The British Journal of General Practice

Viewpoint

Joining the NICE Experts: Grasping the Nettle of an Ambitious Agenda

It seems a long time since the Government's consultation document *A First Class Service: Quality in the NHS*[1] was launched on 1 July 1998. In that document the intention to establish a National Institute for Clinical Excellence (NICE) was confirmed. One year later, NICE's objectives were emphasized in simple terms: to end postcode prescribing, spread good value and new treatments through the NHS more quickly, and protect patients against outdated or inefficient treatments.[2] The Institute has developed against an ambitious timetable with the appointment of the Chairman and officers, the Board, the Partners Council, the Appraisal Committee, and, most recently, the members of the first Rapid Appraisal Committee. Given the high profile nature of some of the therapies chosen for early examination — from the use of beta interferon to the treatment of Alzheimer's Disease — the media speculation has been running high with many professionals feeling that NICE has been handed a 'poisoned chalice' by Government.[3]

This summer, I received two unexpected letters. The first was in August, from Sir Michael Rawlins, the recently appointed Chairman of NICE, inviting me to serve as a member of the Institute's Appraisal Committee. With a mixture of excitement and trepidation regarding the amount of time required for meetings, reading, and preparation I agreed to participate, feeling that the committee would prove both difficult and rewarding. It was emphasized that the letter was a formal invitation on behalf of the Board and the Secretary of State for Health. The first meeting of the committee was held at the end of October and it is likely that the committee will meet monthly thereafter. The Appraisal Committee will conduct technical evaluations based on submissions from manufacturers, patient groups, professional organizations and trade bodies. It is clear that our work will investigate the delicate balance of clinical and cost-effectiveness. Questions remain concerning how readily general practice and our patients will adopt the guidance we recommend. All the topics are likely to generate considerable debate.

My levels of anxiety increased as my perceived involvement in NICE became imminent. My second letter invited me to serve on the (Relenza) Rapid Assessment Committee and this represented a request for early participation in the new process of rapid appraisal with a group selected especially for the task. We have read and debated the evidence at length and survived our first real test. Our advice has now been submitted to the Secretary of State and his response has been widely reported. The membership and existence of the committee has also been made public together with the professional backgrounds of the individual members. Hence, our period of isolation from media attention has passed.

So why did I agree to commit time and give advice to an organization surrounded by controversy and debate? As a clinical generalist with a background in academic and service practice I admit that I am interested in all aspects of the Institute's work. I hope to bring a clinical perspective from inner-city primary care working in an area of deprivation with a multicultural population and an academic perspective grounded in health services research and education and training. I hope that my knowledge of the NHS and experience working at the primary–secondary and primary–community interface will be beneficial. A pragmatic awareness of the 'White Paper' agenda, particularly in relation to quality of care, deprivation and partnership working, will also, I hope, be important in the Institute's future recommendations.

Yvonne Carter

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2. Anonymous. NICE words, shame about the angry people with flu. *Health Services Journal*, 12 August, 1999.
3. Anonymous. NICE prepares to take the flak. *BMA News Review*, 9 October 1999.

The Back Pages...

'The French generalist, then, is beholden to his patient in a manner that British GPs ... would find intolerable ...'

Iain Bamforth, page 944

'How do we celebrate the distinctiveness of these isles of cold tides and farmer-fishermen? By closing their coastguard station in the interests of efficiency ...'

Alan Munro, page 952

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New Editor for the British Journal of General Practice

Dr David Jewell, Consultant Senior Lecturer in Primary Health Care at the University of Bristol and a part-time GP at the Horfield Health Centre, has been appointed as the new Editor of the *British Journal of General Practice*. He succeeds Dr Alastair Wright, who had edited the *Journal* for the past 10 years.

Dr Jewell brings an extensive background in writing and publishing to the post, having served as an editorial advisor to the *BMJ* since 1990. Most recently he has co-edited a multi-author book on men's health and was previously a member of the *Journal* Editorial Board. He also has a considerable experience of primary care research, having spent 19 years working in an academic department of general practice, and over the past three years he has edited a monthly community newsletter called *Alonim*.

David Jewell joins the *Journal* at a very exciting time, as the world of scientific publishing moves inexorably towards the electronic medium. He will be presiding over the challenge of adopting the new technology while maintaining and enhancing the *Journal*'s reputation.

College PEP CD ROM

PEP is the RCGP's own self-assessment tool. The CD ROM is widely used throughout the UK and internationally, with 1000 copies sold to date.

PEP consists of 14 programmes that cover a wide range of general practice subjects. Each programme contains both Multiple Choice Questions and Patient Management Problems. The CD format makes possible instant feedback on your responses and access to related information.

Self assessment for Registrars

PEP's coverage includes Opthalmology, ENT and Dermatology, so that Registrars and their trainers can assess overall knowledge. It will also help to identify specific areas where knowledge is particularly strong or weak. As well as being a useful revision tool, the Patient Management Problems are a good base for discussion with colleagues and Trainers.

PGEA opportunities for Principals

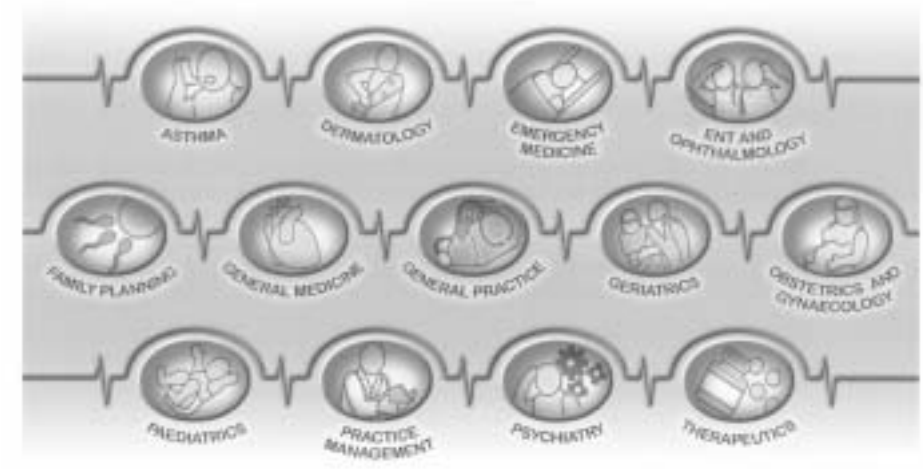
For Principals, PEP provides an opportunity to gain PGEA points through distance learning, in a way that is both flexible and enjoyable. Two hours of PGEA are available for each of the 14 programmes, which cover Practice Management and Therapeutics in addition to purely clinical subjects.

If you would like to sample PEP before considering a purchase, a short demonstration is available through the College Website at *www.rcgp.org.uk*.

The CD ROM costs £45 for College Members and £52 for non-members, or £115 for a multi-user disk, which would allow all your practice partners to use the disk. An additional charge of £20 is made for every two hours of PGEA applied for.

Application forms for the disk are available from the PEP Office at Scottish Council's new building. Please note that we cannot dispatch your order until we have received payment by cheque.

RCGP Scottish Council, 25 Queen Street, Edinburgh, EH2 1JX; tel: 0131 260 6800; E-mail: *chempsall@rcgp-scotland.org.uk*



16th WONCA in South Africa

The South African Academy of Family Practice will be hosting the 16th World Congress of Family Doctors in 2001, at the International Convention Centre in Durban. Some 3000 delegates are expected to attend.

The theme of the Congress is 'Family Medicine: The Leading Edge'. On successive days delegates will debate critical issues that will affect all practitioners and will discuss desirable outcomes of family practice, the processes required to meet these outcomes, and the resources necessary to maintain a family doctor's practice as a leading edge practice. In the final plenary, a panel of family practitioners from around the world will present the best available evidence for the successes and shortcomings of family medicine at the leading edge.

The programme aims to revitalize practitioner's dedication to family medicine and to their patients. It will consist of daily plenaries, workshops, free papers, posters, skills laboratories, self-evaluation programmes, and interactive discussion groups. Interactive learning and personal growth will be central to the programme. Visits to community-based sites will contribute to the learning experience.

Excellence in various domains of family medicine will be explored, including clinical practice and skills; family, community, and society; women's health; practice management; personal professional development; information technology; and rural and remote medicine.

There will be a fully functioning Internet cafe, plus a range of exhibits of the latest international medical products and services.

For more information and to register, visit the WONCA Congress 2001 web site at *www.wonca2001.org.za*

Memorial Plaque for Sir Joseph Banks at Lincoln Cathedral

A plaque acknowledging the contribution made by one of Lincolnshire's most famous residents is to be put up in Lincoln Cathedral. Sir Joseph Banks was renowned throughout the world as a botanist, and was involved in many exploits, some of which continue to influence our lives today. He accompanied Captain James Cook in the expedition that discovered Australia and it was Banks who first suggested that a settlement be made there. His many contributions earned him the title of 'Father of Australia'. He is still acknowledged as one of their most important historic figures.

With the support of King George III, Banks established Kew Gardens, and his concern for the community was demonstrated when he suggested that the government introduce qualifications for doctors, thereby preventing 'quacks' from practising. In Horncastle, his local market town, he established a 'people's dispensary'.

During his expedition to Australia, Banks discovered and named the plant genus *Banksia*, of which 75 species are now known. A drawing of a leaf of *Banksia dentata* on the memorial plaque was based on a drawing made by Banks' companion, Sydney Parkinson, in 1770.

The British Australia Society in Lincolnshire has been given permission by the Dean and Chapter of Lincoln to put up the plaque, which will be unveiled next year.

John Fry Memorial Plaque — Page 950

Guidelines in Urology for General Practice

The *Guidelines in Urology for General Practice* was initiated in 1992 as a guide for local primary care practices using the Southmead and Weston Urology services. The original intention was simply to inform on what was available and how best referring practices could steer patients through the investigative obstacle course prevailing at the time. A draft was prepared by urologists and comment invited from four practices in the area.

The response was immediate and candid, with a call for more evidence-backed guidance on current practice in urology as well as suggestions on what could be achieved with shared care or the avoidance of referral to a hospital-based service.

Following this major involvement of primary care and also input from renal physicians, the first version of the *Guidelines* was circulated and well received.

Shortly after the initial circulation, the local Medical Committee and the Purchasing Authority contributed their views to clarify local policy in aspects of prostate cancer diagnosis and management. The *Guidelines* were then published by the Bristol Urological Institute and distributed to all practices in the area by the purchasers. As a result of developing interest outside the Bristol area, the 1999 version was published on the BUI website.

The whole enterprise has evolved as a collaborative venture that has brought all the interested parties to a better understanding of each other's approach to the care of patients with urological problems and has helped to streamline the process of care in many areas. The *Guidelines* are by no means comprehensive but form an easy reference point, and are continually updated on some of the common and less common, but nevertheless pressing problems, arising in practice.

Above all, they deal with the practicalities of care.

Anthony Hinchliffe
Consultant Urologist

P Male
General practitioner
www.bui.ac.uk

Looking Through the Glass Ceiling: academic careers in general practice

Seven years ago, while a full-time general practitioner in north Staffordshire, I attended a seminar at the RCGP about academic careers in general practice. Two people particularly impressed me that day. With her commitment to research, Ann Louise Kinmonth had clearly 'made it' through the glass ceiling as a senior GP academic. I also remembered Professor Denis Pereira Gray, particularly his ability to publish in the peer reviewed literature, and his signature had previously endorsed my MRCGP certificate in 1987 when he was Chairman of RCGP Council! He spoke eloquently of the need to form closer alliances between academic departments of general practice and the postgraduate general practice network and to forge career pathways between the two. He also described the mentoring and support offered to members of his academic department and gave details of their progress towards higher degrees.

At coffee I spoke informally of my dilemma: to apply for a part-time senior lecturer post or to continue my full-time GP principal post with the long-term financial security that this offered. The conversation covered my progress towards completing an MD thesis and the difficulty of finding adequate protected time while continuing life as a doctor, wife, and mother. I had wanted to obtain an MD from my days as an undergraduate; most of my role models in St Mary's Hospital Medical School had one and it never occurred to me that, as a GP, I should not also aspire to achieve a higher degree.

Much has happened since that seminar. Certainly the careers of the main players have moved on. Professor Pereira Gray was knighted in the New Year's Honours List and is currently the President of the RCGP. Professor Ann Louse Kinmonth, having moved from the Chair in General Practice in Southampton, is now the Foundation Professor of General Practice in the University of Cambridge and a Fellow of St John's College. She was the only GP directly involved in the Report of an Independent Task Force on Clinical Academic Careers chaired by Sir Rex Richards. More recently she has again taken up the gauntlet as the only GP involved in a Working Party on Academic Careers for the newly formed Academy of Medical Sciences. On a personal academic note I have progressed from honorary research fellow at Keele, to senior lecturer in Birmingham, to Professor and Head of Department at Queen Mary and Westfield College in London, and belong to that slowly increasing group of women who hold Chairs in UK general practice.

In June this year I experienced a feeling of *déjà vu*. This time, as the RCGP Chairman of Research, I welcomed over 60 delegates to a seminar at the College on academic career pathways. With my co-chairman, Professor Sean Hilton, Chairman of the Association of University Departments of General Practice, we once again rehearsed some of the opportunities and pitfalls of combining service practice with teaching and research. Why was I not surprised when one delegate asked why it took seven years to hold another meeting on the subject? What progress had been made in the interregnum to remove the obstacles to career development for academics in general practice?

Once again Sir Denis spoke of the need to bridge the gap between research and education. Perhaps the greatest challenge that we face is how to integrate the two branches of our discipline: the academic undergraduate departments with the postgraduate network — those who do research with those who teach. Research methods training must become a lynchpin in our lifelong learning.

Admitting that it was not an exciting bed-time read, Professor Kinmonth also discussed her role in the Report of the Richards Task Force[1] and its implications for career development. The Task Force was set up in response to the perceived problem of recruiting and retaining staff in clinical academic medicine and dentistry. A number of recommendations were made, including particular attention to the terms and conditions of academic staff to ensure that those of senior clinical academic general practitioners match those of other University-funded clinical academic staff (including eligibility for merit awards). The report did not fully address the infrastructure requirements necessary for GPs to be able to get a foot on the first rung of the academic careers ladder. However, taken together with two other reports published in 1997, that of the National Working Group on R&D in Primary Care,[2] chaired by Professor David Mant, and that of the MRC's Topic Review in Primary Health Care,[3] it has set the scene for a series of steps towards achieving the potential of an integrated clinical academic career structure in primary care.

The Mant Report has been of relevance to all professional groups working in primary care and set specific objectives, including increasing the recruitment, development, and

retention of R&D leaders in primary care. Part of the report's implementation has been the creation of career scientist and researcher development awards. This year I have had the pleasure of chairing the first commissioning panel of the NHS R&D National Primary Care Awards and am currently reporting on the process and outcomes this Autumn. Opportunities to engage in primary care research and development are growing and the scope for those wishing to become involved is finally widening but there are still insufficient opportunities for people wishing to enter academic general practice and gain the basic skills in research and teaching as well as management and leadership. Academic general practitioners also need to undertake clinical work in order to maintain 'street credibility' with their service colleagues. Infrastructure funding for research active practices (from Budget 1; Culyer)[4] and the evolution of primary care research networks should both help to improve the research capacity and blur some of the boundaries between academic departments and clinical practice.

The establishment of Primary Care Groups in 1999 has set a new agenda for service development and research in the NHS. Academic general practice has an important role to play in 'valuing' general practice and it enables the evolution of the underlying discipline. Some solutions to career progression include the introduction of more flexibility in clinical academic careers with early opportunities for training, both during and after completion of vocational training; increased availability of research training fellowships linked to salaried clinical posts; and better integration of education, research, and service practice, recognizing the symbiosis that exists between them.

Yvonne Carter

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The Palestine Family Practice Programme

One of the first projects that the International Committee of the RCGP became involved with was the development of Primary Care for Palestinians. After an approach from Medical Aid for Palestinians (MAP) for help in re-establishing primary care, initially in the Gaza Strip, I did a feasibility study in March 1995 and spent a week looking at the facilities and meeting the doctors in that war-torn area of land where almost a million people live in an area of 210 square miles. A former colleague and trainer on the Kuwait Family Practice Programme, Dr Abdul Motaleb El-Qawasmeh, had returned home to Gaza and was keen to establish a training course for primary care doctors. MAP had had the support of the Ministry of Health of the Palestine National Authority and this was conveyed to me at a meeting I had with the Minister of Health, himself a doctor.

On the ground, conditions were challenging. General practice as we know it did not exist. Primary care doctors worked in poorly maintained clinics, without any significant facilities or support. They saw an apparently endless stream of patients who had high expectations of medical care and who came with exaggerated beliefs in the efficacy of prescriptions, particularly for antibiotics, which were generally not available. There was little record keeping, no follow-up, and patients went from one clinic to another until their self-limiting condition got better. Often they went to a hospital where treatment was worse. Morale in primary care was not just at a low ebb — the tide was out.

I had seen something similar before, in Kuwait, as a tutor on Professor Robin Fraser's Family Practice Programme. But I had also seen that a properly designed educational plan could give back to doctors some sense of their worth and effectiveness. One hoped to re-awaken the professional pride and motivation that had taken these doctors into medical school in the first place, but that had been submerged by isolation, disempowerment, and deprivation. Once self-respect had been regained enthusiasm would spread. My intention was ultimately to provide a system which would make the doctors self-reliant but in order to do that we also had to identify those whose motivation and ability were strong enough to stimulate the development of education among their peers. The second aim, therefore, would be to identify eight or 10 doctors who could become 'tutors', whose task would be to cascade teaching in small groups throughout their localities.

We would have to start from the ground up, acknowledging that not all doctors had had the same experience. Many had trained in Eastern European schools, in a language neither Arabic nor English; their linguistic versatility was quite remarkable, matched almost by the diversity of their medical training. Rather than perpetuate the kind of top-down lecturing from specialists that had been the only experience of postgraduate education they knew, we adopted a more involving and participative approach. This would be developed and enlarged, depending on the perceived needs of the learners, within the framework of what was practical and achievable. The first courses in Basic Skills were held in August and September 1995, with 20 doctors on each occasion. These courses included hypothesis generation, critical reasoning, and problem-solving. Dr Abdul Motaleb and I ran the first of these and Dr Stewart Bailey, who had also been a tutor on the Kuwait programme, ran the second one. A third took place the following year. In subsequent advanced courses we addressed principles of diagnosis, plans of management, and prescribing. While such methods have been criticized as being less mature than might be expected in a postgraduate environment, they were ideally suited to doctors who had been in professional isolation for a decade or more. The participants found them stimulating and as word of the courses spread, more and more applied to participate.

Pre- and post-course assessments had enabled us to identify eight doctors who had the potential to become teachers themselves. A 'New Tutors Course' was undertaken with them in February 1996. This was a new venture and, one has to admit, something of an experiment. While ambitions had been expressed to develop a Vocational Training Programme, there was simply not the infrastructure in place to attempt it at this stage; for a start the hospitals were quite unprepared and the

Acknowledgements
Professor Robin Fraser was generous with advice and help in the early stages of planning and I am grateful to Stewart Bailey, Alistair Moulds, Pip Jago, Mary Polkinghorn, Sue Holmes, Jim Cox, and Simon Brown, all of whom have contributed in significant ways to the success of the Programme.

Dr Abdul Motaleb, who holds the RCGP/Kuwait diploma, was awarded an Honorary Membership of the College in 1998 in recognition of his outstanding contribution to general practice.

The photograph shows Rob Caird (third from left) and Andrew Motaleb (fourth from left) with a group of tutors from the West Bank.

few people who understood education were already almost overwhelmed. So there would have to be a 'short-cut'. We assessed their attitude towards teaching, with their fears and expectations; we discussed different teaching methods; they worked in small groups, role-playing as tutors; they made short presentations to the group ... we concentrated a great deal into a short week. But it worked !

From then on several strands have developed: the Gaza tutors have formed local day release groups; two more Basic Skills Courses have brought another 50 or so doctors 'on stream'. The basic skills have been supplemented by courses in management of chronic diseases, and advanced courses in paediatrics and in obstetrics have been delivered by RCGP tutors. All of these have been supervised by the indefatigable Dr Abdul Motaleb.

The West Bank got its first Basic Skills Courses in 1997. The situation there is different in that the geographical separation divides the land in three areas, based on Jenin in the north, Ramallah in the centre, and Beth'lehem in the south. A modular approach was taken there initially, to provide a constant input, but the general objectives of basic skills and advanced topics with identification of potential tutors has been maintained, so far with success. Altogether more than 180 doctors have participated in the Palestine Family Practice Programme in the Gaza Strip and the West Bank. The challenges now are to maintain impetus and to provide Continuing Medical Education, particularly for those who embarked on the programme in its early stages. MAP is providing selected journals and attempts to establish libraries are being made. Yet it still remains to overcome an attitude of educational dependence in doctors, which is probably a legacy of the years of neglect and isolation.

Support from the Ministry has been genuine, and the implementation of change is no slower than other administrations. They are gradually being convinced that general practice is cost-effective but there is always the tendency to be seduced by the glamour of high technology advances and the belief that you cannot have a 'good' health service without the latest scanner or whatever. Notwithstanding this, the District Medical Officers are financing Day Release and they are upgrading the larger clinics to improve the working environment which includes educational facilities. So the culture is changing; they recognize that well educated doctors will provide a better quality of care and that that, in turn, will reduce demand for — and waste of — expensive secondary care.

Robert Caird

Jill Thistlethwaite

Cambodia

"The city walls are approximately twenty furlongs (4 km) in circumference. They have five gateways and each gate is a double one. There are two gates to the east; the other sides have only one gate each. On the outer side of the wall is a great moat and beyond the moat are a series of large buildings spanning the access moats. On either side of the bridges are fifty-four stone gods like 'stone generals'; they are gigantic and terrible to look at …"

So wrote Chou Ta-Kuan, a Chinese visitor to Cambodia, in 1296. He was describing the city of Angkor Thom (meaning 'the great city'), built in the late 12th century and abandoned in 1431.

The *Lonely Planet* guidebook for Cambodia describes one of the main temples of Angkor Thom, the Bayon, as "a kind of Buddhism meets Gormenghast". Throw in a hint of Indiana Jones and who could resist the temptation of travelling to one of the most awe-inspiring monuments in one of the most tragic countries in the world?

Angkor is a collection of temples and buildings, built by a succession of Khmer kings, in the Siem Reap region of northern Cambodia. At the height of the Khmer Empire about 75 000 people lived and worked in the area. Angkor Wat is the largest of the monuments, reached by a causeway across a moat. Today, on this causeway, the visitor has to pass through a cordon of beggars; some missing limbs, some twisted in grotesque body positions. The desire to dispense largesse is overwhelming.

It costs 40 US dollars to buy a three-day pass allowing unlimited access to the main temple groups. This money, a small fortune for the average Cambodian, probably ends up in some government or army pocket. A vociferous Texan of Cambodian origins was able to get in free, owing to his looks and his slight grasp of the Khmer language. He loudly denounced his homeland and people for its corruption and poverty. He stood on the causeway and demonstrated the futility of handing out money to the beggars who sat quietly waiting to be noticed. "Give to one and they all expect some rials." His disdain of Cambodia and his admiration of his adopted country were plain to see in the cut of his clothes and the size of his camera. Of course, scattering notes solves nothing but it helps a tourist like myself to enjoy the monuments with some slight easing of conscience.

That same *Lonely Planet* guidebook, published in 1996, is now out of date. It is no longer dangerous to take the ferry from Phnom Penh to Siem Reap, the town nearest to Angkor. The journey takes five hours and at the landing the mainly foreign passengers are greeted by a crowd of entrepreneurs hoisting aloft signs designed to entice anyone to their particular guesthouse. Siem Reap is a 20-minute moped ride from Angkor. The regulations state that a Cambodian must accompany all tourists when entering the temple complex. This translates for all but the most affluent travellers as hiring a guide complete with motor bike each day. However, the guide can be left to his own devices while you explore individual monuments on foot.

The locals rarely visit the bars in Siem Reap. Apart for those tourists seeking a touch of after dark entertainment, the drinkers playing pool (a national obsession) are American NGOs (non-government officers) and British VSO stalwarts. There are tales of corruption in high places, teachers being threatened into awarding high grades by a strategically placed gun, and foreigners going quietly mad to the accompaniment of alcohol and drugs. While the local hospital is said to be a place from which few sick adults return, on the road to Angkor are two new children's hospitals, brickwork and gilded roofs gleaming, built by two different charitable countries.

The reason to pursue the Cambodian vacation experience, however, is Angkor: the Bayon, with its 200 smiling faces of the god Avalokiteshvara sculpted into the walls; Ta Prohm, left to the jungle in the state in which it was rediscovered by the French in the 1860s; the Roluos group, where hardly another person is in evidence.

Recently, there was a threat to turn Angkor into a theme park complete with sound and light show, but the country was unable to generate enough electricity to provide this millennium spectacle. Who knows what will happen to Cambodia and its awe-inspiring heritage in the next few decades? I looked into the faces of people my age and knew that they must have suffered terribly under Pol Pot. I stood in Tuol Sleng museum, a former high school in Phnom Penh that, under the Khmer Rouge, became Security Prison 21. In the courtyard are the pupils' swings and parallel bars; in the classrooms are instruments of torture, makeshift cells, and rows of photographs of the people who were detained here.

There is no easy answer to the questions posed by tourism: exploitation and destruction, or regeneration and enrichment? I hope the country as a whole benefits from my dollars; but, I expect, like the majority of countries on the planet, the rich will get richer and the poor will get poorer.

A Brief Cultural History of French Medicine

France and Britain might be neighbours, but language, empire, and weather have conspired, despite a remarkably similar population size and median age, to estrange us. Not least in the way we practise medicine. Mention Paget's disease to a British doctor and he'll assume you're talking about Paget's disease of bone, osteitis deformans; say *maladie de Paget* to a French doctor and he'll think you're referring to intraductal carcinoma of the breast. Similarly, toxic diffuse goitre might be Graves' disease in English, but a Frenchman will look blank until he hears it as *maladie de Basedow*.

There are other instances, not just terminological. In France, common antibiotics (e.g. amoxycillin) are given at twice the British dose strength. Short-course oral steroids are used widely by the French, whereas the very word is a bogey to British patients. Last time I checked, soluble insulin came as 40 units/ml, not as the 100 units/ml my British patients were used to. Post-viral syndrome doesn't seem to have crossed the Channel southwards, despite the fact that Marcel Proust's father was an expert on its 19th century avatar, neurasthenia. The French, besides an ancient Galenic, not to say Gallic, obsession with their livers, can boast a unique syndrome called *spasmophilie*. It resembles what most of the medical world calls a 'panic attack'. In France it would be demeaning to give a patient a paper bag as a treatment; instead injectable calcium is offered and the patient soothed with all the authority of what Madame de Sévigné called 'a Big Word'.

Differences are more than folk beliefs surviving in the alien cultural landscape of the French 'hexagon'. Some differences are structural, not cultural. In France, the patient is king. After the war, the British, against the fierce resistance of the medical profession, got the NHS: the mood of rationing, scarcity, and waiting has prevailed ever since. The French regard the NHS as a Victorian dystopia, and think the GP is some kind of a salaried state employee. Liberal medicine is held up, by contrast, as a guarantee that civil authority cannot intrude on the person: there is no great difference between how a generalist runs his *cabinet* today and the artisanal manner in which Madame Bovary's husband ran his in 1857. Ironically, it was the sacrifice of individual freedom to an all-powerful state that made the 19th century French medicine's *grand siècle*. Foreign students used to flock to Paris because it was so easy to perform autopsies there, and Balzac and Zola's novels go in awe of the new-found 'objective' arts of semiology and diagnosis. Evidence-based medicine is perhaps being more honest than it knows when it claims the Paris School as one of its inspirations.

The *Sécu*, of which the French are proud, was planned by the Vichy government in 1944, and later endorsed by De Gaulle at a time when the country was deeply divided. At that time, much of active France was rural (34% of the population), a figure that rapidly fell in what is known as the 'Trentes Glorieuses', a period of unparalleled economic growth that peaked in 1975, and that now gives France a GDP of $26 000 per capita; about 30% higher than that of the UK. To forget how quickly France was modernized — in one generation — is to overlook a capital fact about its history: The tenacious myth of 'la France profonde' actually hides one of the most modern and economically dynamic countries in Europe.

But the greatest difference of all is in health care delivery and spending. France spends about 40% more on health care than Britain: 10% of GDP (compared with 6.7%) or FFr 12 161 (in 1997) per person per year. Co-payments by patients account for 19.2%, compared with 2.2% in the UK, and are largely met by mutual and private insurance funds. There are more doctors too: 2.8 per 1000 compared with 1.6. If Britain is a hybrid society of consensus, France is a centralized republic that stands on the dignity of the individual. Every person is a moral individual, according to Condorcet, and by definition is bound to seek out the best for himself. This results in a looser social contract: generalist malpractice insurance in France costs a tenth of what it does in the UK. British GPs, beset with the problem of being paragons, would find few French patients impressed by the idea that they need to be spoken for. "Every citizen is capable of understanding if he is informed", says the philosopher of health, François Dagognet, a Jacobin notion that fits perfectly with American-style consumerism. But then, as Tocqueville recognized 150 years ago, America has a tradition of taking French ideas and getting better mileage out of them.

Until the 1960s, the place of the GP (*généraliste*) in French society was secure. But the increasingly technical and instrumental nature of medicine, and the rupture of 1968 that opened up the medical schools to anyone with the 'bac', have changed the nature of the profession: the total number of doctors qualifying ballooned by 72% between 1970 and 1985. While the social contract may be Jacobin, the structure of the French medical profession is *ancien régime*: on top the hospital nobility, the 'patrons', then the specialist clergy, and at the bottom of the pyramid the unglamorous third estate — the generalists. Hierarchy is reinforced by a competitive exam called the *internat* in the third year of university studies; those who fail it have no choice but to become generalists. Recruitment by default does not boost the public standing or self-image of generalists. The market's Invisible Hand is abetted by the system: the fallacy that only specialization can provide depth of knowledge is underlined by fees which are higher for technical procedures:

Further reading

- Lynn Payer. *Medicine and Culture: Varieties of treatment in the United States, England, West Germany and France.* Henry Holt, New York, 1988. [Medical anthropology]
- Ed. Michel Richard. *24 heures en France: Portrait insolite de la France et des Français.* Gallimard/Le Point, Paris, 1998. [Mass observation]
- Georges Tchobroutsky, Olivier Wong. *Le Métier de Médecin. Que sais-je?* N° 2812. Presses Universitaires de France, Paris, 1993. [Micropaedic guide]
- Bernard Benuiei. *La Politique de Santé en France. Que sais je?* No. 2814. Presses Universitaires de France, Paris, 1993. [Health Economics]
- François Dagognet. *Pour une philosophie de la maladie.* Les éditions Textuel, Paris, 1996. [Interview]
- Claire Brétecher. *Docteur Ventouse, bobologue.* Interforum, Paris, 1997. [Cartoons]
- Monique Guérin. *Le Généraliste et son Patient.* Flammarion, Paris, 1995. [Essay]
- Several authors. *Infiniment Médecins.* Collection Autrement, Paris. N° 161,2, 1996. [Essays]
- Claude le Pen. *Les habits neufs d'Hippocrate.* Calmann-Lévy, Paris, 1999 [Health economics]
- George Orwell. How the Poor Die in *Decline of the English Murder and Other Essays.* Penguin, London, 1965. [Classic Hospital Memoir.]
- Louis-Ferdinand Céline. *Journey to the end of the night*, tr. Ralph Manheim. John Calder, London, 1988. [Very famous novel]
- Martin Winckler, *La Maladie de Sachs*, P.O.L., Paris, 1998. [Very recent novel]
- The Anglo-French Medical Society, Dr Mark Cottrill, The Moat House, Lymm, Cheshire WA13 0AJ, meets twice yearly and also provides an annual weekend crash course in medical French
- A list of French-language medical web sites can be found at the home page of the Unions Professionnelles des Médecins Liberaux: **www.upml.fr**
- My own piece *Life as an Omnipraticien in France*, *BMJ* Classified 8.11.1997; 2-3 and on the *BMJ*'s web site for practical details about setting up in France **www.bmj.com**

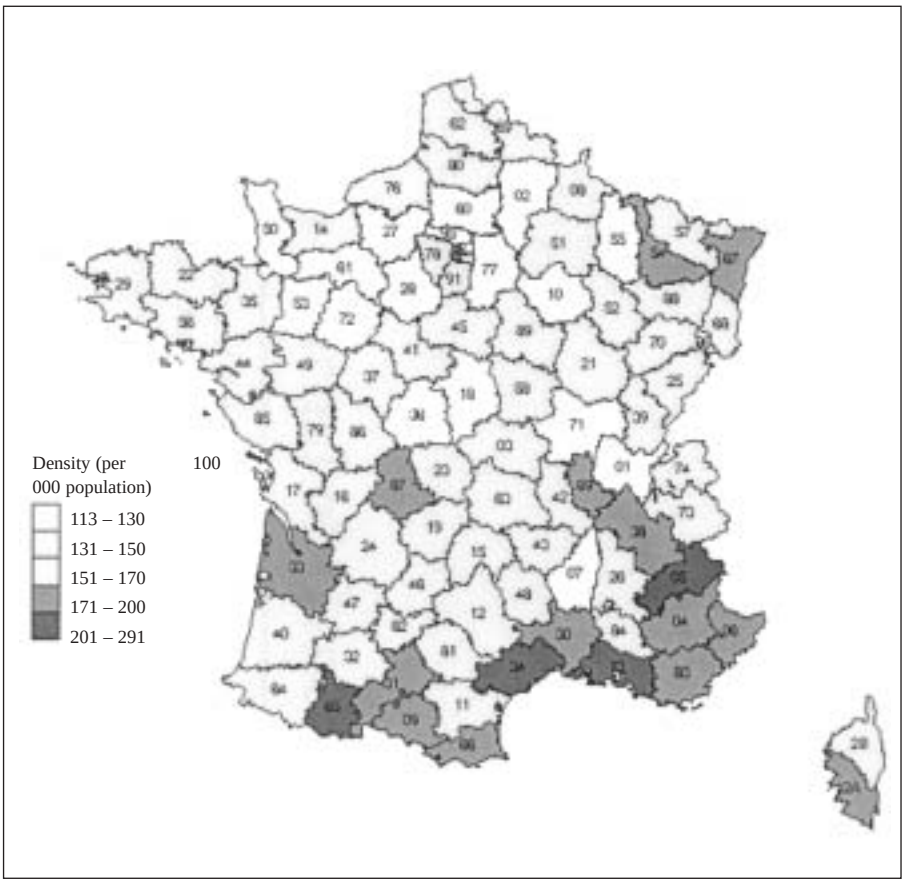
the highest earning doctors in France are radiologists, anaesthetists, and surgeons, who earn three times as much as generalists. In a further division along Cartesian lines, psychoanalysis is taken as gospel; on the other nobody finds anything odd about doctors whose entire field of knowledge is a single body part. The urban generalist, if not driven by such an inflationary system into the arms of homoeopathy or acupuncture, ends up a 'superior nurse' (Dagognet). Or, as some generalists self-mockingly call themselves, a *rassurologue* — but what British GP wouldn't share that feeling? Away from the cities, generalists get on with doing what rural generalists have always done.

The last 20 years have seen a steady erosion in the proportion of generalists in the profession: from 62.3% in 1980, to 52% in 1995, along with rapid feminization. The inverse care law has drawn swarms of specialists to Paris, Strasbourg, and the Mediterranean, reaching the staggering figure of 490 specialists per 100 000 population in Paris (as compared with 58 for a rural region like the Haute-Loire). Collegiality suffers, with different generations and disciplines touting for a diminishing clientele. Article 23 of the *Guide d'Exercice Professionnel* states "medicine should not be practised as a business": a look around the centre of most French towns, where doctors' offices are clustered around commercial centres, will dispel that piety. A young doctor starting out in practice has three possibilities: either to work as a locum (*remplaçant*) and stall the decision, to find a market loophole or *créneau* (the term derives from medieval warfare!) and set up his shingle, or to buy a list from a doctor who wishes to retire. This last method, in a private health system, is an important way of supplementing the rather meagre state pension run by the CARMF, to which payments are obligatory throughout a doctor's working life. Since 1990, essentially all new practices have been created under the *Sécu*, which sets tariffs for the consultation, house visits, and procedures. These doctors are termed *conventionné*. OECD figures put the French generalist behind German, Dutch, and British colleagues in terms of net annual income: $55 825 (in 1993). Half goes on the 'facture sociale' — running costs and taxes. British doctors may be startled to know that a consultation is valued at FFr 115, and a home visit at a mere FFr 135. Despite this low rate of remuneration, up to one in four of the 22 patients seen daily by the French generalist is still visited at home.

The French generalist, then, is beholden to his patient in a manner that British GPs — who, as gatekeepers, handle more than 90% of consultations without referring them to specialists — would find intolerable. Even though the patient pays the doctor, and has to wait several weeks before being reimbursed by his insurance fund (*caisse*), statistics show that the French visit the doctor twice as often as the British (eight times a year). At 2.3 million francs per year each generalist 'spends' more than a specialist (1.5 million); this is largely related to prescribing behaviour (the patient leaves the surgery with an average 3.5 items per prescription). More drugs are taken in France than almost anywhere else in the world, for all classes of medication; spending on them is twice what doctors earn in fees. Why this should be so is intriguing. Is it another feature of a mechanistic understanding of the body? Are they fetishes for a biomedical age? Or is the French pharmaceutical industry simply good at marketing? Perhaps all of these. On being appointed as the Secretary of State for health, one of Bernard Kouchner's first calls was for wide-scale 'lay-off' in drug consumption: he pointed out that, compared with the UK, 19 times more venotonics are bought in France, 15 times more lipid-reducing agents (despite the apparent 'French paradox'), and three times as many psychotropes. The 5% of 'nomad' patients (doctor-hoppers) who go in for second, third, or fourth opinions might just seem confinable, but in percentage terms they account for 14% of expenditure. With such a high general consumption of drugs, an impertinent observer might wonder if the energetic driving and RTA statistics of the French were not to some degree iatrogenic.

The social security deficit bottomed out at a record 67.3 billion francs in 1995 (not all of it health related). Jospin's prudent government, building on the austerity of the Juppé plan that preceded it, has succeeded in recouping most of that figure in a surprisingly short time. Doctors' prescriptions are examined by the *caisses* to see whether they are in line with consensus standards — *références médicales opposables* — and fines imposed on major offenders. Given the nature of the profession, doctors make a convenient scapegoat, as they did for the media in the dog days of 1995–1996: now that the crisis has largely been overcome, there is a recognition that there are serious structural problems in the provision of health care, especially in an increasingly ageing society. While there will continue to be a relative excess of doctors in France over the next decade, chance is that in the coming years the position of the generalist will improve, both at the university level and in society at large. It could scarcely worsen.

Iain Bamforth



Generalists: density by département per 100 000 population (as at 31 December 1997). Source: Ordre des Médecins www.ordmed.org

In Part 2 of this series, Olivier Wong describes how leaders in French general practice seek to raise standards, restore morale, and re-invent the discipline ... in the December Journal.

The Hippocratic Doctor: Ancient Lessons for the Modern World
John Fabre
RSM Press, 1997
PB, 80pp, £9.95, 1 85315339 7

The Hippocratic oath is not a profanity, uttered in response to an ancient needlestick injury. Beyond that, my knowledge of the Father of Medicine was limited; and, I suspect, many of my colleagues are similarly ignorant.

This book is a remarkable achievement. Fabre sets out to summarize *and* classify the whole of the Hippocratic Corpus — nine unstructured volumes — and does this in 73 pages. Clearly not an in-depth prècis, but it is one that provides an efficiently informative overview of the Hippocratic tradition — a kind of Hippocratic crystal.

Here we see the origin of a medicine based on rationality. Even though we now recognize much flawed rationale, the system of devising treatment from scientific and philosophical principles remains the basis of modern medicine. As such, Hippocrates is important to us all, including formal recognition of the psychological contribution to illness and recovery, and his harnessing of the placebo effect. There are areas, particularly of orthopaedic medicine, that may have changed little since Hippocrates taught.

The book highlights parallels and contrasts with modern medicine and society. It does not, unfortunately, and despite its title, propose many lessons from the writings. Perhaps, the best lesson is the implicit thought that, in 2500 years, our medical understanding will prove to have been as wide of the mark as the Hippocratic one. Fabre quotes from Volume VIII: "Medicine ... is... now completely discovered", and this could be as arrogant now as then.

Blair Smith

Patients, Power and Politics
Christine Hogg
Sage, October 1999
PB, 224pp, £16.99 0 76195876 9

In 1997 the government announced a 10-year plan for the NHS, emphasizing the importance of building partnerships with users, improving clinical effectiveness and governance, and tackling accountability. Since then there have been continued recommendations from the government to health professionals to involve users, patients, lay people, and carers in the design of services. There is also a growing awareness of unexplained variations in patterns of medical practice and of gaps between public expectations and the supply of services. This has led the government to consider ways in which the demand for health care can be managed. Partnership has become a key element of public policy. The new emphasis is on shared information, shared evaluation, shared decision making, and shared responsibilities (Coulter, A. Paternalism or partnership? *BMJ* 1999; **319:** 719-720).

Christine Hogg's book, which examines health care and public health from the perspective of the user, is, therefore, very timely. There are nine easily read chapters covering such topics as professional patient relationship, paternalism, access to health, medicalization of certain conditions, research, and how users and citizens can contribute to health policy.

For readers of the *Journal* the longest chapter, entitled 'Patients', is likely to be particularly pertinent. The author teases out the central issues around such topics as consent, sharing information, access, confidentiality, compliance and concordance, patient-held records, complaints, self regulation, and buying health care. The arguments are presented in a clear and balanced way and are well referenced.

The relationship between doctor and patient has been changing in recent years, with a move away from the traditional paternalistic model of health care. As the traditional authority of the medical profession is undermined and as patients become more confident, Christine Hogg suggests that a different basis for the contract between the giver and receiver of health care is needed. A useful chart is provided summarizing different models which could replace paternalism and describing their advantages and disadvantages.

The chapter on research argues for the wider use of user involvement, which the author suggests could reduce the amount of unnecessary research, would include topics for research that were particularly relevant to users and could lead to more appropriate research methodologies. The author also makes a plea for wider dissemination of research results to patient, carer and user groups which, she argues, could lead to more accountability as well as for pressure to implement the results of research.

While the book does have a good section on the role of pressure groups and voluntary organizations it was disappointing not to see the work of the Patient Liaison Groups of the Medical Royal Colleges mentioned. And as a Scot I have to comment on the very common lack of reference to Scottish health services terminology and a recognition that there are some differences between the health systems in our countries!

However, these are minor criticisms in what is a thought provoking and well written book. I particularly like Christine Hogg's description of patients as just people with particular health problems who may be taking medicines or receiving treatment. I would like to see this book on the essential reading list of all GPs.

Patricia Wilkie

The Rise and Fall of Modern Medicine
James Le Fanu
Little Brown, 1999
HB, 490pp, £20, 0 31664836 1

I remember being struck at an early age as my father recounted that, when he was at primary school in the 1920s, no-one considered it unusual when two of his young classmates did not return after the holidays, having died of infectious diseases. It went without saying that the local doctor was held in the highest esteem. Quite a paradox, then, that at the close of the 20th century, when medicine can treat such diseases in a way beyond the dreams of those who set up the National Health Service, that the level of dissatisfaction among doctors and some of their patients is so high.

In addition to disillusioned doctors, Le Fanu also identifies the issues of the large numbers of worried well, the soaring popularity of alternative medicine, and the spiralling costs of health care, as central paradoxes that exist at a time when medicine is more effective than ever before and the population, at least in the West, is healthier than it has ever been. In *The Rise and Fall of Modern Medicine*, Le Fanu explores possible explanations for this strange state of affairs by considering an historical perspective of medicine in the second half of this century. Le Fanu's thesis is, in essence, that the great advances in the middle of the century, such as the discovery of antibiotics and steroids, were largely fortuitous. However, the medical establishment claimed the credit for them for itself and announced they were the result of the triumph of clinical research, thereby tacitly promising the awestruck

public that further victories against disease were 'just around the corner'. All that was required was patience and ever-increasing amounts of funding. Science had, after all, taken man from Kitty Hawk to the moon in less than seventy years; surely the successors to Fleming and Hench would deliver more 'miracles' to mankind. The profession basked in its Golden Age and the brightest school leavers rushed to join the ranks.

Yet, as the years went by, it seemed that the enormous research empires that had grown up to strive unceasingly to fight such diseases as cancer, arthritis, and multiple sclerosis, were either emphasizing the unceasing aspect of their work or were running out of ideas.

Is intellectual bankruptcy really rife in medicine, as it descends into a fall? I suspect things may not be quite as straightforward as Le Fanu would have us believe, but many people both inside and outside medicine are concerned by its recent track record and sense of direction. This well written, extremely readable, and thought provoking book deserves to be widely read, especially by those in the establishment who would say he is wrong.

Rob Hendry

Clinical Evidence:
A compendium of the best available evidence for effective health care
Issue 1, June 1999
BMJ Books, £45, 588 pages

As the evidence-based health care juggernaut steamrollers on, publishers are producing evidence-based books faster than they can be read. There are so many that soon we will have books on evidence-based books and hopefully some randomized, double-blind trials to examine their impact on health care rather than the publisher's profits. One of the more recent tomes is produced by the BMJ Publishing group and the American College of Physicians/American Society of Internal Medicine. The idea behind *Clinical Evidence* was that there should be some ready handbook like the British National Formulary that could be referred to quickly and easily, containing all the relevant evidence pertaining to a topic. This would allow clinicians to be able to keep up to date without having to read all the relevant journals, by having a single, portable reference book for all possible occasions. *Clinical Evidence* is an ongoing project and will be republished every six months with additional evidence added as it becomes available.

As the book is designed to be used as needed, I kept it on my desk for a month and referred to it whenever I felt the need. The book is divided into illnesses and subdivided where necessary, e.g. diabetes has subdivsions on glycaemic control, foot disease, and cardiovascular disease. Each chapter summarizes its findings with interventions categorized into beneficial, unknown, trade off between benefits and harms, and unlikely to be beneficial. There are key messages, but no recommendations (which will irritate litigation lawyers). Following this is the bit which I found most useful, a short section on definition, incidence/prevalence, aetiology, prognosis, aims, outcomes, and methods. As an *aide-memoire* and refresher on a variety of illnesses this section illuminated and engrossed me in equal measures. This section will be most useful for examiners looking for hard facts for multiple choice questions. It will be equally useful to students and examinees of all ages.

There then follows what aficionados of EBM really get off on and that is descriptions of systematic reviews and RCTs. These are unusually readable if you get beyond the summary, but you will not have time to read them during a consultation without severely disrupting your carefully nurtured doctor–patient relationship. It is interesting to note how few good trials have been done and a lot of those do not answer questions which GPs like to ask. I rarely found my prejudices being proved wrong and even found some evidence to stop some treatments which I disagreed with, but had continued on a consultant's 'advice'. Any book that reinforces my prejudices and gets me one up on secondary care cannot be all bad.

Unsurprisingly, the largest section was on cardiovascular disease. Surprisingly there was not much on cholesterol reduction (the first section I examined on receiving my copy) and I was not able to answer the question of which was the most cost-effective treatment. A lot of the trials relate to secondary care and are not particularly useful, except for reinforcing the desire not to refer, as many of their interventions have no evidence base. It did not have any sections on 'feeling tired all the time' or being off one's legs. Nor did it have anything on haemorrhoids, ingrowing toenails, funny little spots, or ear wax. However there were good bits about scabies, head lice, otitis media, and leg ulcers.

As more evidence becomes available I imagine this book will grow too large for all specialities and there will be a need to break it into separate volumes on different topics. At the moment it is a useful addition to your practice library — maybe not to be kept handy on your desk, but to refer to once the patient has gone and you have to time to repent at leisure. I can recommend this book with reservations, but look forward to a similar text focusing on primary care.

Chris Johnstone

The Fine Art of Medicine
Hunterian Musuem,
University of Glasgow
4 October–11 December, 1999
Admission: Free
Opening hours: 0930–1700, Mon to Sat

The Fine Art of Medicine rounds off a year of celebrations for the 400th anniversary of the Royal College of Physicians and Surgeons of Glasgow. Literary and musical themes have already been prominent in this anniversary year, with the College hosting a very successful two-day conference on medicine and literature; holding a short story competition — which led to the publication of a collection of the best, called *The Magic Bullet*; and sponsoring a gala performance by the Royal Scottish National Orchestra.

The exhibition is housed within the high vaulted, gothic space of the Hunterian Museum at the University of Glasgow and is divided into nine themed sections. The themes include 'The artist and anatomy', 'Artists and doctors', 'Art, medicine, and humour', and 'Art, medicine, and war'. There are some predictable inclusions within these sections, such as the works of the Scottish artist David Bellany, and the surgeon Sir Roy Calne in 'Artists and doctors', but there are some surprises too. There is an affectionate, almost cartoon-like sketch by O H Mavor (better known as the Scottish dramatist James Bridie) of his favourite teacher, Dr George Middleton standing among the debris of the demolition of Lister's surgical wards at the Glasgow Royal Infirmary in 1924. We also discover that James McNeil Whistler had a medical brother, William, portrayed in a lithograph by his brother, who served as a confederate army officer in the US Civil War. The section on 'Art and the experience of illness' displays such well known works as Goya's etching of a man crumpled in sleep, his dreams portrayed as a goulish flock of owls rising above him. The pillar on which he lies declares: 'The sleep of reason produces monsters'. Hogarth's 1735 engraving of Bedlam from his series depicting *The Rake's Progress* is also included, as is the gorgeously coloured 'The Convalescent' by Gustave de Jonghe.

It is surprising (and gratifying to a native Glaswegian) to see how much of the exhibition comes from collections in Glasgow itself — from the University collections, the Gallery of Modern Art, and the Royal College of Physicians and Surgeons, which is the main sponsor. It is well worth a visit if you are in Glasgow over the next three months — but remember to avoid Sundays when the University collections are closed.

Jane Macnaughton

in brief...

Medical publishers continue to bombard unsuspecting readers with large format and excessively floppy paperbacks.

Exclamation marks abound… (**What Stress!** Chambers/Davies, [RCGP, 1999], 0-85084-249-2), and better still with a CD ROM stuck to the front cover (**Making Sense of Risk Management**, Lilley/Lambden, [Radcliffe, 1999], 1-35775-490-5). General practice and the NHS, in this world view, is not an environment for the faint hearted — we need **'Survival Skills',** for **GPs** (Chambers, [Radcliffe], 1-85775-334-8) and for **Nurses** (Chambers/Hawksley/Ramjopal, [Radcliffe], 1-85775-339-9).

Now let's get sensible here. General Practice may be a bit rough at present, bu Such Is Life. Navigating the dangers of PCGs and other acronyms might be tricky, but it's not quite the Southern Ocean in an open boat. Even with an Exclamation Mark!!!! All the above are politely commended.

Large format, in a more civilized world, should mean elegant A4-sized periodicals. For maximally stresssed doctors, graduating between 1980 - 1984 (McManus *et al, Lancet* **354,** 9187) ghosts of the **Listener** loom large – that 'stratospherically intellectual' publication has proved irreplacable. Until, perhaps. Prospect (www.prospect-magazine.co.uk) Pleasingly liberal, Europhile, and with properly long essays, few of which have been adequately peer-reviewed. Recent issues dwell of chronic post-vasectomy pain, and an unfashionable defence of Arthur Koessler.

And finally, the Art Book of the Month. While readers await the latest Simon Schama (Rembrandt's Eyes, publishing Oct 28), one cannot do better than invest in Art in Venie (Stefanno Zuffi, [Abrams: New York, 1999], 0-8109-4204-6) spectacularly beautiful, and a bargain at £20.

Worth an exclamation mark.!

Alec Logan

Mentoring in General Practice
Rosslynne Freeman
Butterworth Heinemann, September 1998
PB, 216pp, £22.50, 0 75063940 7

The concept of mentoring in general practice is comparatively new, but well established in nursing, higher education, and in business settings. It is certainly welcome to realize that mentoring in medicine could become an accepted and available part of a medical career, whether it be general practice or other branches.

Dr Freeman describes how she acted as the facilitator in the setting up of a mentoring scheme in the South West Thames Department of General Practice Education. Her experience of higher education no doubt enabled her to bring educational skills to bear in this setting. We are not party to whether the GPs concerned in South West Thames needed convincing that they and their fellow professionals could benefit in the long term.

She explains that potential mentors were self-selected, and were chosen from applicants who were flexible and likely to aim at mentoring, not advising, and giving support, not direction.

Mentees — this is probably a neoligism, but neatly describes their relationship to mentors — are also self-selected and choose their own mentor from the list. They meet in a neutral setting; the time is not necessarily protected. Mentors may act for more than one mentee. When they first meet, the scheme and method of mentoring is explained and that, by the Reflective Cycle, how mentees' difficulties within their partnership, with patients, stress, and personal problems can be explored holistically and plans explored for the mentee to deal with them. It was interesting to learn that there were attitudinal differences arising from different cultural backgrounds, sex, and age, which were potential problems.

Supportive meetings are held regularly for groups of mentors and mentees, and there are regularly plenary meetings.

Dr Freeman looks at the success of the scheme, acknowledging that this can only be done objectively by outside assessment. Mentors themselves reacted favourably, noting that helping colleagues could sometimes be less stressful than helping patients!

There is no doubt that, even accepting the the required expertise and input that Dr Freeman gave, this type of scheme can make a huge contribution to relieving the stresses of professional life, and not only for GPs. Patient demand, the increasing technicality of the job, form filling, and financial problems — not forgetting the increasingly litigantly-aware public — are all potential problems that need strategies to deal with them successfully.

Dr Freeman's book is a valuable contribution at a strategic time and it should be owned by, or available to, all those who feel they can give help, or would benefit from it, to encourage setting up schemes such as she describes.

Mentor Plus
Egton Medical Information Systems Ltd (EMIS) and Oxford University Press (OUP) CD ROM

System requirements: Windows 95, Windows 98 or Windows NT4
£176.25 (including UK VAT)

JA Hersey

Mentor Plus is 'an electronic medical knowledge support system' for use 'wherever doctors and other healthcare professionals encounter patients'. It describes itself in the advertising material as giving 'instant access to expert medical information'.

The CD ROM has been compiled with the help of hospital physicians and GPs and provides details of peer reviewed material on more than 2000 diseases that are cross referenced with more than 25 000 commonly used medical terms, either as single words or medical phrases and their synonyms. Much of this is superfluous to the general practitioner.

The supporting booklet, unlike many other manuals, is relatively easy to follow and a thorough read before installing the CD ROM is advisable. One year's updates are provided free of charge, either by e-mail or floppy disc, and Internet Explorer is provided on the

CD ROM should you require a browser to access the Internet. You will require your own service provider and e-mail address to communicate electronically for the updates.

Installation of the CD ROM went without a hitch. A minimum of 50 megabytes hard disc space is required and a Pentium processor is strongly recommended.

There are three methods for finding articles in Mentor Plus : Browse, Quick Search, and Advanced Search. Which one you use will probably depend on your experience and confidence. Examples are given in the accompanying manual and I found all three search methods easy to use and, with the extensive cross referencing, reliable.

I found the multimedia section least useful, but it can be installed separately if disc space is at a premium. However, the 300 patient information leaflets and the directory of 1000 self help groups, many of which have direct web links and email addresses, are useful resources.

Mentor Plus is basically the Oxford Textbook of Medicine and the electronic British National Formulary with bells and whistles. It is therefore British and the language and disease orientation are easily recognizable as distinct from many similar CD ROMs that mainly emanate from the United States. My main problem with it, as with many electronic 'aides', is its precise role in the increasingly crowded day of a general practitioner. Despite its claim that it will 'save time', in my opinion it will take time; although, with the increasing need to inform patients about increasingly complex problems, skills in information retrieval and appraisal are urgent educational needs for many of us.

CD ROMs such as Mentor Plus are yet another reminder of how much information there is available with increasingly sophisticated methods of accessing it. The challenge for us is to prioritize the time. The challenge for CD ROM makers is to provide material that is helpful 95% of the time, user-friendly in a general practice setting, and employs a rigorous method of updating its material on a regular basis. Mentor Plus fulfils the last criterion, at a price.

Murray Lough

Blair Smith

Poetic justice, please

My breakfast in early August was accompanied by a combined sense of relief, pleasure, and anticipation, as I read the Back Pages of the *Journal*, and the postman whistled his way down the drive. For here, punctuating my Frosties and sweetening my espresso, was Bruce Charlton's advice relating to the appraisal, writing, and publication of poetry. My waiting had not been in vain.

I considered its messages in turn. I recognized the implication that my learned colleagues and I, who review submissions on this organ's behalf, can begin to extrapolate his advice to its logical conclusion. We may reject any scientific paper that does not shatter the frontiers of medical science, such that spontaneous intestinal convulsion is experienced by the reader (i.e. me, or them). Furthermore, we can relax in the presence of our pronouncement that any such paper is of the utmost insignificance, with the new confidence that ours is the only opinion of importance. Members of the College will undoubtedly appreciate the new slimline version of the *Journal* as they use it to line their jam pots. The *British Leaflet of General Practice*.

I noted, however, a simultaneous sense of gratitude that Vladimir Ashkenazy's piano teacher had not given up her profession prematurely on the grounds that her first 200 pupils lacked eminent genius; also that Franz Schubert and Paul McCartney continued songwriting despite their first 20 efforts sounding crap. Had Charlton been in Dublin in 1895, editing the *Belvedere College Gazette*, I wondered, as I spread the marmalade absent-mindedly, how many contemporary works of Joyce Major would have been discarded? And how many subsequent ones would have remained unwritten? Toast for thought.

With temporary grandiose delusions, then, I fantasized the garb of an editorial pair of shoes. Wearing these, I would have requested a re-wording of the first paragraph of Charlton's article, to the effect that we may be living through the first time for 200 years when there has been no recognized Anglo-Scottish poetic genius (while denying responsibility for the inevitable nasal dislocation induced among the several pretenders to the title). Bruce, for example, will never know the extent of his own posthumous acclaim.

John Fry, the General Practice Research Club, and the College

Back in the 1960s, when general practice researchers were regarded as a lunatic fringe by their colleagues, and following a research methods course organized by the College, the General Practice Research Club (GPRC) was established. The idea of the club was to provide a professional and social focus for deranged individuals interested in pursuing research in general practice.[1] Many of the early members of the Club went on to greater things of one sort or another ; Robin Fraser served as Secretary during the 1970s and Roger Jones resuscitated the Club in the mid-1980s and continued as Secretary and Chairman until the Club was wound up in 1997. This was marked by a *Journal* editorial by Roger Jones and Peter Fitton,[2] the Club's Secretary, entitled 'General practice research: deaths and entrances', which pointed out how welcome developments to support research in general practice had rendered the GPRC something of an anachronism.

Sadly, John Fry himself died an 1994. The officers of the Club agreed that the residual funds of the GPRC should be used to provide one of the many commemorations to John Fry's Olympian contribution to general practice research, both nationally and globally. A commemorative plaque has now been erected at John Fry's surgery in Beckenham, Kent, and the remainder of the Club's funds has been transferred to the College to provide continued support for the John Fry Award, given annually to a general practitioner who has demonstrated an outstanding record of achievement in the conduct and publication of research conducted in general practice.

Details of the John Fry Award can be obtained from the Awards office at the College.

1. Jones R, Wilmot J, Fry J. The General Practice Research Club. *Br J Gen Pract* 1991; **41:** 380-381.
2. Jones R, Fitton P. Research in general practice: deaths and entrances. *Br J Gen Pract* 1998; **48:** 873.

Roger Jones

Neville Goodman

Political correctness

The easiest way to circumvent accusations of sexism is to avoid the singular. Use plurals all the time to make he and she (or should that be 'she and he'?) redundant. Actually, I have no objection to 'they' and 'them' being used in the singular. It may upset the traditional grammarian, but they (see: it's not really that painful!) cause considerably less discomfort than the ardent feminist. Another tip to make life easier: ask questions through the chair rather than through the chairman. After only a short period of training this comes quite naturally. The verb ("Can you chair the committee tomorrow?") is common currency; why not the noun?

So far, so good. Leaving aside the inanity of replacing 'history' with 'herstory', the further reaches of political correctness find muddier water. The intention in altering language for political correctness is to change attitudes. Perhaps this works, perhaps it doesn't; but it doesn't take long before unacceptable jokes about dwarves become unacceptable jokes about the vertically challenged. The jokes are worse because jokes about dwarves are old and no-one took much notice; jokes about the vertically challenged are new and more likely to be repeated. It also becomes apparent that surlier members of committees use the term 'chairwoman' only as a term of abuse for female chairs.

There are more sinister undertones. Some things, though true, become unsayable. Evidence of difference becomes evidence of intent to discriminate. Language becomes corrupted. At a seminar I uttered the word 'coloured'. The sharp intake of breath from a couple of people in the group was unmissable. Sensitive to this, and knowing that failure of acknowledgement would only make things worse, I paused.

Sure enough I was taken to task, to be told that I should have said something like 'of different ethnic origin'. Never mind that this is four words to replace one, it is not what I meant. The incident I was recounting did not occur because the person in question was of different ethnic origin; it occurred because he was coloured. It would not have happened if he'd been French or Russian, but because his skin was of a different colour. It did not occur specifically because he was black; other non-white shades of colour would have elicited the same behaviour.

I can already hear the bile rising in some throats: French and Russian! — they're not ethnically different from Brits! Like Kosovans and Serbians, I suppose.

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our contributors

Iain Bamforth is a GP in Strasbourg. His new translation of Franz Kafka's *A Country Doctor*, the first since Edwin Muir's in the 1930s, will be published in the *Journal* in December

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Robert Hendry is a medical advisor to the *Medical and Dental Defence Union of Scotland*. In his spare time he invented the Stolly Bolly, a recipe not as yet available on the MDDUS website...

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A Hinchcliffe is a consultant urologist based at Weston General Hospital, specializing in male lower urinary tract symptoms

Chris Johnstone edits **hoolet,** the journal of the RCGP in Scotland. He claims invention of Prejudice-Based Medicine, and seeks a friendly publisher

By contrast, **Murray Lough** is a scion of Evidence-Based Medicine and sports a rogueish moustache. Murray has published obsessively on Audit, but remains an entertaining turn at fashionable dinner tables

Jane Macnaughton is a GP in Blantyre, Scotland, but not for much longer. In the New Year she will head the first department of medical humanities in a UK medical school, in Durham

Alan Munro's essay for the August issue of the *Journal*, "Reformation", attracted rave reviews, quite deservedly. His masterwork, *A Medico-Philosophical Guide to Anchorages in the Hebrides* remains, stubbornly, in press

Blair Smith has just published in the *Lancet*, and a certain smugness seems justifiable. He is a member of the *Journal*'s editorial board

Jill Thistlethwaite is loosely attached to the academic department in Leeds. She is widely travelled

Patricia Wilkie chairs the RCGP Patient Liaison Group

All our contributors can be contacted via the Journal office

Alan Munro

Difference

Slipping northward on a gently coaxing swell, with a favourable tide and following wind, we adapt to new rhythms. Late summer warmth alternates with the chill of star-drenched night. Food and drink are irregularly continuous, sleep is snatched here and there. The competition from sunset, moonrise, Milky Way, and shooting stars is intense. I lean out against the lee shrouds over pools of dancing moonlight, it is less bother than going below for a pee. So bright is the phosphorescence it is as if my Willie is on fire, like peeing diamonds.

Spray-skirted skerries announce the threshold of the Orkneys. Sweeping, sand fringed bays afford shelter and uninterrupted rest. The tide, rushing in narrow channels, dominates all movement, the moon is the supreme choreographer. Not so much, it seems, is the tide a little later each day, rather the sun is impatiently, improperly impetuous.

The little, low outer islands, seen from the sea on a grey day, are no more than an emphasis on the line of the horizon, an emerging thought in the mind of the ocean. In the sun they are a slash of emerald between sea and sky. In the frequent, fleeting transitions of weather, damp veils of vapour caressed by cataracts of crystal light and teased by the mischievous breeze, blush yellow, orange, blue, and purple.

Sheltering in Kirkwall harbour from rather too actively mischievous cold fronts, we are shepherded into a comfortable berth, given the keys of the local sailing club where we are welcome to use the showers, and advised precisely where to find a pint of Dark Island and the best seafood. Bliss. The local malt is hard to beat, too. The harbour bustles as harbours should, but in Scotland seldom do. The second language on the polite notice to visitors is Norwegian. The accents have an unfamiliar twang. This is a different place.

The forecast is hideous so we become tourists. Skara Brae is a five thousand year old Neolithic farming settlement. So perfectly preserved are the houses that no expert interpretation is required. The domestic arrangements of our very distant forebears are set out for our delight, unambiguously, in stone. Their great monuments at Maes Howe, Stenness and Brodgar, like Stonehenge and similar continental sites, denote a European society, cohesive and sophisticated, and strikingly unfortified. Progress? I suppose we can't know for sure how corrupt their commissioners were. All this before the pyramids, before Minoan Crete, before Homer, before Athens, before Rome, before Christ, before the Vikings, before us.

Us ….? How do we celebrate the distinctiveness of these isles of cold tides and farmer-fishermen? … By closing their coastguard station in the interests of efficiency. The same station that is, which we heard on our radio, co-ordinating the search through a black, wet, windy night for a missing fishing boat, by lifeboat, helicopter, shore parties, and other local boats. Their crews might have been at school together, and the coastguard too.

A reader en passage *through Catalonia claims to have encountered the Editorial Board of the* Journal, *at a valedictory banquet for our retiring editor, Alastair Wright. A photograph is helpfully provided. We thank him for his submission which will shortly go out for peer review ... In the meantime, everyone at the* Journal *congratulates Alastair on a job well done and hopes that he enjoys a well-earned rest.*