practice is well represented.

The sections on 'Illness stories' and 'Pain narratives' are of particular interest and Henrietta Weinbren and Paramjit Gill's interview-based piece exploring the narrated experiences of childhood epilepsy is especially insightful. This would be a good point to declare that I am an oral historian (someone who interviews people about their lives) currently employed in a Department of General Practice. I therefore have an interest in the ways in which people tell stories and particularly stories with reference to medicine, health and illness.

I did rather worry that, as an introduction to narrative-based approaches, there was too little on memory in this publication, despite the social anthropologist Vieda Skultans, in one of the book's best essays, asserting that there is an important interconnection between memory and narrative. Similar points could be made about the links between narrative and history and it was perhaps a missed opportunity by Stuart Hogarth and Lara Marks in their otherwise thoughtful overview of the changing relationship between patient and healer in the history of medicine.

It is understandable that clinicians need to create their own ways of understanding (and indeed narratives) of approaches that are new to their own disciplines, in order that these advances can be appropriated and used. There is a danger however that in doing so earlier insights might be missed. There are hints, by Anna Donald and Sir Richard Bayliss, for example, (and of course in the patient-based accounts) that narratives are contested and change over time. Changing and contested narrative, in both private memory and public history, has been of particular concern to oral historians for at least the last decade.

Trisha Greenhalgh, in the book's penultimate and key chapter, powerfully argues that to apply empirical evidence with validity 'requires a solid grounding in the narrative-based world'. Greenhalgh makes clear that the editors are not suggesting an alternative approach to evidence-based medicine. She does suggest, however, that something might be missing from evidence-based medicine — a concern that was 'the germ of this book'. Such an application of narrative-based medicine may also require an exploration of the many ways in which evidence-based medicine is interpreted and retold — even those narratives identified by Greenhalgh as 'incorrectly held'.

Graham Smith

Clinical Guidelines and the Law
Brian Hurwitz
Radcliffe Medical Press
Oxford, 1998
PB, 135pp, £18.50 (1-85775-044-6)

What are guidelines (or protocols or practice policies)? Which, if any, do we have to follow? What happens if we choose not to follow them? What is their status in law?

As the pile of guidelines in my consulting room continues to grow, I find myself asking these questions with increasing desperation. Happily, I am able to report that this book supplies the answers. It is short, concise, and readable.

It begins with a quotation from Lady Thatcher about guidelines: 'Of course they have to be followed, they need to be followed for what they are — guidelines.' (Well that's clear then!) and ends with Plato rejecting guidelines as rules and doctors as being ruled by them.

This book is scholarly and well referenced. It deals with the legal status and validity of guidelines and also the vulnerability of those issuing them. It also serves as an exellent exposition of medical law with appendices which tell clearly the stories of relevant legal cases and critically direct the reader to further reading in this area. Negligence and the Bolam test are explained well and succinctly. It not only deals with the law in the UK but also gives an insight into how the law is developing in the USA (and what may be around the corner for us over here).

I found that the main message of the book was a reminder that although there are benefits to be had from developing and following guidelines, doctors in this country are still regarded by the courts as having clinical autonomy. This means that they are expected to exercise clinical judgment as 'uncritical adherence to guidelines can lead to innappropriate clinical care'. Because of this, 'rigid adherence to guidelines cannot be a formal managerial or legal expectation of the NHS.' Primary care groups might do well to reflect on this conclusion.

I would recommend this book as a practice library purchase. Why not spend some time reading it instead of reading the next couple of guidelines which come your way — it will probably do your patients more good!

Dennis Cox

Good
by C P Taylor
Donmar Warehouse, London
(until 22 May 1999)

Good *is the story of a fall from grace — slow, steady, smooth, uncomplicated. It charts a descent from integrity into the abyss as Halder, a German literary academic, embraces the entire intellectual apparatus of Nazism.*

The Party seeks respectability for its Euthanasia Programme, and considers its thinking to be echoed in one of Halder's novels. Thus headhunted and seduced, his degradation begins. He becomes involved in the Programme itself, a template for Auschwitz. Old Jewish friends, appealing with increasing desperation for help, are cut off. He masters his new language, with its lies and sophistries, its intellectual inversions, and crackpot theories, and — as the State tightens its noose — so do his justifications become ever more easy and glib.

He sympathizes with the inarticulate and deprived, newly-uniformed and lifted out of the gutter by the Regime to claim what they see as their own, while expressing their hatred in the language of the gutter. He sympathizes with the educated, the officials for whom the rituals of racial cruelty and oppression are occasionally tedious duties to be carried out as they progress to higher positions. As the doors start to close and the ovens are lit, so do Halder and his mistress constantly reassure each other that all will be well if they are but good to each other and to people around them — this at a time when the normal concept of good has long since vanished.

This dichotomy — talk of good co-existing with the practice of evil — drags us into the heart of the play, which offers nothing for our comfort while placing us in the seat of judgement where, inevitably, we are forced to judge ourselves. The language is simple and direct, the staging almost skeletal in its simplicity, and the sole concession to theatrical device is the music, which only Halder can hear, and which provides a coup de foudre *of sickening power at the very end of the play. By this time, through his onstage changing into SS uniform, he completes his metamorphosis, and travels to Auschwitz. There, through the music, he is brought face to face with the hell he has helped to create.*

Good *was first seen in London 17 years ago, since when it has become recognized as one of this generation's most important plays. This revival shows it to be a timeless text, perhaps never more so than now, when it looks as though history may be starting to repeat itself.*

Michael Lasserson

uk council, march 1999

Revalidation
Mike Pringle introduced a paper on *Revalidation* following the Council decision in November 1998 to support the resolution of the General Medical Council that 'specialists and general practitioners (all doctors on the Medical Register) must be able to demonstrate on a regular basis that they are keeping themselves up-to-date and to remain fit to practise in their chosen field.' On 10 February 1999 the GMC approved a paper that set out a range of activities that will underpin revalidation, including profiling a doctor at work through, for example, audit and continuing professional development, and external peer review.

Professor Pringle's paper proposes to set up a working group which will formulate plans for the revalidation of GPs, take account of experiences from the Accredited Professional Development Programme, and design pilots for models of revalidation. In approving the setting up of the group, Council noted that revalidation will have strong links to clinical governance, and to registration with the GMC. Council agreed that discussion will be needed with other relevant organizations, including the GPC, especially on the question of resources.

Clinical Governance
Council approved a further paper from Mike Pringle setting out an *Action Plan for Clinical Governance*, following the publication of the paper offering practical advice to primary care groups (PCGs) on clinical governance. The plan emphasizes the importance of setting up leadership programmes for the GPs responsible for clinical governance. Maureen Baker will bring to Council proposals for the promotion of leadership skills in primary care. Council noted that there are others who have an interest in PCGs and clinical governance, and that it is important for the College to concentrate on areas of particular relevance to it. Council agreed, therefore, that an electronic group be set up which will submit a report to Council on advice and support to PCGs on issues such as trust status and to individual requests for advice on clinical governance. A Scottish publication has already been issued which takes account of the different situation in Scotland.

Rationing
Our tireless chairman then introduced a paper on *Rationing in the NHS*, reviewing the theoretical and academic background to the issue and the political implications. Council noted the ever increasing expectations of patients on a finite service and emphasized the need to identify and to tackle variations in access to effective health care, the key to an informed public debate on rationing. Council suggested that the paper be expanded to include topics such as the provision of social services, private practice, the balance between individuals and society, and the underlying ethical principles. The Patients' Liaison Group and the Committee on Medical Ethics will discuss the paper, and a revised document will be submitted to June Council.

The Health Bill
Bill Reith gave a report on the passage of the Health Bill through Parliament. The Bill has now completed its passage through the House of Lords. There has been much disquiet about two particular clauses: one seemed to propose that PCGs could be compelled to become Primary Care Trusts (PCTs); another, as originally drafted, would empower the government to change the primary Acts governing the medical and allied professions by secondary legislation, without normal parliamentary scrutiny. After College representations, the government has now conceded various points, including the need for a vote before PCGs can become PCTs and the safeguarding of the basic responsibilities and rights of the present regulatory bodies. The relevant amendments will be debated in the House of Commons.

Membership by Assessment
Iona Heath reported on the setting up of Membership by Assessment of Performance. Necessary constitutional changes have now been approved by the Privy Council and this new procedure for entry to the College, aimed at existing practitioners who have been in practice for at least five years, started on 1 April. Expressions of interest from potential candidates already number around 300. A conference was held on 10 March for potential trainers and assessors. Council was pleased to note the progress being made in this area, and in other areas of assessment such as the Quality Team Practice Award.

Accredited Professional Development
Following the approval of the College budget for 1999–2000 in January, an invitation to tender for the Accredited Professional Development (APD) Project was sent out in February to RCGP faculties, university departments, and other interested organizations. George Shirriffs, as chair of the management group for the project, announced that, out of eight bids received, a team led by Professors Lesley Southgate and Janet Grant, and Dr Tony Lewis had been successful. Council endorsed a paper from Mike Pringle which sets out the links between Continuing Professional Development, Clinical Governance, Accredited Professional Development and Revalidation for individual practitioners. The

paper will be sent to faculties and the GPC, and posted on the College website.

A&E Services for Children
Council considered a revised draft report from the Joint Working Party on Accident and Emergency Services for Children. The Working Party, convened by the Royal College of Paediatrics and Child Health and with a membership comprising the principal organizations with an interest in the subject, including the College, had taken account of earlier comments received from parent bodies. Council had earlier expressed concern about the lack of research evidence concerning the role of GPs, and the lack of reference to resources in the original document. These and other issues have now been dealt with and Council approved the joint publication of the report.

MRCGP International
Council noted a progress report from Philip Evans, Chairman of the International Committee, on the development by the College of an international system of assessment of general practice/family medicine, based on the health care systems of individual countries. Potentially interested organizations are being consulted and detailed work on assessment and accreditation will be required. Council endorsed the continuing work and was pleased to see that it would further general practice overseas and benefit the College in the UK by informing us of developments abroad and by strengthening College links with key organizations.

Awards Committee
The Awards Committee will meet in May 1999 to consider nominations for various College awards. In particular, nominations are sought for the **John Fry Award** (for the promotion of the discipline of general practice through research and publishing as a younger Member or Fellow of the College), the **Foundation Council Award** (for special meritorious work in connection with the College), and the **President's Medal** (for a Fellow who has done most to promote the aims and objectives of the College and who has not normally achieved recognition for that contribution.)

Fellowship
The Committee on Fellowship meets in May 1999; please therefore give some thought to suitable nominees. Nomination forms are available from the Clerk to the Committee on Fellowship, RCGP, 14 Princes Gate, London SW7 1PU, 0171 581 3232 ext 233 and must be completed and returned by 23 April.

(Enquiries about Fellowship by Assessment should be made to Janet Bailey of the Vale of Trent Faculty, telephone 0115 9194455.)

Date, Time, and Place of Next Meeting ...
9.00am, Friday 18 June 1999, at Princes Gate.

Bill Reith

Neville Goodman

Job Hunting

Here's a newspaper advertisement for a fine job: director of the Cancer Action Team (otherwise known as CAT). See the director as he — or maybe she — directs the team to swoop down on those nasty tumours! See the cells recoil! Marvel at the induced apoptosis! Pausing only briefly to wonder why there should be a CAT but not a HAT (Heart Action Team) or a SAT (Stroke Action Team), I look down the advertisement to see if the appointed director will be issued with a blue and red cape and allowed to wear their pants outside their trousers.

Cancer — as if it were one disease — recently became the commonest cause of death in the United Kingdom. The 1995 Calman-Hine Report gave cancer special emphasis. Oncology departments have since been struggling to implement the required changes and all the interim administrative implications while still dealing adequately with their increasing clinical load. CAT will work with the NHSE "to support the NHS in implementing the strategic framework for cancer services". The problem is not the job, or whether such a job is needed; the problem is the advertisement.

My eyes wander for comparison to the advert alongside, for an assistant director in the training and development section of the Leonard Cheshire organization. The successful candidate "will be required to continue the establishment and delivery of training and development programmes" in a number of developing countries, including a programme "designed to promote independent living skills and employment of disabled people": pretty clear. The implementation programme of CAT, on the other hand, "will involve significant service re-engineering", and CAT is intended as a 'model for other National Service Frameworks' — so we may well be in for HAT and SAT in the future — "demonstrating the effectiveness of working in partnership as well as 'adding value' to the work [of] Regional Cancer Co-ordinators". Clear? Or not clear?

What is 'service re-engineering'? Who needs to be shown that it is worth working in partnership? What on earth does 'adding value' mean? The appointed director will work with the Co-ordinators "providing them with a resource as well as utilizing their experience and communications networks". Some of these Co-ordinators are clinicians. If their communications networks are intact what resource will the Director (on the NHS Senior Managers' pay scale: £28,000–£47,250) provide? Can the country's cancer services — quality monitoring, introduction of new drugs, dissemination of information: these are mentioned specifically in the advert — really be firmly co-ordinated by someone who may command a salary of only £28,000?

Any person attracted by this advertisement is likely to talk in jargon. You can be certain there'll be lots of 'addressing issues' and 'human resource implications'. If you pay peanuts, you get monkeys; if you use weasel-words, you get weasels.

Nev.W.Goodman@bris.ac.uk

our contributors

Tina Ambury is an elected member of UK Council. She is a freelance medical writer, and deputy editor of the General Practitioners Writers Association journal

Our columnist, **Bruce Charleton**, is on the advisory board of *Medical Hypotheses*, and the editorial committee of the *Journal of Evaluation of Clinical Practice*

Dennis Cox is a GP in St Ives, Cambridgeshire, and now embraces interesting part-time employment as the attachment director of law and ethics at Cambridge Clinical School

David Haslam, who chairs the RCGP education network, underestimates the challenges of editorship. Recent copy for the BJGP arrived on time but exceeded the word count by four; disappointing profligacy for a renowned editor

Michael Lasserson lives and works in south London

Wayne Lewis, our token Welshman, was almost as surprised as Tim Rodber to watch Scott Gibb cross the try line at Wembley in early April. Ten centuries of cruel historical reverse suddenly seemed more bearable

Ian McWhinney Order of Canada, MD, FRCGP, FCFP, FRCP Professor Emeritus Department of Family Medicine, The University of Western Ontario, London, Ontario Canada ... like many future Nobel laureates, was forged in Lanarkshire

Catti Moss takes a dog to work each day, in rural Northamptonshire. She has been medical vice-chair of the RCGP Patient Liaison Group and has written widely on issues relating to sexual health

Joe Neary wasn't always a pillar of East Anglian general practice. He started life as a chef, and in this capacity poisoned the future deputy editor of the *BJGP*, serving a freshly baked but memorably gruesome eel pie as their large naval yacht traversed a tidal race north of Alderney. The recipe may well be available at his practice website: **http://www.trinity-surgery.co.uk**

Bill Reith comes to the end of his tenure as Honorary Secretary of the RCGP in the near future. He is a GP in Aberdeen

Graham Smith is an oral historian, pioneering links with general practice at the academic unit in Glasgow

Peter Toon is editor of College publications and is presently communing with Slavs. He is a gifted chorister

James Willis has been known to do a bit of general practice, but is presently progressing around the British Isles gathering material for a new masterwork. Back copies of *Paradox of Progress* are available in the interim

Bruce Charlton

Resistance is futile

The Borg (nothing to do with Swedish tennis players) are the deadliest threat to the universe in *Star Trek — The Next Generation*. Part man, part machine, with each member participating in the group consciousness; the Borg act with a single ant-like will, and when one is defeated another steps forward to take its place. The Borg appear invincible, but again and again their rigid strategies are defeated by weaker opponents: individuals human beings (or humanoids) working in small groups that refuse to be daunted.

In fact, the Borg are the ultimate bureaucrats. And both have exactly the same mission statement — resistance is futile. Sound familiar?

In real life, the Borg are government, the civil service, managers and administrators, and doctors, academics, and teachers are the crew of the Starship Enterprise. In fact anyone who actually does something counts as one of the humans — those who act independently, as opposed to following orders or telling other people what they ought to be doing. Such knights of freedom are being strangled in a relentlessly tightening regulatory noose.

However, the Borg are not as powerful as they pretend, and can only exert control by destroying resistance. This is working well in medicine: doctors have almost given up the fight for autonomy. The ultimate aspiration of today's clinician is a quiet life and early retirement. GPs are crumbling under snowballing clerical tasks, the daily onslaught of manipulated media scandals, and bombardment with relentless pro-government propaganda from the BMA.

Another element is the corruption of the professional leadership who act as a fifth column, subverting the profession from within. Unlike Captain Jean-Luc Picard, the current crop of doctors 'leaders' have easily been duped and bribed into collusion. History will remember them as architects of the destruction of the UK medical profession. Presumably the flattery, gongs, and largesse will help them sleep at night. Control of resources, salaries and conditions, medical education and training, licensing to practice, and even the specifics of prescribing, referral and clinical logistics are increasingly in the hands of the Borg. Power is being centralized while responsibility remains firmly with the practitioner.

Does anyone who has not been lobotomized by daily contact with the Borg really believe that the re-accreditation plans and 'clinical governance' — to mention but two of the contemporary lunacies — are anything other than plausible excuses for more regulation? Why can't the medical profession see this? Are people really that stupid — or just too punch-drunk to do anything about it?

The most powerful weapon wielded by the Borg is the sense of hopelessness it induces. A programme of continuous 'reform' from the regulators breeds an endemic mood of short-term cynicism among the doers. Professional life is seen purely as a series of short-term survival tasks. The daydream is that if we clear the next hurdle then somehow things will get better — in fact they always get worse. Escalation is built into the system. Five-year re-accreditation will not be the end of the matter. When present proposals fail they will not be abandoned, but made more frequent and invasive — because control of doctors is their true *raison d'être*.

Do you want to see the future of medicine? Talk to a teacher. An OFSTED inspection is now routinely recognized in psychiatric practice as a significant 'life event' on a par with compulsory redundancy. OFSTED inspections are driving good educators to the private sector, to part-time work, to retirement and to other jobs — anything but State school teaching. This scenario is exactly what lies in store for medicine, unless doctors resist.

What to do is easy to state but difficult to accomplish, although not as difficult as people imagine. The medical profession, and individual doctors, have forgotten their considerable power and influence. If doctors are obstructive individually, refuse to cooperate *en masse*, argue their corner, explain their case, and especially if they build new formal alliances with patients, then some of these bad things will not happen, and some good things might happen instead. The Borg can be defeated.

Maybe it doesn't matter much in the larger scheme of things if the British medical profession is destroyed (except for a handful of elite specialists who service the politicians and managers). But if doctors become bureaucratic functionaries whose allegiance is to the organization rather than to patients, then it is patients who will suffer most. People think 'it couldn't happen here' — I don't see why not. This is exactly how medicine is practised in most countries. Bear that in mind as you fight for clinical freedom.

Because fight you must — unless you intend to escape practice altogether, and quickly. Doctors are losing power and conditions; next will come salary and status. Soon many clinicians could become something closer to government clerks in a dole office than the ideal of a 'personal physician'. Terrible for medics; but the biggest losers will be the public.