The British Journal of General Practice

Viewpoint

Walk in! Walk out? What *is* it all about?

In April, general practice was given a nasty shock when the Prime Minister announced that 20 'Walk-in' Health Centres were to be set up.[1] Thirty million pounds to be spent introducing a new way of accessing the health service? Surely not! Just three months later, the Secretary of State has that announced 19 centres (out of 99 bids) are going ahead.[2]

The shock was all the greater because we had no idea that this was around the corner, nor what had precipitated such a move. When did GPs, out-of-hours cooperatives, and accident departments stop providing primary healthcare around the clock? Was a third way really needed?

The day before the announcement had seen the release of a public survey of general practice.[3] Reassuringly, the results confirmed that most patients are generally satisfied with the service. Eighty per cent of patients thought their appointment was as soon as necessary, 87% felt that the GP spent the right amount of time with them, and 79% of patients admitted that even the receptionists had not hindered their access.

Some 15% of patients had commented that they were put off visiting their GP because of inconvenient surgery times and 20% claimed that they had to wait four or more days for an appointment with their GP. The survey didn't indicate the urgency of problems for those who 'had' to wait or the inappropriateness of such a wait. Interestingly, fewer older patients were dissatisfied with waiting for an appointment, perhaps reflecting their greater experience and more realistic expectations. Since virtually all GPs do see urgent cases on the same day and since maximising doctors time is essential, such a wait probably reflects how efficiently general practice manages the demand.

Despite this endorsement there is no doubt that the service is under pressure, deluged as it is by patient demand and by new work. The profession is caught between aspirations of quality health care[4] and a harsh reality where such dreams are difficult to fulfil. Whilst much is expected of GPs, the overwhelming demand and underfunding make striving for gold a rapid route to burn-out. The money being thrown at Walk-in Health Centres would have gone a long way to addressing these problems.

The key attributes of a life-long medical record, of patient registration, and of continuity are vital to managing care and inherent to our gate-keeping role and our cost effectiveness. They need 'talking up' since their loss will lead to fragmentation and greater overall costs. It seems such attributes are being sacrificed to consumerism and political gain. The lack of commitment to evaluate Walk-in centres amounts to a reckless experiment with public money, but is it the role of GPs to defend the public from political diktats that have no concern for the big picture? If we do we will be accused of being protectionist, especially if we are not supported by the patients' organisations.

Of course there is a need to review the way we work and the access to services. We want to enhance quality, to implement evidence-based medicine, and to improve access with continuity. Adequate resources are the ways to do this. Drop-in health centres are not.

Walk-in Health Centres address significant niggles that should have been addressed within the established structures. The omission to do so reflects the value of established general practice to politicians. Access, if not treatment, by postcode will continue unless centres are to be set up across the country. If they are, is the writing on the wall for traditional general practice? If it is, this fight is about protectionism, for the public's sake and the whole of the NHS.

Shaun O'Connell

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Doctors in distress

As we near the end of the 20th century, it's hard to believe that members of the medical profession might find themselves in need. As a profession we are reasonably well paid and jobs are relatively secure. We have the NHS Pension Scheme and can take out insurance policies, which, at first sight and at a price, cover most eventualities.

Unfortunately, we have no special immunity to the tragedies that affect other mortals — accidents that cause disability, incurable illnesses, breakdowns or dependence after years of coping with pressure. These can strike at any time and hit families too. Younger doctors are often especially vulnerable.

Fortunately, an organisation that has been helping doctors and their families for over 160 years exists and is still going strong.

The Royal Medical Benevolent Fund is the leading charity of its kind, providing financial assistance for medical professionals and their dependents who, through illness or other misfortune, find themselves in need. The amount of financial help is expected to exceed £900,000 this year and accounts for half of all annual charitable expenditure in this field.

Over the years the Fund has built up a high level of expertise in providing help when and where it's most needed. Three full-time professional case workers supported by a national network of 100 volunteer area visitors ensure each application receives proper consideration. A monthly Case Committee ensures rapid decisions are made to enable the provision of timely help.

If every doctor does a little to help the Fund, it can do a lot to help those most in need.

To discover how your contribution can make a difference, contact the Fund at 24 King's Road, Wimbledon, London SW19 8QN; 'phone them on 020 7540 9194, or visit the website on www.rmbf.co.uk

Stroke Association's Annual Stroke Awareness Week

September 27th-October 3rd

Blood pressure — the focus for this year's Stroke Awareness Week

This year The Stroke Association's annual Stroke Awareness Week is being held from September 27th to October 3rd. As the campaign is concentrating on blood pressure, GPs should be aware that there might be an increase in patients asking for their blood pressure to be checked.

"Raised blood pressure is one of the main risk factors for stroke," says Eoin Redahan of The Stroke Association. "Because of this, we are planning to really push this message home during our awareness week."

The Association is hoping that 100,000 blood pressures will be measured during the week — a thousand for every year of the charity's existence. There are already plans underway to run checks in libraries, town halls, supermarkets, and shopping centres, and the charity has written to every practice manager and occupational health nurse in England and Wales to ask them to get involved.

The campaign is being supported by promotional posters and leaflets using the catchline 'Don't Wait For A Stroke To Find Out If You Have High Blood Pressure', and also 'A Stroke Is One Way Of Finding Out If You Have High Blood Pressure. We Know A Better Way.'

"Stroke is very much on the health agenda now," says Eoin Redahan. "The Government has just produced it's white paper '*Our Healthier Nation — Saving Lives*' which included a joint target with heart disease for reducing death by 40 per cent in the under 75 year-olds."

"With new drugs coming on line, especially neuroprotectors and clot busters, the pharmaceutical industry is putting a lot of money into stroke research and prevention," adds Mr Redahan. "Just recently they published a booklet called Target Stroke, which sets out how actively the industry is involved."

The charity has already sent out more than 200,000 leaflets in response to requests in preparation for Stroke Awareness Week and at least 2000 practices have indicated they hope to get involved.

For further information about Stroke Awareness Week contact Sue Knight at The Stroke Association on 020 7566 0328.

Susan Knight

Raising stroke awareness for general practice

When we are prioritising our efforts in Health Improvement Plans and other initiatives, we must not forget the terrible human and financial costs that result from strokes. Each year over 100,000 people in England and Wales have a first stroke, and this is the third most common cause of death after heart disease and cancer. It is also the largest cause of severe disability, with 300,000 people being affected at any one time in England and Wales. Stroke Awareness Week is designed to try to get these facts over to the general public and to encourage people to ask to have a blood pressure check on a regular basis. As patients and public come to realise the significance of this illness and the value of prevention, it will become even more meaningful to us as health professionals in primary care. It might encourage us to take a more integrated approach to both primary and secondary prevention of stroke.

My practice has recently undergone a review of our chronic disease management. We have reviewed the recent literature in the management of non-insulin dependent diabetes and ischaemic heart disease. Heart disease prevention is the major theme of our local Health Improvement Plan and we await further guidance from the National Service Framework, soon to be launched. No doubt many practices and primary care groups have similar priorities, and the integrated approach that is being adopted will hopefully have a significant impact on the management of these conditions and consequently on the incidence of stroke.

I welcome Stroke Awareness Week and I hope that there will be an impact from this in my practice. If patients are better informed about strokes then I hope they will be more likely to take up offers of health promotion interventions, give greater thought to lifestyle advice, and comply with any treatment regimens relating to management of hypertension, diabetes, etc. The publicity has already helped me to think more about strokes and the impact that I can have on this condition as a GP. I hope more health professionals and commissioners of health will be similarly motivated to raise the profile of this condition. The reward would be to see a positive effect on outcomes.

Dr Maureen Baker *FRCGP*
Assistant Honorary Secretary

First English Quality Practice Award goes to South London surgery

The Balham Park Surgery in South London has become the first GP practice in England to receive a coveted Quality Practice Award (QPA) from the Royal College of General Practitioners (RCGP).

The award has been presented to the practice team in recognition of the high standards in the quality of care and service given to patients. The practice was also successful earlier in the year when it became one of the first to receive a Beacon Award for its practice management innovations.

Dr Sangeeta Patel, MRCGP, who led the application for the QPA, said:

"We are delighted to have the honour of receiving the first English QPA. The award provided us with specific and tangible criteria of practice organisation and patient care, and gave us the extra impetus to complete administration and clinical protocols to ensure that the practice runs smoothly and the patients are well looked after. It gave us the opportunity to work together to put our good intentions into practice."

The QPA, which was launched in November 1997, was developed by the North East Scotland Faculty of the RCGP. To date, six Scottish practices have been presented with the award. The Balham Park Surgery is the first English practice to gain the QPA.

The award works by focusing on the key functions of general practice and has been developed to reflect the patient perspective by asking what they would expect of a practice that has achieved such an award. All practices that apply for the QPA have to meet set criteria, ranging from demonstrating details of clinical care to health and safety issues, which is submitted in written form. This is followed up with a practice visit by an assessment team to interview staff and patients and inspect the premises.

The Balham Park Surgery will be presented with a plaque which they will be entitled to display for a period of five years from the date of the award.

Information on the Quality Practice Award is available from Sheila Veale, at the RCGP North East Scotland Faculty, Tel: 01224 840761.

'Tackling Migraine Together' Migraine Awareness Week 6 - 12 September

National Migraine Awareness Week 1999 commences on the 6th September. The theme of the week is 'Tackling Migraine Together'. Newly commissioned research seeking the views of both migraine patients and GPs will offer insights into how doctors and patients tackle migraine. Full details will be provided at a special news conference on 2nd September.

Spearheaded by the Migraine Action Association — with the support of the Patients Association and the Migraine in Primary Care Advisors Group (MIPCA) — Migraine Awareness Week 1999 aims to make migraine sufferers more aware of the importance of the doctor-patient partnership, and in particular how best to communicate the impact migraine has on their life.

Ann Turner, Director of the Migraine Action Association, commented, "Migraine can have a major impact on sufferers' lives, dramatically affecting their quality of life, and that of their friends and family too. Many migraine sufferers never see their doctor about migraine. Often they believe, mistakenly, that nothing can be done, or that the doctor will not understand the effect their migraine has on their life. For 1999, Migraine Awareness Week intends to break down communication barriers, help sufferers develop a good relationship with their GP and make informed choices about their migraine."

A new leaflet entitled 'Tackling Migraine Together' has been prepared for Migraine Awareness Week, with the aim of helping sufferers to understand more about their condition, effective communication with their GP, and how to prepare for a consultation.

Copies of the leaflet are available from:

Migraine Action Association
178a High Road
Byfleet
Surrey KT14 7ED
Tel: 01932 352468
Fax: 01932 351257
Email: info@migraine.org.uk
Web: www.migraine.org.uk

Recommended treatment guidelines for migraine — endorsed by MIPCA — are available from MIPCA Secretariat, PO Box 226, Richmond, Surrey TW9 1LU

Professor Margot Jefferys

I want to pay tribute here to Professor Margot Jefferys, an Honorary Fellow of this College, who died in March this year. She was one of the pioneers of medical sociology and the first among them to become a professor. This way of looking at health and social care, and at those who provide and receive it, has added valuable contributions to our understanding and clinical work, unknown or neglected at the time when the College was founded. Their acceptance owes much to Margot's sensitivity and charm. Working with doctors and nurses, she was always willing to understand their difficulties with unfamiliar language and with observations and theories that were not always welcome at first hearing.

I experienced her skill, along with all those who then worked at the Kentish Town Health Centre, when our work and the reaction of our patients to it were being continually observed and recorded in detail by Margot and her team over a considerable period of time.[1] The two group practices in the Centre were compared with two nearby practices that were single-handed — sometimes to our disadvantage. Several of us were interviewed in depth and at length by Margot herself. I remember the experience as entirely enjoyable.

In an obituary in *The Times*, Professor Stacey, another pioneer in the same field, describes Margot as strong, independently minded, generous, and loving. I cannot better this description of someone whom I knew, respected, and loved, meeting or working with her in a variety of contexts over 30 years. It was a special pleasure for me, when I was President of the College, to confer the honorary fellowship of the College on her and, at the same occasion, on Ann Cartwright, her colleague and close friend.

John Horder

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Yes

During a recent UK Council meeting of RCGP, Dr Roger Neighbour presented a very comprehensive report on the history and present status of the MRCGP examination. There have been several major changes in response to the need for summative assessment procedures for GP Registrars. While reading and listening to the report, my previous reservations about the oral examination came back to my mind.

They are surely now anachronistic and unsupportable.

I write as an ex-examiner, having given up almost four years ago, and perhaps I am out of touch but I did spend many years examining and gave much thought over this period to the oral examination.

It is a subjective assessment of a doctor's clinical, therapeutic, and wider skills. In recent years attempts have been made to make it more rational and objective. How can it ever achieve that? Standard questions might be asked, seeking markable answers, but that standardisation detracts from the interplay of examiners and candidates. If there is to be no interplay then why an oral examination? It takes the fun out of examining. Should it be fun?

Oral examinations have a long history in medicine and can be a very direct way of examining knowledge. However, nowadays, we have very sophisticated techniques to ensure fairness and equity in the assessment of knowledge and skills, and these alternatives are reliable, repeatable, and valid. Is history the only justification for their survival?

Are there areas of clinical practice that cannot be addressed in any other way? Often in the oral examination there are questions and scenarios put to the candidate to test how they might deal with them. They may involve complex ethical, legal, or clinical dilemmas. Such areas may very well be approached through extended written decision-making questions. Are these types of areas or questions a post-hoc rationalisation for oral examinations?

What is the oral exam's unique selling point? Is it necessary to see the candidate before admitting them to the College? That is surely a remnant of 'clubability' and bears no relevance to the granting of membership to candidates who pass objective criteria. It smacks of the old boy network.

The oral examinations have been and are likely to be the source of complaints about irrelevancies such as the attitude of candidates, examiners, mode of dress, language skills, and racial bias. There have been strenuous efforts to weed out unfair examiners and to rationalise the oral examination process. However, with a process that depends on inter-reaction between personalities, there will always be the potential for ambiguity and unfairness.

The oral examinations are very expensive in terms of cost in both doctors' time away from work or home and locum costs. The costs will have to be charged to the examination fees, which will inevitably have to be increased to absorb them. Is that expenditure worth it?

What can we say for them? The examiners believe that one way of keeping a team of examiners together has a lot to do with the social interaction of 5-7 days examining in pairs. One gets to know most of the examiners and the relationships can be very long lasting. However, the opposite is also true, examining with an 'unsympathetic' colleague can be hell.

If that is all the good we can say then let us scrap them now!

Jim Rodger

tion should be scrapped...

No

That anyone should consider scrapping the MRCGP oral examination reflects badly on a preoccupation with economic efficiency and an obsession with what is easily measured. There is a grand tradition, if not mystique, surrounding *viva voce* examinations. As early as the Middle Ages, admission to a (medical) guild involved an oral examination; for admission to a Guild of Medical Men an oral test was conducted in Latin! Thankfully the process has evolved but nevertheless the oral examination remains a cornerstone in the rite of passage to admission as a voting member of every Royal medical college. Many in our College believe general practice is a specialty in its own right and the presence of an oral examination allows the RCGP to stand as equal to its sister colleges.

The oral examination has been criticised in the past for not being sufficiently robust as to its fairness. In the light of recent evidence presented at the June Council meeting of RCGP, I believe that the oral examination is fair. The documents laid before the Council showed that we should be proud of our oral examination because it is a reliable and consistent test that compares favourably with similar examinations.

The advent of the modularisation of the MRCGP examination has freed the oral examination to focus on personal and professional qualities which are difficult, if not impossible, to assess in written papers and self-selected consultations for the videotape assessment. In a way the oral examiners are like big game hunters — when they see an elephant they know it is an elephant. That is, the extensive and intensive training to which the examiners are subjected, develops in each one an instinct for detecting candidates' attributes within the framework of professional values being assessed. These values are in the context of care of patients, working with colleagues, the role of general practice in society, and the doctor's personal responsibilities. The candidates' decision-making should be coherent, rational, ethical, and sensitive.

Having recently been assessed under the modern format, I believe there are other attributes that can only be assessed by the oral examination. These other areas include: effective reasoning, language skills, handling a combative encounter in a 'pressure-cooker' situation not dissimilar to a demanding (angry) patient, responding to the unknown and the unknowable, and the simulation of some aspects of the doctor-patient relationship by the rapid development of rapport and understanding with a stranger while answering questions.

Crucially, the oral examination properly reflects what doctors do everyday; namely, communicate with people, be they patients, staff, or other doctors. To properly assess new doctors' competency for face-to-face encounters, some of which will be awkward, we must support a *viva voce* assessment simulating such situations.

To my mind the current arrangements are reliable, valid, generalisable, and user-friendly. The MRCGP oral component assesses a candidate's attitude to — and knowledge of — the Philosophy of General Practice and Family Medicine. The oral examination introduces prospective GPs to their College in a very personal way like no other form of testing.

In summary, the MRCGP oral examination should not be scrapped. It is a fair test of the competencies it sets out to assess. It lends credibility to the assessment process of future GPs that our patients respect. This module encourages candidates to reflect on the foundations of our discipline and their attitudes to general practice and family medicine like no other assessment process.

In conclusion, the price of this mode of examination is certainly great, but the price for abandoning the oral examination could be terrible.

David Lewis

Oral history, biography, life history: broadening the evidence

Writing in the *BMJ*,[1] Colin Borland, a consultant physician, describes how his attitude towards an elderly patient in a day room completely changed when he learned about the man's past. Admittedly this particular patient had been party to an exceptional event. As a tour guide in Egypt in the 1920s he'd seen Howard Carter and Lord Carnarvon open Tutankhamun's tomb and could describe what happened in detail. However, Borland goes on to explain how, listening to these and to other patients' accounts, he came to realise that, by encouraging patients to take part in 'sharing their secrets' about their past lives, his attitude towards them became more positive and he found himself suggesting 'unusual diagnoses'. In what is only a short piece of writing he identifies two key recommendations for an oral history, life history or biographical approach in medical practice: the benefits to patients and doctors of an awareness of individual worth and the generation of interventions that are individually sensitive and appropriate.

Oral history is a way of recording biography or life story narratives and encompasses a wide variety of approaches that can be used for many different purposes.[2] There are however a number of common features that can be identified, including the aim of many oral historians to collect the memories of people whose lives are otherwise hidden from history. Oral history also attempts to gain an understanding of people's daily lives, including the congruous and mundane, through accounts framed by the familial, generational, and communal, and grounded in their political, social, cultural, and historical contexts. Another key to oral history, and indeed to many of the other biographical approaches, is an understanding of the dynamics of the life history interview and the many processes embedded in this social exchange. These include understanding the contribution of the interview to the construction and maintenance of identity, acknowledging shifts in expertise and power as stories unfold, and identifying the differing perspectives and objectives of interviewer and interviewee. Such work also encourages an acknowledgment of the ways in which memory and recall of the past orientates itself to the present and the future as well as the past, while accepting the fluidity of boundaries between real and imagined experience.

The Disintegration of the Persistence of Memory, 1952-54 by Salvador Dali (1904-89). Copyright Salvador Dali Museum, USA/Bridgeman Art Library. © Salvador Dali - Foundacion Gala - Salvador Dali/DACS 1999.

Biographical approaches, as a way of gathering information about the past of a 'whole person', particularly in collecting patient histories, have long been important in general practice. General practitioners have a wealth of interviewing experience from 'taking histories', with life histories gathered over a number of consultations and, in some cases, gathered over many years. As a result these biographies are, in contrast to histories taken by hospital doctors, rich in detail, providing longitudinal information about family and the other social groups patients belong to, as well as charting the life changes in individual patients and wider social historical change over time. Indeed it has been argued that it was a growing appreciation of 'biographical medicine' that represented a significant development in National Health Service medicine by providing a positive identity for general practice in relation to hospital medicine.[3] This has more recently begun to be reflected in the new medical curriculum, particularly in the communication skills courses, as well as the life history and family projects, that are being taken by tomorrow's doctors. Given the importance of biographical approaches in general practice, developments that have tended to happen elsewhere, particularly in the social sciences, are of some significance. Drawing from across the social science disciplines it is possible to identify what might be called the 'new history', where oral and narrative sources are given due respect in what has been described as an emerging body of 'biographical work'.[4]

Examples of an oral history or biographically-based approach in health and social care are many. Here we identify just a few key contributions. Biographical approaches have typically developed most extensively in work with the older people. In this work the representation of a past life is of significance in negotiating appropriate strategies in, for example, providing care and support. In addition the process also plays a developmental role in assisting with transitions such as the loss of a partner and

essay

changes in employment, health status, and location. Coleman, a psychologist, has researched the contribution of reminiscence in the ageing process, making use of oral history interviews over a twelve-year period to establish differences in attitudes to recall of the past amongst a group of older people living in sheltered accommodation. More recently he has used a similar approach to investigate meaning at a much later stage of life, showing that certain identity themes connected with family in life stories persist. He argues that awareness of such themes on the part of practitioners can be helpful in resolving the problems and dissatisfactions that may be obstructive to developmental tasks, such as coping with loss and physical change and achieving acceptance of lived life in late old age.[5]

That the opportunity to present a past life can facilitate talk indicating awareness of, and preparedness for, death, is widely recognised amongst general practitioners. At the same time the contribution that an oral history or biographical approach can make to the care of the dying person has also been identified in research. Another theme is the way in which knowledge of life history information amongst carers and clinicians promotes positive views of those they are caring for, including helping to explain expressed preferences or apparently aberrant behavior patterns. This may prove especially significant in the management of challenging or difficult behaviour resulting from mental disorders, including dementias.[6] Biographical approaches can also be used to assess and negotiate care plans. Dant and Gearing, for example, describe the development and application of an oral history/biographical tool in assessing older people's community care needs in a research project located in four Gloucestershire primary care teams.[7]

Although oral history and biographical approaches have been elaborated in most detail in relation to the care of older people, developments in work with younger groups of patients have also begun to emerge. Cohen and Taylor are amongst those who, following a review of reminiscence as an assumed feature of late life, suggest the need to consider whether reminiscence might not also be functional for a younger person with a terminal illness.[8] Indeed Rickard's work recommends just such a role for a biographical approach for people with HIV/AIDS as well as being a model of the sort of reflexive practice that is such 'an intimate part of oral history'.[9]

Oral history testimonies are socially constructed narratives offering the potential to raise the importance of cultural contexts and promote an understanding of cultural difference. While awareness of a past life may be helpful to practitioners both in relation to the balance of their own preconceptions, and to patients and clients, as a means to securing individually appropriate interventions, an oral history or biographical approach also presents an opportunity for a shift in the power relationships of clinical and care exchanges. Opportunities to speak from experience, and to be listened to, become a basis for effective human agency on both sides of the exchange.[10] Nowhere has this perhaps been more dramatically demonstrated than in recent work with people with learning disability and with disabled people, whose stories and accounts of family and then institutional care, are now contributing to the development of more sensitive policies for care and support in community settings.[11,12]

Oral history encourages:

- The recovery of life stories that are normally hidden from history;
- Considerations of the 'whole person';
- Understanding life stories in their social, cultural, and historical contexts;
- Reflections on the relationship between researcher and researched;
- Informed and individually appropriate interventions;
- Identity maintenance and presentation, particularly at times of stress or in changing circumstances;
- Co-production by promoting a more equal relationship between service users and practitioners.

Narratives, and in particular case studies and anecdotes, have historically played a significant part in the practice of medicine. It is, however, only recently that attempts have been made to familiarise clinicians with the tools required to further understanding of the significance of narratives and their potential usefulness in the diagnostic encounter, in the therapeutic process, in the education of practitioners and patients, and in research.[13] We would also suggest that such an understanding could be extended by a greater appreciation of the part played by memory and history in the social construction of narratives. The approaches we have discussed here can be used to avoid the fragmentation of lives into specialisms and the dislocation of people from their life stories.

Finally, we would hope that oral history, biography, and life history approaches can contribute towards the process of broadening the evidence base in general practice and aid the development of recipients of health care as co-producers rather than as consumers. As Julian Tudor Hart has pointed out, cooperative decision-making in a 'broader, socialised definition of science' can produce better and more appropriate outcomes for all involved.[14] Many general practitioners are already specialists in communication with an understanding of the power of biography. We would argue that there is a place for the use and development of life history methods, including oral history, in a general practice that recognises the interconnectiveness of people's lives. Biographical approaches offer an important channel by which life experiences and beliefs can be understood as evidence in the co-production that involves recognising that people have histories.

Graham Smith, Joanna Bornat

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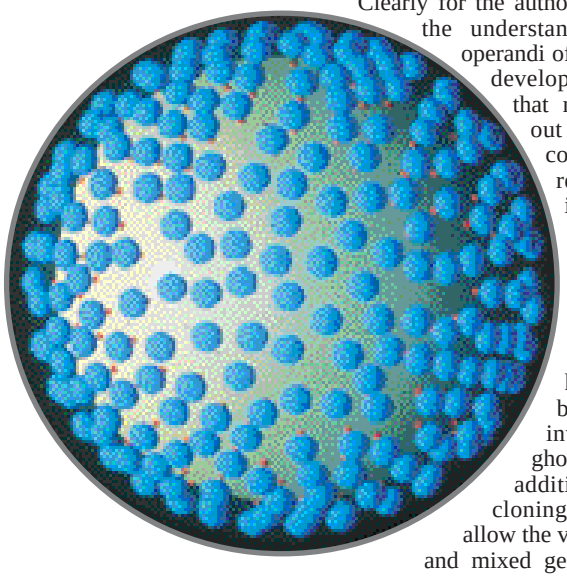
Viral sex — the nature of AIDS
Jaap Goudsmit

OUP, New York, 1999
PB, 221pp, $14.95 (0-19-512496-0)

For anyone with the slightest interest in what is now described as the global HIV epidemic, and there can be very few people who are not, there is a multitude of unanswered questions. AIDS, as they say, has changed many social attitudes in Western society and, in science, has had a considerable impact on many areas of virology, epidemiology, and pharmacology. The unfolding discoveries of the virological part of the AIDS epidemic, as the author says, finally has to be recorded for general readership. Most of us are unaware of the contribution of virology to the understanding of HIV and how it can best be contained. This book, however, goes further than that, portraying the discoveries of various HIV viruses and subtypes in a sort of global viral epidemiological discovery. Extrapolating backwards, this can be enlarged to provide a historical perspective, the whole story emerging as a scientific treatise on the emergence of HIV in Africa, its gradual spread of some less virulent prodromes to Europe, and its subsequent mutation to the highly aggressive and malignant form of the virus that exploded into the homosexual cultures of Western Europe and North America in the 1980s.

This book is written from a European perspective and from the basis of a scientific and virological discipline. It contrasts beautifully with Schiltz's journalistic account of the epidemic from a North American perspective and, despite its scientific and clinical background, has the same sort of chilling effect more reminiscent of fiction than fact.

The viral sex referred to in the title is the recurring theme in the book and refers to the unique method of reproduction of the virus that makes it so devastatingly successful as an agent that can survive and propagate itself but also as its potential for control. Clearly for the author, who is a virologist, the understanding of the modus operandi of the virus is critical to developing an intervention that might eventually turn out to be the key to controlling the virus replication. The invasion of the RNA virus into the host DNA is intriguing, and its ability to lie dormant in human cells and then multiply when the host cell is stimulated by a third party, foreign invader reads like a ghoulish horror story. The additional features of cloning and recombination allow the virus to propagate itself and mixed genes of parent viruses causing the remarkable flexibility and changes in offspring.



Computer model of HIV virus — Barnaby's Picture Library

The author unfolds the story of the understanding of HIV virology, writing it in simple language and providing, as we go along, the explanation of the implications of each discovery. This allows for an insight into the science behind successive discoveries and a clearer view than ever before of the mechanism of the various epidemics worldwide and the potential for control. As the reader goes on, he or she develops a clearer understanding of the dynamics of viral change and how the potential for change has led HIV-1 to adapt to its present situation as a global pathogen from its early days, possibly in the early 1950s and 1960s, as a low pathogen organism gradually seeping into the human host pool. Concepts like this allow the reader a new understanding of the dynamics of viral evolution, which at times intrigue like a science fiction thriller and at other times overawe the reader in the face of nature at work. The stories of recombinant subtypes (whoops! I'm beginning to sound like a virologist) HIV-0 and HIV2 provide further insights into the mechanism of viral spread and how it might, and is, emerging in new subpopulations in Europe and the subcontinent. Further types and subtypes identified in the 1990s suggest mainly heterosexual transmission, one group tending to dominate and even excluding others in different populations. The overwhelming impression is of a virus able to evolve and adapt but also able to hold on to an adaptation when it reaches a suitable host or host population; this is like observing evolution in fast motion. The potential threat of immense epidemics caused by HIV–1E and HIVC in Asia is explained with spine-chilling simplicity.

Reading the virological transmission from host to host, evolution of epidemics and subtypes, gives the clinician insight into the characteristics of our scientific colleagues that have, in the past, been most disturbing. The apparent indifference to the suffering of populations in the face of fascination of unfolding viral discoveries is familiar in conferences and meetings since the beginning of the AIDS story. This book, for the first time, gives the non-scientist that perspective and, as one reads the scientific implications of one discovery after another, at times transcends the human misery in its wake. The contribution of the scientists however is clear. The possibility of improving our understanding of viral replications and viral sex to the point that a drug or vaccine could be developed is the Holy Grail.

The story becomes even more fascinating in the detection of virus evolution in the African rainforest and among non-human primates. The author explores all sorts of possibilities including the bizarre and unethical experiments carried out by virologists in the 1950s using human subjects infected with chimpanzee blood to

investigate malarial transmission. Fascinating descriptions of chimpanzee hunters and the lives of forest people give an idea of the extent of the author's commitment to HIV research and the interaction between the basic science of biology and the social and biomedical sciences. Further than that, history lessons of the political events in Africa and Europe in the 20th century remind one just how unstable that continent has been during the past hundred years. Goudsmit's treatment of the part of the HIV story in monkeys is equally thorough and comprehensive. His scholarship on the Egyptology and the returning of the eye to God Ra by Thoth and Tfnut leads into a story about uncovering catacombs full of mummified baboons. This and donations from the British museum were used as the basis for the search for virus in ancient times and the complication of human cells with HIV present in all mummy parts. Again, the complication of viral techniques and their potential for misinterpretation becomes an intriguing diversion. The possible historical connection with cat immunodeficiency virus and how this might have entered the monkey population and subsequently the human population allows further historical and contemporary speculation.

As with most chapters in the book, the ultimate chapter on vaccines ends with questions rather than answers. The possibility of a living vaccine giving rise to a worldwide immunity to HIV-1 is intriguing but acknowledged as an almost impossible task, and the book ends with a rather cryptic and depressing eulogy about a man's responsibility in the world ecosystem.

This book is profoundly interesting and important, drawing together the available knowledge on the scientific aspects of virology of various immunological types and relating them to the medical manifestations of HIV infection and the behavioural sciences and social consequences of the AIDS pandemic. Goudsmit is unusual in his ability to record it in a readable and accessible form.

Roy Robertson

Towards a Philosophy of General Practice:
a Study of the Virtuous Practitioner
Peter Toon
RCGP Occasional Paper 78
RCGP, London 1999
PB 74pp (0 85084 252 2)

As a rule, doctors do not make good philosophers. But the very fact that we are medical practitioners implies that we are followers of a philosophical tradition: we are all disciples, if you like, of Descartes. Whether we recognise it specifically or not, doctors do hold a particular ontological view of disease — a real entity out there in the real world. We have a particular epistemological standpoint, which asserts (roughly) that real objective knowledge can be constructed through careful scientific observation and experiment. And, in our therapeutic decisions, we assume a fairly simple notion of causality based on a linear connection between cause and effect.

In his new Occasional Paper 78, Peter Toon critiques the basis of these central, rarely questioned assumptions, and introduces the reader to the school of moral philosophy that focuses on virtues. Reflecting on fortitude, prudence, hope, charity, and justice, Toon constructs a jigsaw, fitting the relevant features of virtue ethics alongside the tenets of psychology and moral decision-making. Quite simply, he constructs a fresh understanding of the nature of medical practice.

Toon's aim is to apply the benefits of virtue ethics to the particular problems of contemporary clinical practice. In so doing, he is unashamed about tackling head on the fundamental questions of reality (ontology) and knowledge (epistemology), the nature of illness, and the role of medicine. Rather than simply listing well-recognised virtues (courage, patience, temperance), he grounds his analysis in an impeccable academic exposition of meta-ethics; to do otherwise, as he says in his introduction, would simply be a display of organised prejudice.

His exploration of virtues has three elements. He makes some observations on the virtues required to be a good general practitioner, and then explores in one complete chapter the theory of justice, trying to reconcile the conflicting demands of different patients, and the tension between patients' and doctors' needs. In the final chapter he offers some suggestions on how people can cultivate the virtues, and considers how organizations might help them flourish.

Toon's analysis is based on the Christian taxonomy of virtues, chosen for its widespread recognition rather than for their intrinsic religiosity. The four cardinal virtues of courage, prudence, temperance, and justice are explored before Toon reflects on the three theological virtues of faith, hope, and charity. What is most appealing in Toon's analysis of the virtues is his insistence on grounding description in real practice. Thus, when reflecting on courage, Toon offers two case studies showing the importance of physical courage (dealing with drug addicts) and moral courage (disabusing patients of potentially harmful health beliefs). When illustrating prudence, Toon grounds his esoteric analysis once again in real clinical situations: a doctor may subconsciously harbour a particular prejudice to over- or underdiagnose certain conditions, or judge people differently on the grounds of class, sex, or race. Prudence is the virtue that tempers such failings. Toon describes hope using a letter received by him from a retired general practitioner. The entire chapter on justice reflects on the problems of waiting lists, and the potentially conflicting roles of gatekeeper and patient's advocate.

It is rare for the *Journal* to review an Occasional Paper, but this is an appropriate exception. Toon's paper is an important contribution to general practice. Reflecting upon philosophical assumptions that underpin clinical practice is no longer the indulgent pursuit of crackpots. Quite simply, in contemporary health care policy, science in medicine is presented as an intellectually celibate, unassailable paradigm; biomedicine has become a political ideology. In order to expose the potential dangers inherent in this, doctors should understand the assumptions that support the philosophical premises with which we currently practice. Toon deals with this admirably in the first half of this Occasional Paper and in the second half introduces the radically new idea of virtue as the basis of clinical practice. He does so with a combination of clarity and sense of purpose that retains the reader's interest throughout.

This is quite a difficult Occasional Paper to read. But it is important, and rewarding, and should be commended to all those currently in medical practice and for those preparing to embark.

Kieran Sweeney

The New Renaissance: computers and the next level of civilization
Douglas S Robertson
OUP, New York 1998
PB 200, $25.00 (0-19-512189-9)

Most books with this sort of title consist of informed speculation mixed with breathless hype or despairing doom. Not this one though. Douglas Robertson's passion is maths and his premise is that, since computation is at heart a mathematical operation, it is the geography of mathematics that will in the end determine how the computer revolution turns out. He takes you on an enthusiast's tour of the outer reaches of maths — imagine a numerate David Bellamy.

Fundamentally Robertson is interested in what computers can not do, in setting the mathematically defined outer limits of the possible. Some things are intrinsically non-computable no matter how grand the technology, and dimly, through my non-mathematician's fog, I began to understand a little of these limitations. Thanks to Bill Gates *et al*, such limits are still a little way off and the book is rather less interesting on what might happen before we reach them.

Whether this book is worth reading depends on how you feel about maths. When faced with large chunks of the stuff I default to one of two options: sink or skim. En route I get a tourist's notion about the general topography but I never come back laden with 'I ♥ maths' sunhats or a burning desire to get into the subject more deeply. For aficionados, however, this book might be worth the money. At the very least it's a great way to mine the philosophical roots of computation for reasons why hype will always have its limits.

Paul Hodgkin

Intercollegiate Forum on Poverty in Healthcare — *Our Healthier Nation*

The Intercollegiate Forum on Poverty and Healthcare hosted a conference to mark the launch of the Government's white paper, *Saving Lives — Our Healthier Nation*. The forum — made up of representatives from the medical Royal Colleges and World Health Organisation primary care programme — welcomed the opportunity to promote healthier living through reducing inequalities in health in England, as set out in the paper. The meeting brought together leading members of the health care professions to discuss the implications of health inequalities for their own disciplines.

The Chief Medical Officer, Professor Liam Donaldson, addressed the conference, which was held at The Royal College of General Practitioners on Thursday July 22. There were presentations from the leaders of a number of organisations, including several Royal Colleges and the British Medical Association Public Health Committee. John Ransford, of the Local Government Association, examined the implications for local government, and Dr Sheila Adam, Deputy Chief Medical Officer, led a discussion entitled, The Way Forward.

Chair of the Intercollegiate Forum on Poverty and Health, Dr Iona Heath, said:

"Poorer people lead shorter lives blighted by more disease and illness. This is a terrible social injustice. Efforts to reduce the malign effects of poverty on health must extend well beyond the National Health Service, reaching right across society and all the agencies of Government. Nonetheless, health professionals have a significant role to play in treating ill-health already caused by past socio-economic inequality and in trying to prevent current inequalities being manifested in more ill-health in the future, by targeting interventions on the most vulnerable."

The Intercollegiate Forum on Poverty in Healthcare, held at the Royal College of General Practitioners, Thursday 22nd July, included Dr Sian Griffiths, Dr Noel Olsen, Professor Sarah Cowley, Surgeon Captain JJW Sykes, Professor Mike Pringle, Mrs Lorna Muirhead, Ms Jane Naish, Dr Mary Hepburn, Dr Margaret Lynch, and Professor KGMMA Alberti.

new web sites...

Cardiovascular medicine in primary care, with splendid colour reproduction of Sheffield and Auckland risk tables, hypertension guidelines, and much, much more. Maintained by Chris Burton, a GP in Sanquhar, who clearly has too much time on his hands. Investigate at **http://medicine21.com/heartGP**

Meanwhile, ***Hoolet***, the anarchic and lovable journal of the RCGP in Scotland, is now available full text on the web, in glorious technicolour. Look up **www.hoolet.org.uk**

Shaping the Future: a Primary Care Research Strategy for Scotland

A group of Scottish medical bodies has joined forces to launch an innovative strategy for research and development in primary care, which is set to ensure consistent high quality in standards of patient care within Scotland.

'Shaping the Future: a Primary Care Research Strategy for Scotland' is a collaborative document that has been drawn up by the Scottish Academic Forum of General Practice, which is made up of representatives from the Royal College of General Practitioners, the Scottish Council for Postgraduate Medical and Dental Education, University Departments of General practice and Primary Care, the Scottish General Practitioners Committee, Regional Directors of Postgraduate General Practice Education, the Joint Committee for Postgraduate General Practice, and the Scottish Office Directorate of Primary Care.

The strategy, which aims to develop a knowledge-based service for doctors and to encourage a research culture in primary care, has been produced in response to the Scottish Chief Scientist's 1998 Annual Report and Strategy, which highlighted the need for providing doctors and other health care professionals with good evidence as to the best clinical practice to ensure good patient care.

Shaping the Future has three main strands:
•Establishing a Scottish School of Primary Care which will stimulate and coordinate a cohesive programme of research and training across Scotalnd. It will be a 'virtual school' with participation from a number of organisations and institutions.
•A comprehensive system for research training ensuring that primary care professionals have the skills to provide quality research in the community setting.
•Designated research practices that will facilitate research close to the patient, complementing recent changes in the NHS, particularly Local Health Care Cooperatives and Primary Care NHS Trusts, thus helping research to thrive.

The strategy was launched at the Muirhouse Medical practice where GP, Dr Roy Robertson, has led reserach into the pattern of care for patients with drug addiction problems. The new strategy will increase opportunities and support for primary care professionals wishing to undertake similar research. The launch took place on Tuesday 22 June 1999.

Neville Goodman

On students and consent

'How many of these have you done then?' Whether asked in jest I couldn't tell. My colleague — a consultant surgeon with whom I've worked for 16 years — found some form of words that did not include a number but seemed to satisfy the patient. At a rough estimate, two hernias on a list at two lists per week for 35 weeks of the year for 16 years is 2240 hernias, and that's only the ones for which I've given the anaesthetic. Would the patient have been happy with that figure? Or would he have been better knowing how many hernias my colleague had repaired in the past year?

The emphasis is on patients' rights to know, but patients often don't know what they need to know: they don't know what's important, nor how to interpret what is important. It's up to us to help them, but that can be difficult in our all-too-short consultations when the patient starts in the wrong place.

Things are not going to get easier. According to an article in *Vogue*, patients have the right to see their notes, query their treatments, change their GP, and decline to have medical students present. Nothing untoward there but where did 'refuse to have a trainee perform a medical procedure' come from? The absurdity of this patients' 'right' is self-evident. Patients have the right to expect whoever does their operation to be competent, or to be competently supervised by someone who is competent. There may be some patients for whom expediency dictates that it would be wiser for the consultant to wield the knife. But that is far from patients having the right to refuse medical treatment from a trainee.

And it may be misguided. Many years ago, a consultant anaesthetist came in to give an epidural to a colleague's wife who was in labour. He gave her a dural tap, unsurprisingly considering that the consultant had not done an epidural for some years. The trainee, on the other hand, was at the time doing up to 10 epidurals a day.

When I was a student, one of the consultant surgeons used to say, ''If they don't want to see students, they don't need to see me' and patients would be diverted to the registrar's clinic. Embarrassing diseases and special circumstances aside, what gives anyone the right, within a National Health Service paid for out of public money, to claim privilege? It is no more nor less than rights slipping into selfishness.

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our contributors

Maureen Baker is the RCGP Hon Sec elect, and, like other key figures in European general practice, hails from the quaint Clydesdale fishing village of Wishaw, Lanarkshire (Carstairs deprivation category [n]). These days she practises in Lincoln, which has a bigger Cathedral

Joanna Bornat is a senior lecturer in the School of Health and Social Welfare at the Open University. She is an editor of *Oral History* and has studied the links between reminiscence work and oral history for a number of years

Liam Farrell's elegant prose now decorates the pages of *Doctor*

Neville Goodman is an anaesthetist in Bristol

Paul Hodgkin is co-director of the Centre for Innovation in Primary Care, Sheffield. His year-long series on general practice in the 21st century will begin in the *BJGP* January 2000

David Lewis is a Registrar Observer to RCGP Council and has just joined a practice in Watford. He has an interest in the History of Medicine

Shaun O'Connell is a GP in North Yorkshire

Roy Robertson has published widely on drug addiction. He is a GP in Muirhouse, Edinburgh, and a lecturer at the Department of General Practice, University of Edinburgh

Jim Rodger is a member of UK Council and a past chairman of RCGP Scottish Council. He is a medical advisor to the Medical and Dental Defence Union of Scotland

Graham Smith is currently undertaking an oral history of changes in innovation, knowledge and networks in general practice, a joint initiative involving the Wellcome Unit for the History of Medicine and the Department of General Practice, both at the University of Glasgow.

Kieran Sweeney is a GP in Exeter. His publications include, with Evans, RCGP Occasional Paper No 76, *The Human Side of Medicine*

All our contributors can be contacted via the *Journal* office

Liam Farrell

The greatest gift

My uncle died a few months ago. He was a man of great vigour and fecundity — many children, legions of grandchildren, and acres of great-grandchildren — so, although I was very fond of him, I was only a peripheral mourner.

The wake started well before he died; so, for many days, he had the company of his family, hearing their voices, feeling the touch of their hands, sensing the presence of all those he loved best close by his side; no man was ever less alone.

And at the end, we did not let him go quietly. The wake became like a football match: cars parked as far as the eye could see; the house packed to the rafters; people sitting up all night, telling stories and spinning yarns and singing songs; plenty of tears but much laughter as well, just as my uncle would have liked.

We carried him all the way from the church to the graveyard, and every step of it relentlessly uphill. Although there were many willing shoulders, he was a heavy burden, so progress was very slow and, if the mourners weren't exactly falling by the wayside, certainly the spring had well left our steps before we reached our final destination. Darkness was falling soft as the rain by the time we laid him down at the last beneath his native sod, and may it rest lightly on him.

My cousin's faith in their family doctor was striking. The family looked forward to his visits, mulled over his every word for hours afterward, and was deeply grateful for all his support. They described the care he gave my uncle as 'extraordinary'. An out-of-hours co-op exists in our area but, even so, he visited my uncle regularly, whether after hours or at the weekend.

One of the criticisms of the co-ops when they first started was that they could not offer the continuity of care necessary for dying patients. However, a survey within a local co-op showed that GPs were willing to remain available to their dying patients when they were needed most, even if they were off duty. This confirms what was demonstrated by a questionnaire I sent out to the GPs in my area, while wearing another hat as a Macmillan facilitator in primary care. One of the questions asked was whether, despite being one of the most onerous, demanding, and time-consuming aspects of our work, we still considered care of the dying as a core function of general practice. One hundred per cent of the responders agreed. The commitment is still there.

It was edifying and reassuring to see from the outside how important a caring, attentive, and skilful doctor can be to a dying patient and their family, and I only hope that some of my patients might think of me in the same way. We can give the family and friends memories to make them smile rather than flinch away, and we give ourselves that rare privilege of knowing that we made a real difference. Helping someone to a good death is a great gift, perhaps the greatest gift of all, and perhaps even the metaphysical equivalent of a Sony Playstation (with Metal Gear Solid included).