The British Journal of General Practice

Viewpoint

Walk-in centres: caution not cynicism

When the health service was founded in 1948, all those who needed health care were to be treated free at the point of delivery from the cradle to the grave.[1] Access was for all. But over the last 50 years, many studies have shown that access is problematic.[2]. There is evidence that some people receive poorer health services because of who they are and where they live. There is the question of the location of the health service facilities. The number of different GP surgeries has been reduced as single-handed doctors or smaller practices moved in to new health centres. Some GPs seem reluctant to be torn away from leafy suburbs, and others may be based in poor premises. GPs undoubtedly work long hours. But under their terms of service they are responsible for the provision of medical care 24 hours a day, 365 days per year. In this respect GPs have been ahead of the times.

In 1997, the government identified access to health services as a key political issue and introduced two new initiatives: NHS Direct and walk-in centres. NHS Direct is now being established as a national programme.

At first glance, walk-in centres would appear to be answering some of the problems that the public have faced in accessing health care. They are to be open for long hours, weekends and public holidays. They will also offer a nurse consultation: that is good. They are to be situated in urban areas. But precisely where they are to be located will be crucial in attracting those patients who need them most. The locations of some are known. But are others to be found where there are homeless people, in the larger of the local authority housing estates and in the inner-city areas of multiple deprivation? If they are not they may simply be offering more choices to those who can already access the services well.

Concern has been expressed by GPs that personal doctoring and continuity of care may be lost by the introduction of these new services. Continuity of care is indeed important. But continuity of care is usually described from the perspective of those organising that care. However, from a patient s perspective, if they find it difficult to get an appointment with the same doctor when they go to the surgery, continuity of care becomes illusory. Many patients may see little difference in consulting an unknown partner at their surgery and using a walk-in centre. In any case, concerns about continuity of care could surely be eased by introducing some system of patient-held records, the arguments for which become ever more compelling.

GUM clinics work very successfully with a philosophy of anonymity. Some patients wishing to consult a GP, may actually prefer the anonymity that walk-in centres could offer. It is of course already possible to consult a GP in another area, utilising Temporary Resident procedures. But that requires some knowledge of local GP surgeries and of appointment systems. In the meantime too few GPs offer all but emergency appointments outwith 9 to 6, Mondays to Fridays, complicating access to primary care for a working population. Has general practice been sufficiently innovative in offering access to patients?

Much debate is still to take place issues of costs, of impact on other primary care activity, of what patients not related to Cabinet ministers really want, and, more importantly, need. The medical profession must engage in these debates contructively and, lest you forget, must listen to patients. Sulking in tents will only strengthen the hand of those who would dismiss doctors as dark forces of conservatism.

In 1976 Mildred Blaxter argued cogently for providers of medical care to ensure that good health was not simply a question of luck.[4] She commented that other countries have found it practicable to have a tier of more accessible, less highly qualified medical workers able to deal perfectly efficiently with routine illness. Could this be a function of walk-in clinics? Let patients and doctors discuss constructively.

Patricia Wilkie
Alec Logan

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The Back Pages

Respond to a false alarm on the night-bell — and it can't be made good, ever again...

Franz Kafka,
A country doctor, page 1036

contents

RCGP 'Doctor of the Year' Award Winners

Five RCGP members have won awards at Doctor of the Year 1999 in five categories, including Doctor of the Year itself.

Dr Robert Marriott won the highest accolade for developing a computer application which manages chronic disease. The judges said his approach epitomised the very best of general practice and illuminated a fruitful direction for the future.

Dr David Lewis won the GP Registrar award which aims to highlight the most original audit by a GP Registrar. At his surgery in Maidenhead, Berkshire he devised a programme to improve the quality of care for patients diagnosed with epilepsy and to assess the effectiveness of the practice s computerised disease management system. Dr Lewis has just finished a two-year term as Registrar Observer on the RCGP Council.

Other winners who are members of the RCGP included **Dr Peter Hick** for his commitment to dermatology in primary care, **Dr Barbara Hakin** for an innovative PCG (Bradford South and West), and to Dr Ian Greaves for a strategy to tackle men s health with targeted screening programmes for testicular and prostate cancer and opportunistic checks for urinary symptoms in men over 50.

Caring for People with Learning Disabilities in General Practice

Members of the RCGP Learning Disabilities Group were key players at this conference held in Birmingham on 6 October by the Midland Access to Health Group, with the support of the regional NHS Executive. About a hundred delegates from learning disability teams, secondary care, commissioning, management, and general practice heard presentations on clinical and management issues. Three of these were given by members of the RCGP working group; one by Dr Mike Kerr on Management of Epilepsy for People with Learning Disabilities and another by Dr Glyn Jones on Use and Abuse of Psychotropics for People with Behavioural Difficulties . The third was given by Dr Graham Martin, who described the construction of a register for people with severe learning disability in his large Nuneaton practice. The register was then used to invite patients identified for an annual health check for health gain.

The presentation that aroused most debate during the conference was one on Communication and Consent by Dr Oliver Russel. He discussed how capacity to consent was determined, particularly in relation to invasive, irreversible treatments, for example sterilisation, and the issues involved in determining what is in the best interests of a patient. Questions from the floor provided a graphic snapshot of the practical difficulties which those present encountered in their daily working lives.

Afternoon workshops developed themes raised in the morning clinical issues, communication and consent, carers views, interface issues between specialist learning disability services, and primary health care teams, and residential home care: core or non-core? There was also an RCGP learning disabilities working group workshop, which set out the group s priorities and tested these with a multi-disciplinary group working at the coal face. The major issues emerging from this workshop were the need for more input on learning disabilities to medical education at all levels, the importance of access and the need to define from a clinicians perspective, what is meant by learning disability .

The conference overall had a pragmatic and utilitarian feel made up of professionals who worked in a field which they recognised required meaningful co-operation. There was anecdotal evidence of inequalities, an issue which was picked up by representatives of the Health Service Directorate, who requested details of cases to be forwarded to them for action. Participants went away with positive reactions, but tempered by the sort of experience which one nurse described to me in the taxi to the station. She told how, at College, her tutor had responded to her informing him of her decision to work with patients with learning disabilities with the comment What a waste!

Fiona van Zwanenberg

WONCA 2000

Details of the WONCA combined European and World Conference being held in Vienna next year on 2 6 July are now available from the College. The conference, on the theme of Patient Care: Values and Trends in General Practice , is being organised by the Austrian College of GPs.

A copy of the preliminary programme, including the outline scientific programme, was circulated to the faculties. Anyone else who wishes to receive a copy can e-mail the College at the address below. Information is and will continue to be available from the Conference website at www.oegam.at

The College has agreed both its official and WONCA 2002 host Organising Committee representation. The College will be considering its role in the academic programme over the next few months. If you know of any faculty or network activity being planned, then please advise the International office so that we can attempt to co-ordinate events.

The deadline for the submission of abstracts is 15 December 1999 and the deadline for discounted registration is 31 March 2000.

Sarah Young
syoung@rcgp.org.uk

The Royal College of General Practitioners is grateful to Wyeth Laboratories for their generous donation towards the cost of providing advice booklets free of charge to RCGP members and the general public. Their donation has supported Clinical Governance: Practical Advice for Primary Care in England and Wales*, that was distributed to RCGP members in the June edition of* The British Journal of General Practice*. For further information about this series, please contact the RCGP Sales Office on 0171 823 9698*

The Vale of Trent Faculty of the Royal College of General Practitioners is proud to launch the Fourth Edition of the...

Reading and Reference Book List for General Practice.

The 1999 Edition of the List contains 93 pages of titles specifically selected for GPs, covering all the clinical specialities plus sections on: Practice Management, Clinical Governance, Education, etc. The price is £10.00 per copy but discounts are available to GP Registrars and for bulk orders. Orders can be placed:by post at:

The Vale of Trent Faculty Office, Division of General Practice, Medical School, Queen s Medical Centre, Nottingham, NG7 2UH; or by telephone: 0115 919 4455; or by fax: 0115 970 9389; or by e-mail: susie.johnson@nottingham.ac.uk.

Revised RCGP Information Sheet available

RCGP Information Sheet Number 13, *Children and General Practice*, has been updated and is now available from the Information Services Section (ISS) at Princes Gate. The sheet gives details of children s use of health services, with statistics for mortality rates and the average number of GP consultations per year for children. It also addresses:

- socioeconomic factors in the rate of GP consultation for children
- GP payments for immunisation
- the NHS Regulations on child health surveillance
- paediatric education and training for the Diploma in Child Health
- the role of health visitors in child health surveillance
- the role of the practice nurse
- the RCGP s involvement in child health

The text is extensively referenced and lists useful contacts and organisations involved in child health.

All College information sheets are available from the ISS direct, or via the RCGP web site at:

www.rcgp.org.uk/informat/rci0002.htm

An MEQ for Christmas ...

1. Mrs Bessie Bingham attends your surgery as a temporary resident accompanied by a deaf and dumb friend. Mrs. Bingham claims to feel all of a doodah , and adds that she has to leave in exactly 10 minutes
How would you attempt to discover whether her symptoms were genuine or simulated?

2. Peter and Patricia Tatum consult you jointly. They are shortly to appear on a television game show in which video tape of their daily life will be discussed by a panel of psychiatrists. The Tatums ask if you would prescribe a sedative to prevent them from arguing while the recording is being made.
Discuss the ethical issues raised by this request.

3. Wenceslas Darilovich Goodwinski, who lives in sheltered accommodation, is brought by his care worker. The care worker asks you to arrange a vasectomy for Mr.Goodwinski, who appears not to understand your explanation of what is involved.
Draw a series of sketches which would convey to Mr. Goodwinski the process and outcome of vasectomy.

4. John Wakeford, aged over 21, brings his stepson Richard Foulkes, who still wets the bed at the age of 3.72 years. Master Foulkes tells you that his life is providentially serendipitous, thank you, and that there are 4,608,331 little green squiggles on the wall paper in your waiting room.
Describe a non-violent way of conducting this consultation.

5. Bessie Bingham s deaf-mute companion (see Question 1) returns and consults you unaccompanied.
Describe how, using oral techniques, you might attempt to establish the extent of his or her personal growth.

6. You are making a video recording of your surgery for assessment purposes. One patient, Donna Irvine, describes her life as devoid of any options, implications, or choices, and sobs that she has no ideas, concerns or expectations whatsoever.
Explain why you might be tempted to erase this consultation from the tape.

7. An unnaturally cheerful pharmaceutical representative, Hank Daslem, leaves you a sample of his company s latest anti-depressant, Proz n conzac.
What may be the effects of slipping it in the tea of the GP Registrar attached to your practice?

8. For many years your Senior Partner, Dr Jonas Dymond, has consulted at the rate of 20 patients an hour, but has resolutely declined to explain his model of the consultation. You visit him as he lies prostrated by gastro-enteritis following a surfeit of oysters. He asks you to administer a potentially lethal dose of morphine to relieve his distress.
What conditions, if any, would you impose before acceding to his request?

9. Your neighbour s housekeeper, a former circus trapeze artist, has been found strangled with a piece of safety netting. You are interviewed by police in the course of their enquiries.
Furnish either an alibi or a confession and plea of mitigation.

10. Evaluate the role of Critical Reading in the aetiology of
A *secondary impotence*
B *Mid Afternoon Onset Bilateral Ptosis*
C *travellers' Dwyerrhoea.*

11. Give one (1) single example each, four (4) in all, real or imaginary, of a general practice clinical scenario;
A *in which it is unnecessary to involve the health visitor.*
B *which you would not feel the need to discuss at a meeting of the Primary Health Care Team*
C *which might be better managed by a doctor than by a non-medical reader of* The Guardian *or* The Observer *newspapers.*
D *which has no implications for the practice, the community, the extended family, the FHSA, the NHS, the Government, society as a whole, or the European Union.*

12.A private facility, the Southgate Clinic, has recently opened in premises near your Surgery. You see from its brochure (attached) that it specialises in treating *Chlamydia* infections of overseas inner-city dwelling women with English as a second language.
Underline any passages in the brochure which in your opinion represent lapses of political correctness or good taste.

Andrew Hicks

Viva Cuba!

Have you ever felt as if you are a trampoline a mere jumping off spot for your patients on their way to hospital? In Cuba, I was told, family doctors were not to be trampolines. The family doctor service was introduced in 1983 at a time when Cubans, if they wanted medical help, would go directly to a hospital or a polyclinic, serving a population of about 20 000.[1] Now, after training 30 000 family doctors and establishing a nationwide network of consultorios , there is a family doctor and nurse per 600 population.[2]

In establishing their family doctor service, Cuba used the British system as a model but their system has developed quite distinctively. My aim was to compare the two.

As a GP working in inner-city Glasgow, a visit to Cuba as autumn approached was very tempting and it gave me a chance to use my Spanish. I spent a week in Havana, based in a polyclinic near the Plaza de la Revoluci n where the revolutionary slogans and mural of Che Guevara remind you of the government s commitment to health and education, even through the special period .[3] Economic disaster hit the country with the collapse of support from the Soviet Union in 1990 and the continuing United States blockade. Lack of fuel is a major problem; people use bicycles, horse-drawn carriages or hitch hike everywhere. My second week was based in Fomento, a small town whose hospital has had links with Scotland for several years. A final week on the coast in the beautiful old colonial town of Trinidad famous for its music, mountains and of course the Caribbean was definitely holiday!

During my visit I interviewed eight family doctors within their consultorios in a mixture of urban and rural areas, and met with a further five for open discussion. I was also introduced to the wider family doctor service through visits to a family planning clinic, gymnasium, maternity pavilion, grandparents circle, nursery, dental clinic, and rural and municipal hospitals. I interviewed medical assessors in the polyclinics in both Havana and Fomento as well as the heads of nursing and nurse education in Plaza. A visit to the medical school gave an opportunity to explore further how Cuba has produced family doctors who, when asked what is their greatest priority, will all without fail say prevention . Could we honestly say that that is our priority?

Cuba is a developing country spending approximately £7 per capita annually on health care (we spend £750) and yet life expectancy and infant mortality rates are similar to ours and better than those of its nearest neighbour, the US. Cuban doctors told me proudly that Cubans die of first world diseases cancer and heart disease so their priority is prevention (despite the prominence of Havana cigars!) The Cuban doctor starting on her housecalls, cigarette between her lips, told me that it did not stop her discussing smoking with her patients. (25% of Cuban doctors smoke but there is no smoking on health service premises.) A major part of a Cuban GP s time is spent in health education but the effectiveness of it is difficult to assess.

GPs live in the community, usually in a flat above the consultorio and in some places the nurse has a flat adjoining. Six hundred patients may seem a nice manageable number but many GPs still feel the frustration of never having the time to do anything well. They have a large number of programmes that must be complied with. Every patient on their list must be seen on a regular basis and half of all patient contacts should be in the home. The frequency of contact is determined by age and presence of disease or risk factors. Open surgeries are held in the morning and the afternoon is spent doing housecalls in the heat of the day.

GPs are visited monthly by their basic group of specialists, comprising a physician, paediatrician, gynaecologist, psychologist, social worker, epidemiology technician and nurse. This group is based in the local polyclinic and supports and supervises approximately ten GPs. Their visits allow joint consultation where a specialist opinion is required and family records and individual casenotes are examined to ensure that the GP is carrying out the work

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I was supported by an RCGP International Travel Scholarship.

Useful contacts
Scottish Medical Aid for Cuba

In the photograph are Dra Marus Galero Rodriguez and Enfermera Miladys Rosgrete with their 'patient', Marus's daughter, at a consultario in Sopimpa, a village outside Formento,.

required. GPs are certainly not isolated, but it seemed to me that they had little independence and the monitoring seemed rather too close for comfort.

However, should we be left so much to our own devices? A form of critical event analysis takes place following every premature death and all aspects of medical care are examined both at primary and secondary level. Woe betide any GP who was not carrying out the required visits to his asthmatic patient who died prematurely. Could we cope with such an examination of our care of those on our chronic disease registers? Our care is only examined when a patient complains. Should the onus be on the patient?

Cuba has certainly followed a line we find difficult to contemplate.There is no shortage of health personnel at all levels in Cuba salaries are low, with doctors earning $22 per month. The shortages they do have are of medicines and all kinds of supplies. Each GP has to determine what medicines are available in their local pharmacy and prescribe accordingly. Owing to the shortage of medicines the use of complementary therapies such as herbal medicine and acupuncture has been encouraged. All GPs receive some training in herbal medicine and all consultorios have their own herb garden these were in varying states when I visited. Herbal medicines are also produced at a national level and dispensed in specific pharmacies.

Community involvement is mandatory and GPs must work with the local formal and informal community leaders. They must participate at least every three months in neighbourhood meetings and also carry out an annual community health diagnosis to establish priorities for the following year. Examples of agreed priorities included concerns about a rubbish dump, water quality, control of mosquitoes, prevalence of smokers, and low attendance for follow-up of hypertension.

Cuba has achieved very impressive health statistics despite its status as a developing country. How much can be attributable to the family doctor system is difficult to say, but it is certainly a very well organised service. Cubans are well aware of the success of their medical system and welcome visitors to learn from it: medical student electives and visits by other interested medical personnel are (relatively) easily organised.

Some tropical sun, rum and salsa into the bargain can make it a very enjoyable time.

Margaret Craig

Dr Kenneth and the Heartsink Patients of *Wuthering Heights*

Wuthering Heights, published in 1847, was the only novel of Emily Brontº.

If you haven t read Emily Brontº s amazing novel for a long time you may not remember that a minor but important role in the story is played by the local GP who is called Dr Kenneth. While following the tempestuous saga of the love between the passionate, wilful Cathy and the demonic Heathcliff the attentive reader will also perceive the figure of Dr Kenneth scurrying importantly between Thrushcross Grange and Wuthering Heights, attending to the often desperate needs of his patients. To a modern observer of general practice, Kenneth seems to do far too many home visits; indeed, he never seems to spend any time in the surgery at all, let alone go to PCG meetings. His professional life is a constant battle against the two major threats to public health in the rural district of Gimmerton: tuberculosis and psychopathic personality disorder.

Portrait of Emily Brontë (1818–1848) engraved by Walker and Boutall by Patrick Branwell Brontë (1817–1848) (after) Private Collection/The Stapleton Collection/Bridgeman Art Library

Early in the book (chapter 8) we witness the first of Dr Kenneth s disastrous series of home confinements. Frances Earnshaw, wife of the disagreeable Hindley Earnshaw, gives birth to a boy called Hareton. The baby is beautiful, it seems, but Kenneth loses no time in telling the proud father that his wife is in a poor way. He has a wonderfully direct way of breaking bad news: When she came I felt convinced we shouldn t keep her long; and now, I must tell you, the winter will probably finish her. Don t take on, and fret about it too much, it can t be helped. And besides, you should have known better than to choose such a rush of a lass.

His wife soon dies as the doctor predicted and Hindley himself develops a serious drinking problem. He now becomes one of Dr Kenneth s more troublesome patients. In chapter 9, Hindley enters the house vociferating oaths dreadful to hear and grabbing hold of Nelly, the servant, he threatens to make her swallow the carving knife. But, worse than that, for those of us who are deeply concerned about the increasing problem of violent attacks on GPs, he proudly tells her: I ve just crammed Kenneth, head-downmost, in the Blackhorse marsh. One can only wonder that Hindley wasn t immediately struck off the list for this outrageous behaviour along with the rest of his dysfunctional family. But Dr Kenneth is amazingly forgiving, not to say resilient. His next professional appearance occurs when he is summoned to treat Cathy, the heroine of Wuthering Heights. She has a fever, possibly due to pneumonia from having spent a night out in the rain desperately looking for Heathcliff to return. It s one of the most heart-stopping chapters in the story of Cathy and Heathcliff and the events of that terrible night determine their whole future. But we haven t time for that just now because, being GPs, we are chiefly concerned with our hero, Dr Kenneth.

The good doctor is sent for once more when Cathy (now married to the rich but rather pallid Egar Linton) is feverish yet again. He prescribes a diet of whey and water gruel and tells the family to take care that the patient doesn t throw herself down the stairs or out of the window: ... and then he left; for he had enough to do in the parish, where two or three miles was the ordinary distance between cottage and cottage . I don t blame him for not hanging about any longer. After all he doesn t have a bleep or a mobile phone and Lord knows what epidemic may be breaking out in some of those cottages. I can t think why he doesn t tell them all to put the patients in the back of a gig and bring them down to the surgery.

A little later, after a violent scene with her husband and Heathcliff, Cathy suffers another fit, possibly epileptic, possibly hysterical, it s hard to be sure, although I would favour the latter diagnosis. In a state of extreme agitation she attacks the faithful Nelly who hurries fearfully out to look for the doctor. Fortunately she spots him coming out of his house on the way to another call and intercepts him.

Nelly Dean, said he, I can t help fancying there s an extra cause for this. What s there been to do at the Grange?

In fact shrewd old Kenneth knows perfectly well that Cathy is receiving clandestine visits from Heathcliff, her former playmate and lover. Like any country doctor he hears plenty of gossip

and is obviously kept well informed about all the village scandals. When he arrives at the Grange, the patient s frenzy has abated and she lies in a troubled sleep . Doctor Kenneth examines her (apparently without waking her) and gives her husband a hopeful prognosis if only she can have perfect peace and tranquillity . But he warns Nelly that there is a risk of permanent alienation of intellect .

Unhappily, Cathy s tranquillity is disturbed by yet another passionate encounter with Heathcliff, after which she is carried to bed, gives birth to a daughter at seven months, and expires two hours later. Curiously, Emily Brontº makes no mention of Dr Kenneth in connection with either the birth of the infant or the death of the mother. We didn t even know that Cathy was pregnant. I doubt if Dr Kenneth even knew about the pregnancy but, if he did, the information remained confidential between him and his patient.

The last reference to our colleague is in the final chapter, when Heathcliff himself has finally succumbed and Nelly tells us that Dr Kenneth was perplexed to pronounce of what disorder the master died . This diagnostic reticence is unusual for Kenneth. It s true that Nelly had concealed from him that Heathcliff has swallowed nothing for four days, but surely his other patients would have kept the good doctor informed about what was going on. The death certificate should have said perished because he had lost the appetite for revenge and longed only to be re-united in death with his beloved Cathy . I guess Dr Kenneth was too prosaic to write anything like that even if the Gimmerton Coroner had been willing to allow it.

And so Dr Kenneth passes out of English Literature to be heard of no more. Emily Brontº did not really care for doctors much, so it s unlikely that she would have given him a more heroic role in a later novel even if she had lived. But I must say that I am tantalised by these fragmentary glimpses of a GP just like ourselves, who practices in such a literary landscape. I often think of him toiling across the moors to witness yet another tragedy which he is powerless to avert. I like to think that he eventually enjoyed a peaceful retirement painting water-colours of moorland scenes, no longer at the beck and call of Emily Brontº s demanding patients with their crumbling lungs and disordered personalities.

John Salinsky

Toby Lipman

Personal assistants and other status symbols

Glorious weather, plans to wash my classic Citr en DS 21, and the August *British Journal of General Practice* with my coffee and muesli. A perfect Saturday. I love washing the car as much as I hate doing housework. I have been told this is a gender thing and rather sad! Sometimes I chat with the neighbours as they walk by, and sometimes I just ruminate on ... anything at all. Simple pleasures.

Today I see Trish Greenhalgh has defined her status as that point in academe where she boasts a Personal Assistant , and I can t help a twinge of envy. I could do with one of those to sort my diary and remind me where to go and who to see, to look after my correspondence (and make sure I only get my own!), to protect me from unwelcome intrusions in short, to bring order to chaos. My recently retired senior partner used regularly to suggest that we should employ personal secretaries (although nothing so grand as Personal Assistants), and we used to sigh yes, it would be great, but we can t afford it, more s the pity .

I mentioned my thoughts about personal assistants to a passing neighbour and she said, Of course they re status symbols! And so they are. Having a personal assistant defines you as someone important enough to have one, and since we have to struggle on with two excellent but overworked secretaries between eight GPs, it means we aren t that important. In the old days, when Dr Finlay kept his casebook, most GPs had a personal assistant called a wife (or if they were bachelors, like Dr Finlay, there would be a housekeeper called Janet).

Today, a housekeeper would be as much a status symbol as a personal assistant. My father, a dentist with delusions of grandeur, lived in a large, detached Edwardian house in the best part of town. We always had a gardener, cleaners and, on occasion, a housekeeper. Letters from horticultural suppliers would be delivered to the house addressed to The Head Gardener .

Most younger GPs can t afford the kind of houses previous generations took for granted. My present house (bought in 1986) is worth at least six times my income, and neither I, nor any of my younger partners could afford to buy it today. Yes, it s a status symbol! I remember an older GP asking, in puzzlement, why a younger colleague chose to live in a deprived area , with the unspoken implication that this was letting the side down.

Some GPs still manage to indulge in upmarket cars: BMWs, Mercedes, even the occasional Porsche. Occasionally they have personalised number plates, which have always seemed a two-edged status symbol to me. They are a bit spivvish, like second-hand Mark II Jaguars in pre-Inspector Morse days, before they became classic cars. Once, I saw an advertisement for the number DS 21 and might have been tempted if the price hadn t been ludicrously beyond my means. I could see the attraction, and even a spurious justification (it'll increase the value of the car!). Nonsense! It s pure vanity!

Some doctors drive small Renaults, or diesel Golfs, and may even go to the extreme of running something downright dowdy and unfashionable, such as a 10-year-old Ford Fiesta. Is this a high minded disregard for status, or a perverse statement that their status is already so high that they don t need to symbolise it by their choice of wheels? In academia, status is enhanced by not needing a car at all. You often see academics arriving at work by bicycle or even on foot (in Newcastle, being able to walk to the University is a sign that you probably live in fashionable Jesmond, a status symbol in itself ... there s no getting away from it!).

While it is politically correct to deprecate the importance of status, I ve found that things which enhance my status make me feel better about myself. We are going through a period when just being a GP seems to have a lower status than a couple of decades ago, and I can t help feeling that this plays a part in many GPs low morale. Perhaps the GPC should negotiate for funds to employ a Personal Assistant for each of us?

The Quiet Revolution: how general medicine is being revived in France

French liberal medicine experienced its boom years between 1945 and 1968.[1] During that time there was a single Faculty of Medicine in Paris, and medical studies lasted seven years. After an initial year of scientific studies and two pre-med years, students spent their third year as observers. Theoretical training in semiology and pathology was followed by a competitive exam (the *concours de l'externat*), opening the way to clinical posts. Studies were completed by working as an intern for a year, before sitting a viva. A French degree has always required preparation of a thesis.

In the early post-war years, the doctor was an important figure in the community. Medical demographics were propitious for generalists, and paediatrics and obstetrics still fell within his purview. Rural doctors regularly performed home deliveries, reduced fractures, and treated tuberculosis. Specialists were hospital consultants who trained for an extra four to five years following a competitive exam (the *concours de l'internat*).[2]

However, accelerating technical progress, increasing demand from a public made solvent by generous social welfare and supplementary insurance schemes led to a second route to specialisation: specialised study certificates (CES). These new specialists had a solid theoretical grounding but sometimes very little clinical training: they are still massively present in French cities, though many have long since ceased hospital practice. In disciplines such as paediatrics and medical gynaecology, they may practice primary care within their field of competence, and *de facto* compete with generalists.

For French political and medical life, 1968 was a watershed. The Paris Faculty was subdivided into 11 university teaching hospitals, each with a dean: more than 12 000 students graduated annually.[1,3] In the 1970s, the twin route of access to specialisation gained pace, and new private practices caused problems for longer established colleagues. A *numerus clausus* was imposed on students entering the second year: numbers fell from 6000 at the end of the 1970s to 3500 in the mid-1980s.[1,2,3] In 1979, the government allowed doctors to exceed the reimbursable fixed fee system in return for which they had to pay higher social charges. Fees charged by specialists soared, the non-reimbursable portion being met by supplementary insurance. The number of female doctors also increased dramatically. General medicine steadily lost ground because of increased competition between specialists, including those offering primary care. As if that were not enough, larger cities saw the creation of 24-hour emergency services (SOS mØdecins) providing home visits under the health insurance scheme.

European regulation 83/785 ended the twin route of access to specialist practice in 1984;[4] students sat a competitive exam at the end of their sixth year before specialist training (four to six years), that usually included one year of research. Future generalists had to train for two years in hospital under the same conditions as future specialist colleagues. Although too often selected by their failure to pass this competitive exam, generalists benefited most from this reform, which prolonged training and provided more bedside teaching. Their discipline was also given a concrete definition, the MD title being awarded in either general medicine or a speciality.

This distinction was important, since generalists qualifying after 1984 had a medicolegal ruling to defend their turf . Another decree in 1989[1] restricted access of new doctors to the floating fee sector (*honoraires libres*), which was reserved for former consultants entering private practice. In fact, generalists setting up after 1990 are obliged to adhere to the tariffs set by the health insurance system (currently 115 FF for a GP consultation). The current annual income of generalists is 620 214 FF compared to 1 035 966 for specialists (5); about half of this amount is absorbed by social charges and business running costs leaving a pretax revenue of between 200-300,000 FF. 'Intellectual' specialities (paediatrics, gynaecology, psychiatry) attract a similar income, while 'technical' specialities such as ophthalmological surgery, anaesthesia, cardiology and radiology can earn up to four times as much. Incomes are lowest in Paris, where the relative numbers of doctors to population is at its highest.

Closure of the floating fee sector, demographic imbalances and historical differences in training have driven a wedge between different generations of doctors. Practitioners are not represented by a single body like the BMA or AMA, but by different unions each representing a medical subcategory. Even so, only one-quarter of all French doctors pay union dues. The Ordre des MØdecins, which, like the GMC oversees fitness to practise and makes disciplinary decisions, may in the future be reformed to meet the profession s need for unity and modernisation. Such tensions have been readily exploited by government regulators the last decision-making instance whose style of divide and rule has not benefited the profession or patients.[6]

A major event has been the involvement of generalists in university teaching. This took place on an experimental footing in the early 1980s, and developed with the creation of sessional posts and hands-on training. In 1992, the first generalists were awarded part-time renewable contracts as associate

References
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Some French websites:
http://www.chu-rouen.fr
http://www.agmed.sante.gouv.fr
http://www.bium.univ-paris5.fr
http://www.anaes.fr
http://www.legeneraliste.presse.fr
http://www.quotimed.com.
http://www.cegetel.rss.fr
http://cri.ensp.fr/biam/www/Iusb.html
http://www.credes.fr

lecturers (*maîtres de conférence*). The appointment of a generalist to associate professorship by the President of the Republic was a radical move for the French university system. In November 1997, the setting up of obligatory six-month paid training posts supervised by experienced urban generalists, as part of vocational training (*résidanat*), has undeniably helped to give the profession a fresh sense of purpose. It now takes nine years to become a generalist after completion of secondary studies at the age of 18.

There are at present about 30 associate lecturers or professors, 900 generalists with sessional teaching duties, and 3500 accredited trainers (*maîtres de stage*) out of a pool of 60 000 practising generalists. About 3500 students qualify yearly, half of whom go on to practise general medicine. Usually, a student s training programme is co-ordinated by two or three trainers, and an increasing number of MD theses deal solely with issues in generalist care outside of hospital medicine.

The impact of Europe and the rise of managed care in the USA have awakened considerable hope that the generalist will be able to regain a rightful place within the health system. Since 1997, the health insurance fund has made it possible for generalists to act as gate-keepers by providing an annual partial capitation fee and third-party payment of fees: in return doctors have to follow guidelines drawn up by standard-setting agencies and prescribe a certain percentage of generic drugs. Patients wishing to join this system sign a contract obliging them to consult a doctor of their choice as primary care adviser. At the moment, this option has had relatively little success due to its poor remuneration, the bureaucratic hurdles of third-party payment, and the few patients who wish to relinquish the freedom of direct access to specialists. However, the ability to limit expenditure by giving incentives to generalists and promoting third-party payment may be a driving force for future reforms in a manner similar to that of fundholding in the UK.

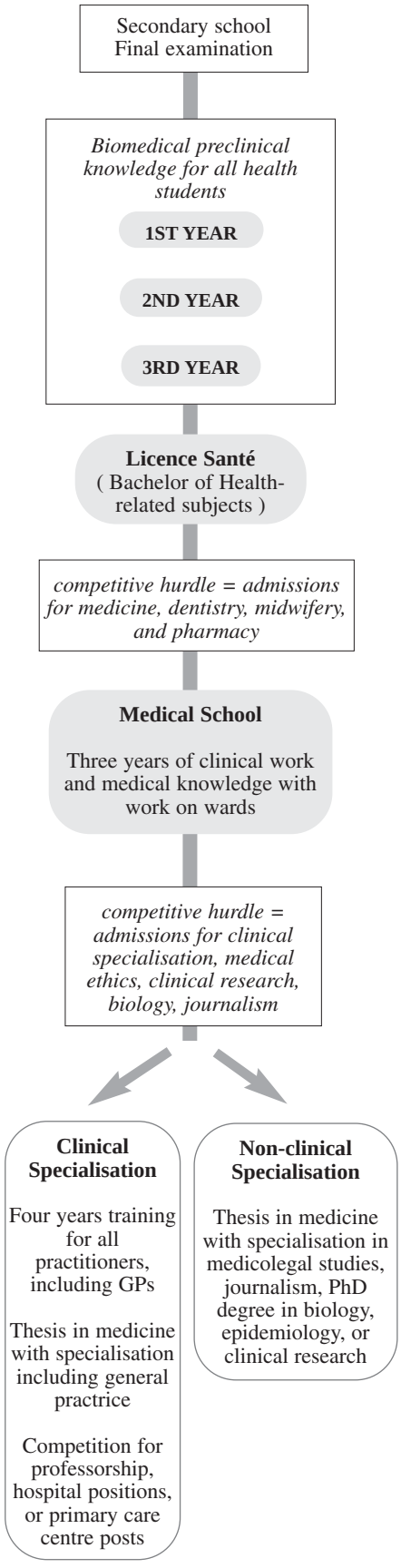
Regulatory changes are likely to rely on private insurance to an ever greater extent. Insurance companies that have hitherto reimbursed extra costs based on health insurance tariffs now offer policies covering those areas of care in which basic health cover is only partial, such as provision of hearing aids, dental prostheses and glasses. Some mutual companies reimburse Zanamivir for influenza patients or third-generation OCPs for students. Everything is gearing up for health to become a market like any other, in which the French equivalent of the HMO will be a public company floated on the stock market. Commercialisation and profit-making lie in wait. However, for regulatory reasons, this type of approach remains marginal, much like BUPA or SOS Doctors in the UK.

A reform currently under discussion aims to make general medicine a speciality in its own right by extending training by one year in addition to the two years of hospital-based internship. The competitive exam (*concours de l'internat*) will be obligatory for all doctors including generalists who intend to practise clinical medicine. With the encouragement of Europe,[4] some deans,[7] and numerous influential public figures, including the Prime Minister,[8] general medicine is likely to be increasingly accepted as a proper university discipline. Quebec recognised the importance of academic general medicine several years ago, and generalist trainers from French-speaking Canada regularly attend the annual congress of French teaching generalists. (It meets this year on 4 5 December at the Sorbonne to discuss university certification of future generalists.) Group practices should also continue to expand, and indeed become dominant. Health education, protected exchange of patient data, decision-making aids, and telemedicine are also likely to develop rapidly. A legal obligation since 1997, postgraduate training is likely to be encouraged by insurers. Marked regional disparities in health care will be corrected by a major restructuration of hospital resources, university facilities, and health networks, as is already the case for AIDS, drug misuse, geriatrics and in the near future diabetes, hypertension, and heart failure. Health networks will optimise current practice by allocating resources to allow safe electronic file-keeping, adherence to patient management plans based on consensus recommendations, and structures determining how patients consult different players within the health system. Two related areas of concern which have to be remedied are the low involvement of nurses and other paramedical staff in patient education, and the wide variability of practice in chronic disease management. Preventive medicine, public health, school medicine and occupational health also need radical overhaul.

Restoring professional status to the generalist, both at the university level and in practice, has got off to a vigorous start, and one can only hope that this effort results in improvements in patient care that can transcend French political and class conflicts, along with a greater integration of general medicine in international research. The quality of international exchange in the coming years, in particular with the United Kingdom, will determine whether general practice in France can successfully renew itself. It must, for our patients sake.

Olivier Wong

MEDICAL STUDIES IN FRANCE IN THE FUTURE



Measuring Outcomes in Primary Care: Time for an Injection of Common Sense

The world has gone outcome mad. Providers of health services are now in danger of imploding under the weight of outcome measures in the drive for markers of quality, effectiveness, and efficiency. Old-fashioned mortality is now no longer good enough. Health care has been taken over by a plethora of psychologists, statisticians, and health economists attempting to compress reality into a simple index a universal metric validated for all places at all times. The search is on for the Holy Grail.

This burgeoning industry is now in danger of overtaking research into the actual medical interventions the outcomes of which it seeks to measure. Psychologists have been the main drivers to the bandwagon. But everyone knows only people with hang-ups become psychologists, as the evidence confirms one review found no less than 1430 outcome measures in counselling research alone, but the list is endless. Extending psycho-physiology to psycho-metrics, the resulting exponential explosion in self-indulgent literature has sought unsuccessfully to define the states that reflect affect, mood, and emotions and invoked endless debate as to whether these phenomena are best described as discrete elements or dimensions . You can take your pick from anything between Antonovsky s sense of coherent scale to Ventegodt s measure, which encompasses elements of sexuality, happiness, well-being, existential elements, biological order, and realisation of life potential. But psychologists are not alone in the outcome jamboree.

‘the long and tedious outcome paper chase is finally at an end ...’

‘The celebrity-adjusted life year (CALY) is an instrument by which the output of any health intervention is measured as a function of the magnitude of celebrity endorsement, and the time that is enjoyed in that state.’

Health economists know a market niche when they see one and have not been slow to get in on the act. The master-stroke has been to validate their outcome instrument on the basis of the unassailable rigour of the theory from which it is derived. Thus, instead of concerning themselves with trivial details, such as face validity, they are able to proceed confidently on a foundation of economic theory ... QED. Happy to delude themselves over the multiple complexities of using frameworks based on risk and sacrifice, they proceed to compress the nature of reality into a number between 0 and 1 and come up with the quality adjusted life year (QALY).

GPs, as always, take a more pragmatic approach emphasising the difficulties of attribution, long time horizons, and the multi-factorial nature of health outcomes. For example, Stott reflects this enviroment with a framework of time-sensitive generic measures, notwithstanding the fact that each GP would need a full-time research assistant to undertake the calculations. Touchy-feely outcome measures that reflect the holistic nature of general practice are in profusion but are of little practical benefit.

In summary, the market place is characterised by an over-abundance of instruments directed mainly by academic accreditation exercises which fail to realise that the results of professional activity are extremely diffuse and difficult, if not impossible, to measure. It s time for an injection of common sense.

I propose to end all further debate by defining a universal framework based on three inter-dependent parameters. Two GP perspectives reflecting the personal and technical aspects of our work and one innovative patient-centred measure which traces its ancestry to the QALY.

The GP personal construct derives its validity from the view that life is not always about cosy paternalistic certainties like families, employment, and evidence-based medicine, but a world where GPs have their own narratives and uncertainties and a desire to maximise their own utility. Here the measure is earnings opportunity. Outcome becomes income.

Although some would argue for a romantic perspective the physician healer there is no place for placebos in the New Age. The second perspective is that of the GP technical . Although many have taken a less than sanguine view of this development and its coercive healthism, it is a perspective that will increasingly shape our lives. This construct dictates a relevant physiological measurement.

Prior to 1965, this simple binary system of outcome measurement would have been adequate. But, probably owing to the fact that they all suffer from a seasonal affective disorder, the Scandinavians have to ruin everything. The Treaty of Helsinki defined the rights of patients undergoing medical research and its been downhill ever since. Unfortunately, somewhere along the line the empowered patient has to be included but problems abound. There is a dissonance between patients stated preferences and

revealed preferences, and due to the special nature of health care the latter remain illusive. And can patients really be trusted with the interpretation of the evidence? A recent article in the *Lancet* suggested that 50% of Americans still believe in the theory of evolution as described in Genesis.

My third element is, by reluctant necessity, an approach that accommodates patients values but derived in a way that reflects more closely our modern culture and the influences shaping how we allocate our scarce resources.

The celebrity-adjusted life year (CALY) is an instrument by which the output of any health intervention is measured as a function of the magnitude of celebrity endorsement and the time that is enjoyed in that state. Problems of relevance and validity are overcome by the use of a methodology that incorporates the true values of our modern society. For example, note how Camilla Parker-Bowles put osteoporosis in the spotlight, or how Christopher Reeves, the Superman actor, directed research resources to spinal injury. The CALY has similar flexibility to the QALY in that negative values can also be derived, as the Motor Neurone Disease Association found out to their cost with their patron Sarah Ferguson.

This approach already has an evidence base. A recent paper in the *New England Journal of Medicine* found that US research funding was dependent on lobbying and not need. Further validation studies are currently underway to develop a weighed scoring system based on public exposure as a function of time in *Hello!* magazine and TV chat shows.

This universal instrument I propose presents a simple outcome dataset in a disaggregated form, allowing decision-makers to apply their own values and thereby reflecting the context of commissioning decisions in the real world. With this elegant solution, all other outcome measures become redundant and the resources consumed by their research endeavours can be released and directed to where they really belong into direct health care.

I am able to reassure long-suffering practitioners that the long and tedious outcome paper chase is finally at an end.

D P Kernick

in brief...

Busy month, what with ushering masterworks of Central European literature into the *BJGP*, not to mention easing full frontal nudity past the censors, so *In Brief* must be very brief indeed...

Time to acclaim **The Evolution of Hypnotism**, by Derek Forrest (Black Ace Books, £29.95, 1-872988-37-7), a scholarly treatise, elegantly written, on the history of hypnosis and its enemies.

The GP Quiz Book 1 (Alick Munro, Radcliffe, 1-85775-229-5) provides useful ammunition with which to torment an excessively cocky registrar, and will enliven that flagging Practice Nite Out.

And I would have been thrilled to recommend **The Blair Witch Project** had I summoned up enough courage to see it. Instead, there is always **Tarzan**, the latest Disney which only slightly terrified my two year old. A good family treat for the Christmas break.

Finally, a website - **www.24hourmuseum.org.uk/** is a collaboration between all UK museums and galleries. Simple to navigate, details of opening times and special exhibitions, and meticulous in its nationwide coverage. Rather more than can be said of these reviewing pages. Unsolicited contributions are always welcome...

Alec Logan

Ethics in Medical Research: a handbook of good practice
Trevor Smith
Cambridge University Press, August 1999
PB, 403pp, £29.95, 0 521 62619 6

I wish this handbook had existed when I first developed an interest in general practice research, because many ethical anxieties and knotty conceptual problems would have troubled me less. This lucid and concise treatise, written by a biomedical researcher (also a scientific adviser to an ethics committee) is packed with practical advice to would be researchers and informed by an encyclopaedic command of many declarations official statements, guidelines, and codes of ethics about the ethical conduct of biomedical research.

Clearly structured and written in accessible non-philosophical language, the book offers a sort of moral highway code for those venturing out on their first research travels. Chapters cover confidentiality, clinical trials, research on surplus blood and other tissues, studies with healthy volunteers, children and vulnerable groups, conducting a questionnaire and interview studies, and epidemiological and genetic research. The author aims to help researchers identify and foresee, early in the design phase, where ethical problems in studies are likely to arise, and to point readers in directions that offer both moral illumination and practical help. Touches of the author s experience in the field are frequently apparent, as in his discussion of the emotional exhaustion that can beset investigators in studying, for example, bereavement or foetal death, and in his solicitude for anxieties study participants often feel when first approached to take part in research. In the author s experience, they can usually be allayed by close attention to the wording of letters, and by clearly formulated information sheets he provides helpful examples of both.

The book s focus is upon communicating solutions, rather than on a series of philosophical principles that, arguably, should govern decision-making in this area, or upon a method for arriving at defensible moral positions. This may leave some readers unprepared for conflicts of views apparent in the author s discussion of whether patients permission for access to medical records should always be sought, and if not, whether the views of an ethics committee should then be consulted. Where committees and guidelines differ in their guidance, the author advises contact with a local research ethics committee for advice before proceeding. Prudent, no doubt, but advice of this sort can risk transforming an ethical difficulty involving conflict of interests into an apparent matter of procedure. How validly, one wonders, will the local committee decide the issue, and on what moral grounds? Though an appeals mechanism exists, the author is comparatively silent on whether, and how, researchers should go about testing the moral coherence of committees' decisions.

One reigning assumption the author appears to make is that answers to ethical problems found in official reports or the wise counsel of expert groups are likely to be morally more robust than those fashioned by individuals through contemplation, philosophical discussion, debate, and counter example. It is certainly helpful to know that many of the ethical difficulties researchers face at times have been grappled with before in one form or another; that solutions, or approaches productive of solutions, have been formulated by others, and there is frequently no need to start from first principles, or to re-invent an ethical stance. The impression is conveyed that a deep consensus concerning how these sorts of problems should be tackled can almost always be located, and tapped, to the advantage of the researcher.

Procedural accountability has the upper hand over moral reflection in this handbook and this is likely to appeal to many researchers. The author has produced an excellent compass for use in a difficult terrain. Its careful study should form part of the training researchers undertaking to gain their moral licence to research ethically.

Brian Hurwitz

Renaissance Florence (until 16 January 2000)
Dutch Rooms (Permanent Collection)
— National Gallery, London
The Art of Invention: Leonardo and Renaissance Engineers (until 24 April 2000)
— Science Museum, London

In an exhibition centred around its own almost unrivalled collection of Florentine painting, the National Gallery has brought together an overview of the decorative arts in the Florence of the 1470s, a decade in which the workshops of Verocchio and the Pollaiuolo brothers were breeding such talents as Leonardo da Vinci and Botticelli. Drawings, sculpture, ceramics, and furniture illuminate the taste of the elite under the Medici, whose diplomacy in the cockpit of Italian politics placed great emphasis on compensating for military mediocrity by the glories of a culture which all Italians would wish to make part of their common civilisation.

The exhibits are not numerous this is no blockbuster la Ingres but they offer a cross-section of the highest quality, and in particular show conclusively the greatness of Verocchio. It is notable how many of them are from other collections in London. However, they rarely enjoy this instructive juxtaposition as a result, and the wonderful

Leonardo drawings from the Royal Collection are even more infrequently available for this kind of comparison. The Uffizi s collection of prints and drawings, not by any means on the standard tourist track, has also lent generously. The most astonishing single exhibit is a cameo from the British Museum, believed by Lorenzo de Medici to be antique but actually dating from the 13th century, that depicts Noah, his family, and the Ark in an extraordinary illusion of depth. Lorenzo himself valued this work above any painting in his collection.

Spaciously displayed and well captioned, this is an enjoyable show. It is hampered by its inability to include architecture walls of photographs of the great palazzi of Florence would not be especially effective, but without them any overview is incomplete. For this you need to turn to the catalogue which, in an excellent series of essays, gives this aspect of the city the weight it deserves. Or, alternatively, visit the Science Museum in South Kensington (just around the corner from the College) and revel in the spectacular engineering and architectural glories of Renaissance Italy. Particularly impressive are the models of Brunelleschi s *Duomo* and Leonardo s *Flying Machine*.

Back at the National, the newly refurbished Dutch rooms have been re-opened after over a year. Handsomely decorated in an apricot colour scheme, these smaller, lower-ceilinged spaces offer an excellent setting for the Gallery s large collection of genre paintings and small landscapes in rooms of the scale for which they would have been painted. Well worth a detour if you do come to the Exhibition.

Frank Minns

Rembrandt's Eyes
Simon Shama
Allen Lane/The Penguin Press 1999
HB, 751pp, £30.00 (0 171399384 7)

A reviewer depicted with donkey s ears? The artist squats, bare-assed, in mid evacuation, wiping his rear with the Collected Wisdom of the critics. (page 514). How to comment on such artistic provocation? But I will try, as this is no controversial winner of the Turner prize. This is Rembrandt. Rembrandt as I ve never conceived him. But Simon Schama s masterly history will make the most familiar fan see him anew.

You certainly get a lot of book for your money. Mine weighs in at nearly four pounds. It is superbly illustrated with hundreds of colour prints, in graphic detail to arrest the most casual reader. However keen a Rembrandt scholar you are, many will be unfamiliar. For example, The Sacrifice of Isaac from St Petersburg (page 411) was new to me; a truly shocking depiction of Abraham s murderous intent. Worth buying the book for that one image alone.

Schama is a fluent and dramatic writer, giving a superb account of both the artist and 15th century Holland. The minutest detail of Rembrandt s working practices are relayed along with the sights, sounds, and smells of Dr Tulp s famously preserved dissection. This painting is considered at length and placed within the context of our profession s social status and aspirations. A surgeon achieves immortality through autopsy. The irony is not lost on Schama. His discussion of how the bloody gore of the real event has been converted to a meditation on Christian ideas of mortality is a true contribution to medical humanities.

Rembrandt is far from the only painter you can learn about here. The opening chapters consider Rubens in some detail, showing him to be a major influence on the later artist. At last, a reason to actually look at a Rubens! There is plenty of Caravaggio, and even a mention of Adrian Janszoon van den Burgh no picture, but tantalisingly described as having a double life as both surgeon and painter (handy for battle and martyrdom scenes) (p age 209).

Other cultural life in the Netherlands is no less fascinatingly relayed. I particularly liked the description of Adriaen van de Venne s Tableau of the Ridiculous World , listing forty-two established types of con men and women, including swijgers, who smeared themselves with a mixture of horse shit and water to simulate jaundice. (page 303). Presumably, stress wasn t enough to get a Med 3 in those days.

Rembrandt s self portraits have been the subject of much attention this year, after their exhibition at the National Gallery in London. Most of the major works at that exhibition are shown here, with a convincing commentary from Schama. The late self-portraits are truly remarkable works of art and crystallise Scham 's thesis that we must revisit the much-derided notion of genius when considering this man. Schama s undermining of a strictly reductionist view of art history could provide moral and rhetorical ammunition for anyone who doesn t swallow evidence-based medicine in one Belshazzarian Feast.

The late self-portraits show a man who had been through every imaginable tragedy, with more than enough to make him a burnt-out artist. But Rembrandt at sixty, in the year of his death, could still paint with genius and show his intimate knowledge of what it means to be human. Those GPs who plan to retire at fifty take note; what flowering there can be of one s art with age.

Wayne Lewis

Van Nostrand's
Scientific Encyclopaedia
edited by D M Considine and GD Considine
8th Edition on CD-ROM
John Wiley, 1999
£195

I must admit that I like paper above pixels but life moves on. Van Nostrand s Scientific Encyclopaedia was first published in 1938 and acts as an authoritative resource and exhaustive coverage of virtually every major scientific discipline .

The publishers have clearly made one final attempt to breathe life into their text by converting their volumes to CD-ROM, adding cross-referencing, bookmarks and customised searching software features that no self-respecting database would be without these days. Unfortunately, what they have produced is a worthy but dull new sheep in old sheep s clothing. Like many encyclopaedias it often falls between two stones in many areas not detailed enough for the expert but too advanced for the informed reader. However interesting it is to browse through a catalogue of human scientific endeavour, and apart from a useful homework resource, there is nothing here for the physician or social scientist.

Why not enter the next millennium with an unmatchable one-stop source for an authoritative guide to all areas of science? says the press release. A better question would be Why? Because for three stops you can have all this and much more from the Web for free. *Encyclopaedia Britannica* (www.britannica.com) is being dumped free on the Net and with Sci Central (www.scicentral.com) and PubMed your own reference library will be complete.

Life moves on and the CD ROM book genre may be coming to an end just as it is beginning. If you really want to spend £195 on a piece of history, for the average GP there must be better buys.

David Kernick

Consensus Conference on Biomedical Research Misconduct

"You must always avoid what in New York is called 'The Perp Walk' — the Perpetrator walks, collar turned skywards, into the courtroom, as bulbs flash, muttering 'No Comment'..."

Drummond Rennie
Editor (West), *JAMA*

What is research misconduct? How common is it? What can be done to identify misconduct, and reduce the incidence of misconduct? These issues were debated at a consensus conference in Edinburgh in October, organised by the three UK colleges of physicians and the MRC. The importance of the issue was reflected in a stellar list of participants editors from the *BMJ*, *Lancet*, *JAMA*, *Gut* and other journals; presidents of colleges, the GMC, the MRC; representatives of Cochrane, and delegates from around the globe.

Chicanery in biomedical research has a long and dishonourable history. Pasteur suppressed inconvenient data; Mendel s results were too perfect; Freud and Jung, when the going got tough, got excessively creative. Such is history we can look back smugly on such unenlightened times, confident that now we do things better.

Furthermore, in the UK (and in France, and Germany *les anciennes regimes*) we have, until recently, been especially smug. Misconduct was the province of grubby colonials, or, if it did occur closer to home, a Below Stairs activity, perpetrated by solvency-challenged general practitioners. Not for the UK organisations similar to the US Commission on Research Integrity (1996), or Committees on Scientific Dishonesty in Denmark (1992) or Norway (1994).

But then came high profile cases in Britain. Uzair Siddiqui, a psychiatrist in Durham, fabricated results. Malcolm Pearce, a London obstetrician of international repute, published a paper in the *British Journal of Obstetrics and Gynaecology*, claiming to have transplanted an ectopic pregnancy. Unfortunately he hadn t, and other papers in a glittering CV also transpired to be fraudulent. Occasional GPs have continued to be caught falsifying and fabricating data.

Defining what constitutes misconduct remains problematical, as Richard Smith of the *BMJ* reminded delegates. Misconduct represents a continuum, from glaring wickedness at one end of the scale (Falsification, Fabrication and Plagiarism) universally recognised as Bad but what of lesser offences? Gift authorship , not attempting to publish completed research , undeclared *post hoc* analyses ? Smith suggested that *wilfulness* of misconduct helps to separate the bad from the incompetent or careless, clearly an important difference. He commended the American biostatistician John Bailar s remark that Disclosure is almost a panacea.

How is misconduct unearthed? By accepting that misconduct occurs, and looking for it. Pharmaceutical companies, with their millions, and their credibility, tied up in research projects, now scrutinize research data forensically. Frank Wells, of MedicoLegal Investigations (and, with Stephen Lock, co-author of the standard British text on research misconduct), detailed meticulous safeguards against fraud used by any self-respecting pharmaceutical company Standard Operating Procedures against fraud, well briefed medical advisers and clinical trial monitors, regular reviews of trial sites; Clinical Research Associates look for suspicious uniformity of results, or dates, or signatures, or handwriting, or ECGs, or for research material such as patients diaries that are too pristine. Coffee stains and crumpled paper are reassuring. Statisticians, and ethics committees and journal editors and peer reviewers all have their role to play.

Whistleblowers, of course, are still badly treated. Peter Wilmshurst, a cardiologist formerly at St Thomas s Hospital in London, reported 20 colleagues for questionable research practices to the General Medical Council. The GMC spent eight months investigating accusations of disparagement against Dr Wilmhurst before clearing him and investigating the substance of his complaints. GP whistleblowers, isolated in their practices, risk even more by incurring the wrath of local communities, without peer support. Whether the additional protection of the *Public Interest Disclosure Act 1998*, implemented from 2 July 1999, reduces the trauma of whistleblowing remains to be seen.

The role of journals in the detection of fraud is important, and not a role in which they have so far distinguished themselves. John Grant, the present editor of the *British Journal of Obstetrics and Gynaecology*, revisited the sins of his predecessor, clearly not for the first time. Editors of most medical journals, he reminded the meeting, are gentleman-amateurs small journals do not have the time or the resources to investigate research misconduct properly . He welcomed the foundation in 1997 of the Committee on Publication Ethics (COPE), a resource for editors, and authors, to investigate and advise on research and publication ethics. Michael Farthing of *Gut* suggested that journals should audit the quality of data in submitted papers, and randomly analyze core data, at source, in a small number of papers submitted in any given year. He added that when misconduct is identified editors and journals must not simply reject they are duty bound to pursue and report miscreants to the regulatory authorities

The lively discussion sessions gradually worked towards a **Consensus Statement**. Rather than fruitlessly trying to define the bad, most speakers leaned towards defining

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Edinburgh, October 1999

good practice, in a way piloted by the GMC in definitions of good medical practice. Richard Peto reminded the meeting that excessive concern about misconduct must not obscure the fact that the vast majority of research was ethically sound. The research community must not impose qualifications upon research methodology to the point where research is only affordable by international pharmaceutical combines. Were this to happen then only research that matters to the paymasters will be conducted, and we can forget about big random controlled trials on the subject of cheap generics. The guiding rule, according to Peto, must be the Uncertainty Principle if both doctor and patient are uncertain, both of them, about the efficacy of an intervention, then research that may answer such uncertainty can be ethically justified. Such research must not be stifled by unnecessary bureaucratic intervention.

Where does this leave us as GPs? As researchers we must be trained to follow good practice much better than hitherto. All doctors must be educated in the ethical issues surrounding research from a very early stage in their career. Research establishments, including academic departments of general practice, must train their staff in sound scientific research techniques, and establish systems for sanctifying data.

But most importantly, we must protect our patients, and remember our role as advocates. As we recruit them into distant, impersonal trials, we must ensure that their consent is truly informed. We must explain to them what randomization and the placebo arm of a trial really means. We should inform them of results, and not assume that trial organisers will do so for us. If benefits accrue, then participants deserve to benefit. In the West of Scotland my patch if my patients participate in studies that promote cholesterol reduction then I am honour bound to ensure that such treatments are freely available

Patients, our patients, the subjects of research and the potential beneficiaries of research, must be informed at every stage in the conception and execution of research projects. Otherwise they will no longer submit to experimentation, and the very principles of medical science are devalued.

Patricia Wilkie, in a formidable series of interventions towards the end of the conference, insisted that to have any credibility the Consensus Statement must include frequent reference to Patients. When the Consensus Statement is issued in January we shall see whether her sensible advice has been followed.

Alec Logan

Michael Ebdy

Tangled Webs

I remember Antony well from his interview for the VTS. He was amiable, large, and rather scruffy, but his CV was a mixture of sensible experience, solid achievement and dashing sporting prowess. At the nadir of vocational training there were four applicants for four vacancies, and he was duly appointed.

Two and a half years later he arrived as my registrar for the final six months of his scheme. He began by requesting the first three weeks of his attachment as his honeymoon. I naturally agreed to this and he eventually settled in reasonably well. He was still scruffy, but he was able to acquire a small following among those patients who treasure eccentrics. Not the least of his foibles was his insistence on carrying his equipment in carrier bags rather than a medical case. However, some patients did not appreciate eccentricity and I was soon fielding a complaint about a consultation carried out with his feet on the desk. A word seemed enough, but soon he was attempting to borrow money from the staff. Discussion with his other tutors deepened my concern a little but I believed at this stage that I was dealing with no more than a minor pastoral difficulty in a sound doctor.

Alarm bells rang, however, when I discovered he was sleeping in the surgery, and louder still when I was told that he had owed a sum of money to a hotel for more than a month. His response, that it was only a tenner , did not fill me with pleasure. I was disturbed to learn of two driving bans and incredulous to hear of a visit on which he had used a patient s microwave to re-heat a take-away pizza. In time I became aware that his attendance at day release course was less than 40%. Some of his excuses seemed implausible and I was suddenly reminded of my observation that no wife would allow her husband out looking as scruffy as Antony. I also recalled that the staff had been waiting in vain to see his wedding pictures.

Armed with no more than a horrible suspicion, I rang the personnel department of every hospital within twenty miles, and duly discovered that Antony had spent his honeymoon as a locum SHO in medicine. After mulling this over for a while I set to work on his CV and proved it to consist almost entirely of lies. Each of his window dressing achievements was false. He had claimed academic distinctions he did not achieve and, alarmingly, he had not disclosed in his CV that he had changed medical school midway through his course. It was ironic to think that he would have been appointed to the scheme even without his falsehoods.

I challenged him in due course about his attendance at day release, and he repeated his excuses. I revealed that I knew about the locum, and to this day I remember the look on his face. Even then he stood by his other excuses, though the following day he was forced to admit that all of them were lies. He was not married and had lied about his honeymoon to delay the start of his GP attachment until a driving ban had expired. He begged forgiveness, but my heart was hardened by our itemised phone bill showing calls to his relatives in Australia, and by some letters to Antony from a debt collection agency giving our address.

I suspended him from that day. He protested that his offences were minor, but integrity, like virginity, is not lost by degrees and my mind was made up. I refused him his certificate of satisfactory completion and I saw him only once more, when he returned his books and keys. I was not surprised to find that the books included seventeen volumes that had been removed from local post graduate centres with their library tickets *in situ*.

I heard no more of Antony until I received a letter from the JCPTGP saying he had appealed and asked for his experience to be accredited. I was asked for a report, which I wrote with dark relish, and as a result of my comments Antony was referred to the GMC. I was not initially informed of the outcome, but when I enquired I learned that he had been sent a very strong warning letter about his future conduct.

Here was a doctor who obtained a responsible position by deception; a doctor who lied, whether it was necessary or not, a large part of the time; a doctor who stole, who borrowed from those paid less than he, and who gave my address to his unpaid creditors. I was ashamed to think that the GMC felt a warning letter to be a sufficient response to the episode. I was furthermore troubled to realise that it was only his folly in asking for his experience to be accredited that led to him going before the GMC at all. Had he not done so he could simply have moved to another region to complete his training, or passed unchallenged into many other areas of medicine. Are we really so palsied as a profession that we feel unable to suspend a doctor s registration, even when his behaviour could have attracted a prison sentence? If Antony re-offends in future, as I think he will, how will we cope with the inevitable press scrutiny of our previous responses?

Most doctors would agree that self regulation is an important ideal for the profession. If we are to do it, however, our actions must be both sensible and defensible. I must question whether the handling of Antony s case was either of these. We can surely do a great deal better than this.

Welfare benefits advice in primary care

Next time you are seeing a patient with osteoarthritis or schizophrenia and are altering their medication in the hope of controlling their symptoms a little better, think about what would really improve their quality of life. The answer is often money. General practitioners are aware of the strong links between poverty and health, particularly in people with disabilities, and yet often feel impotent to do much about it. However there are welfare benefits that can make a real difference, in particular Disabiliy Living Allowance (DLA) for those aged under 65, and Attendance Allowance (AA) for older people.

If somebody receives DLA at the higher rate, it will add an extra £88 a week to their weekly income compare this to the standard elderly person s pension of £67 a week. The benefits are not means tested, and once somebody receives the benefits, they are long term, and the person can spend the money however they like. Moreover, receipt of these disability benefits often passports people to other benefits, such as council tax benefit or housing benefit.

However, there are major problems with underclaiming of these benefits, and a recent survey from the Department of Social Security estimates that the uptake of DLA and AA is only 40% 60%.[1] Research in our own and a neighbouring practice of people with arthritis has found that only 58% of severely disabled patients were receiving DLA or AA.[2] Barriers to claiming include people being unaware that they are entitled, thinking of welfare benefits as charity rather than a right, and the difficulty filling in the long claim forms (which can take two hours even for an experienced benefits advice worker) [3]

Fifteen years ago, Professor Brian Jarman developed a computer software package for patients to use in their GP s waiting room to guide them through the welfare benefits system.[4] However, the reality nowadays is that the system is complex and that people need help and support, but that doctors or nurses working in primary care do not have the time or detailed knowledge, and that social workers no longer have welfare benefits advice in their job description.

For the past 18 months, the Air Balloon Surgery in central Bristol has been involved in a pilot outreach project with a local welfare rights advice centre, whereby welfare rights advice is targeted at people when they visit their general practice or have contact with primary health care workers based at the practice. A welfare rights adviser funded by a National Lottery grant, does a half-day surgery in the practice once a week.

A summary of her first year s work is shown in Table 1. Altogether, patients seen during the year have gained an extra £73 872 in welfare benefits. Moreover it is important to note that the funding she helps obtain is cumulative, as most of it is for long term benefits. Her weekly sessions have always been fully booked from the very first week, and most of the people had never consulted an advice worker before. Providing the advice in a health setting, particularly if it had been suggested by a health care worker, seemed to overcome the stigma of being known as a claimant, and gave people the permission to ask about and claim benefits. Easy access, and seeing the advice worker in a familiar setting were also important advantages. Interestingly a proportionally higher number of clients with mental health problems came to sessions at the surgery than at the local advice centre.

The service has been widely welcomed within the practice. She is available for advice to all health workers and attends our primary health care team meetings, and has raised consciousness of welfare benefits issues. It has released some time for nurses, health visitors, and our attached social worker, who previously felt they were giving inadequate and rushed advice. Potentially there is increased work for the GPs, since if more patients claim benefits, GPs are asked for more reports, but many of these attract item-of-service fees, and the GPs have a ready source of help with completing the often complex questions on the forms. Early benefits advice and help with completing the claim forms has also minimised the need for appeal tribunals or reviews for patients, that often need more detailed medical reports.

The welfare rights advice worker has asked people how they have spent the extra money they have received. The money helped in ways connected to health directly and indirectly and intangibly, such as buying aids and adaptations, taking taxis to hospital appointments and when visiting relatives,

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buying food in bulk, keeping heating on, buying matching nighties and dressing gowns for hospital, having windows cleaned and the grass mown. These are the types of things people want to buy which they feel improves the quality of their lives but for which they have previously not had the money. For some people having some savings also helps their peace of mind and they would rather keep lump sum back payments than spend them.

So is there scope for this successful project to be more widely applied? There is the potential for general practices to employ welfare rights advisors in a similar way to the development of counselling services in the last few years. Primary care groups, with their wider perspective of local health needs assessment than a strictly medical model,[5] could choose to develop such services, with a welfare rights advice worker shared between the practices in a PCG, and we are pursuing this locally. As a minimum recommendation , we would encourage GPs and primary care nurses to educate themselves about the various welfare benefits, and establish contact with their local welfare advice centre and Citizens Advice Bureau.

David Memel
Deborah Gubbay

Table 1: Summary of the first years work of the Welfare Rights Advisor

Total number of clients seen	**46**
Gender of clients	
Female	30
Male	16
Age of clients	
16–39	15
40–59	14
60–85	17
Benefits advice	
Disability Living Allowance	27
Attendance Allowance	12
Incapacity Benefit	9
Other benefits	28
Money gained (£)	
Total	**73872**
Mean amount per client	**1606**

Wayne Lewis

Disillusion therapy

A herbal medicine can t do you any harm, can it, doctor?

With a weary crunch I feel the grinding wheels of defensive medicine slip into gear within me.

Of course they can do you harm, I say, Just like any other medicine. Make sure you ask your herbalist what side-effects there might be.

I ve managed to elicit a worried look. A boundless confidence has been shaken. Could alternative medicines really be as toxic as the poisons I keep trying to give her? A blow has been struck for modern medicine! If I ve got to tell every ibuprofen swallower they may collapse in a fountain of vomited blood then why shouldn t the opposition come clean too? Sadly, I don t feel very proud of myself as she leaves the room. She may be a little bit more informed, a touch more aware of the risks. But have I just managed to turn her away from a treatment that might have succeeded where I ve failed?

Now, I m no big fan of alternative medicines, but I do have a residual belief in fair play. It has taken modern medicine at least a hundred years to descend from grace in the popular imagination. We don t administer a city of scientific light offering certain cures anymore, but preside over Side-Effectsville, a sprawling shantytown of broken therapeutic promises. In contrast, alternative cures have been around longer but largely kept off the front page of the *Daily Mail*. This can t last forever, as recent exposØs of some Chinese medicine demonstrates. No doubt evidence-based aromatherapy is just around the corner. Rare reports of hypersensitivity to the water in homeopathic remedies will soon come flooding in. But I wish I didn t feel obliged to warn my patients of all this, just to avoid the headline: GP implicated in St. John s Mort(uary) shock.

Could we all agree just not to comment? Stay out of the impending private grief of our alternative colleagues as far as possible? Meanwhile, our patients might benefit from the last few years of human belief in any sort of cure. Unfortunately, I think not. The alternatively injured won t be taking their claims for damages to alternative solicitors, or accepting a bottle of grass clippings dissolved in olive oil as compensation. We ll just have to go on doling out disillusion therapy whenever we spot cheerful looks on a patient s face. Heretical beliefs in certain cures can have no place in the modern, risk assessed medical world.

A Country Doctor

Franz Kafka

A word on Kafka's *A Country Doctor*

Kafka's volume, *Ein Landarzt* (*A Country Doctor*), appeared 80 years ago from the Leipzig publisher Kurt Wolff. Title story to fourteen very short stories, it is famous for its compact symbolism and helter skelter action. It is, in fact, one long paragraph of gasped phrases. Kafka takes his cue from 19th century German Romantic writers (Heinrich von Kleist), ancient shamanic traditions, and Jewish folk literature, especially the Hasidic wonder tales of eastern Europe collected by Martin Buber. His country doctor is a partial self-portrait, but one that also nods towards his favourite uncle, Siegfried L wy (1867 1942), a country doctor in Moravia.

A Country Doctor explores a wound : it was not long after writing this story not long either after his famously unsatisfactory love affair with Felice Bauer that Kafka discovered he had TB, an event that prompted him to assert that his head and lungs had come to an agreement behind [his] back . His country doctor gets sent on a mission of no return. He seems at the end of his tether, in a psychological space as uncharted as it is claustrophobic. Moments of uplift and resignation follow pell-mell. Two horses are born from a keyhole; a groom assaults his maid; a family distracts him; a young man lies in bed with a self-inflicted wound that initially escapes his attention; he ends up stripped and horror of horrors in bed with his patient. And that festering wound: is it syphilitic chancre, caseating lesion, some kind of self-castration even? How did his maid get to be as pink [Rose] as the wound? And how could a humble servant of the empirical fall victim to a metaphor? Off he wanders off into some cosmic blizzard, unsure of the road, unsure of his calling. One false move, and any poor aspirant to rational practice can end up doomed, his chance of being a world-reformer gone forever.

Now that Kafka is venerated as a prophet, it is perhaps difficult to imagine him as a writer, even less a comic writer. But that is what he is, one whose idiom renders the implausible as matter of fact: a false alarm on a night-bell rings out the Last Judgement as a children s chorus. There is a telling scene in the biography by Max Brod, the man who rescued his manuscripts from oblivion and made that adjective *kafkaesque* instantly recognisable: one evening Franz had to abandon reading a clutch of his stories aloud to his friends they were all doubled-up, laughing their heads off. By all means read *A Country Doctor* with one eye on the Viennese witch-doctor (Nabokov s term for Freud), alert to the dangers of counter-transference, but read it too for its exuberance. Hell for leather, hell for Gladstone bags.

Iain Bamforth

My life with *A country doctor*

I first came across Kafka s story about a country doctor when I was starting out in general practice and hence becoming a sort of urban country doctor myself. All I knew was that story was the source of a famous quotation which goes: To write a prescription is easy, but to come to an understanding with people is hard. To those of us starting our careers in the Brave New General Practice of the 1970s that sentence seemed to encapsulate what it was all about. I imagined that the remark was a wise saying addressed by a kindly old Czech family doctor to his wide-eyed younger colleague. Having read Kafka s *The Trial* as a student, I should have known better.

When I did read the story for myself I was knocked out by its power and its vivid, dream-like presentation. It s a very visual story and would make a wonderful film in the hands of the right director. One has only to think of the whirlwind dash through the snow, the moonlit courtyard, and the two mysterious horses peering inquisitively at the poor doctor through the windows of the patient s house.

For a doctor reader, the story seems to convey exactly what it feels like to be dragged out on a horrible, apparently pointless night call, just when you have pressing problems to deal with at home; and then to discover that the patient s plight is not trivial after all but beyond your power to help..

How did Kafka know so much about doctors, I wondered. I was delighted to discover that he had an uncle Siegfried who was a country doctor and the young Franz spent some relatively angst-free days with him on holiday. Conceivably he may even have accompanied his uncle on a night visit.

But the story is not just about doctors. According to my literary friend, Alistair, it is not really about doctors at all. The more you think about the story and about Kafka s life the more levels of meaning are revealed. The relationship between the old doctor and the young patient suggests Kafka s endless preoccupation with his relationship with his father; the young man s anguish over his terrible wound (A fine wound is all I brought into the world:) reminds us of Franz agonising over his painful literary responsibility. On yet another level the wound in the side evokes the person of Jesus Christ being crucified. And his relationship with His Father.

There is plenty of scope for all sorts of interpretations in this magical little story. It speaks about the human condition and the nature of responsibility. And yet it also seems to say something directly to us doctors. We all hate doing night calls; but when we go we generally learn something new about our patient and sometimes we discover something surprising about ourselves. I feel rather sad that with the coming of the Age of the Co-op, the horrible night call may soon be relegated to the history books.

John Salinsky

A Country Doctor

I was at my wit s end: an urgent journey lay ahead of me; a seriously ill patient was expecting me in a village ten miles off; a dense snowstorm filled the wide space between him and me; I had a trap, a light trap with big wheels, just right for our country roads; muffled in furs, instrument bag in my hand, I stood ready and waiting in the courtyard; but not a horse was to be had, not a horse. My own horse had died in the night, worn out by the grind of this icy winter; my servant girl was now running round the village to get the loan of a horse; but it was hopeless, I knew it, and there I stood aimlessly, more and more snowed under, more and more unable to move. The girl appeared in the gateway, alone, and swung the lantern; but who lends his horse at a time like this for a journey like that? I strode across the courtyard again; I could think of no alternative; upset, I absent-mindedly gave a kick to the ramshackle door of the ancient unused pig-sty. It flew open and flapped to and fro on its hinges. A horselike warmth and stench came out to meet me. A dim stable lantern was swinging inside on a rope. A man, squatting down in that low hovel, showed his face, frank and blue-eyed. Shall I yoke up? he asked, crawling out on all fours. I didn t know what to say and merely bent down to see what else was in the shed. The servant-girl was standing beside me. You just don t know what you re going to stumble across in your own house she said, and we both laughed. Hey Brother, hey Sister! the stable boy called, and two horses, huge beasts with strong flanks, legs flush against the torso, shapely heads bent like camels, only by powerful contortions of their hindquarters squeezed out one behind the other through the keyhole which they filled entirely. At once they stood there, long-legged, their bodies thick clouds of steam. Give him a hand , I said, and the girl promptly hurried over to help the stable boy with the harnessing. Hardly was she beside him when he grabbed hold of her and pressed his face against hers. She screamed and fled back to me; the imprint of two rows of teeth stood out red on her cheek. You beast , I yelled in fury, do you want a whipping? , but at the same time realised he was a stranger; that I didn t know where he d come from, and that he was volunteering to help me out when everyone else had turned a deaf ear. As if he d read my mind, he took no offence at my threat, and instead simply turned towards me once more while he worked with the horses. Get in , he said, and sure enough: everything was ready. I d never ridden, I thought, with such a splendid pair of horses, and I climbed in cheerfully. But I ll take the reins , I said, You don t know the way. Sure , he said, I m not coming

with you anyway, I m staying with Rose. No , shrieked Rose and rushed into the house, knowing in her bones that her fate couldn t be averted; I heard the door-chain clatter as she put it up; I heard the key scrape in the lock; I also saw how she put the lights out, first in the corridor and then from room to room, to prevent herself from being found. You're coming with me , I said to the stable boy, or I m not going at all, urgent though the journey is. I wouldn t even think of paying for it by handing you the girl. Gee up! , he said; clapped his hands; the trap sprang off like a log in a rapid; I could just hear the door of my house split and burst under the stable boy s assault, and then I was blinded and deafened by a roaring noise that buffeted all my senses. But that too for only a moment, since already I was there as if my patient s yard had opened out just in front of my own gate; the horses were standing quietly; it had stopped snowing; moonlight all around; my patient s parents hurrying out of the house; his sister behind them; they almost lifted me out of the carriage; I couldn t catch anything of their confused talking all at once; in the sick-room the air was hardly fit to breath; the stove was unattended and smoking away; I thought to heave open the window; but first I wanted to see my patient. Gaunt, no fever, not cold, not warm, his eyes vacant, the young man hauled himself up shirtless from under his eiderdown, clasped my neck, and whispered in my ear: Doctor, let me die. I glanced around; nobody had heard it; the parents stood stooped and silent, awaiting my verdict; the sister had set a chair for my doctor s bag. I opened the bag and rummaged through my instruments; the young man kept leaning out of bed to grasp me, and remind me of his plea; I picked up a pair of forceps, examined them in the candle light and put them down again. Yes , I thought blasphemously, in cases like this the gods help out, send the missing horse, couple it with another because of the urgency, and then to crown it all donate a stable boy
And only then did I think of Rose again; what was I to do, how could I rescue her, how could I pull her out from under that stable boy, ten miles away from her, my carriage drawn by ungovernable horses? These horses, they d somehow slipped loose of the reins; pushed open the windows, I don t know how, from outside; each stuck a head in through a window and undeterred by the family s commotion, ogled the patient. I ll go back straightaway , I thought, as if the horses were summoning me for the trip, but I allowed the sister, who thought me dazed by the heat, to relieve me of my fur coat. A glass of rum was laid out for me, the old man clapped me on the shoulder, his familiarity justified by the offer of his prized rum. I shook my head; in the immediate confines of the old man s thinking I felt ill; only for that reason did I decline the drink. The mother stood by the bed and enticed me towards it; I yielded and while one of the horses brayed loudly at the ceiling laid my head on the young man s chest which trembled under my wet beard. It confirmed what I already knew: the young man was healthy, a few circulatory problems, saturated with coffee by the solicitous mother, but healthy and best bundled out of bed with a good shove. I m no world reformer, so I let him lie. I m the district doctor and do my duty as far as possible, to the brink of overdoing it. Badly paid, but I give what I have, ready to help the poor. I still have to look after Rose, and then the young man might be right and I too about to die. What was I doing here in this endless winter! My horse was dead, and nobody in the village would lend me another. I d had to get my team out of the pig-sty; if they hadn t happened to be horses, I would have been travelling with pigs. That s how it was. And I nodded to the family. They knew nothing about it, and had they known, wouldn t have believed it. Writing prescriptions is easy, but coming to an understanding with people is hard. So, that should have been that, my visit ended, called out unnecessarily once again: I was used to it, the whole district tortured me with my night-bell; but that I d had to surrender Rose this time too, the lovely girl who d lived in my house for years without my hardly noticing this sacrifice was too much, and I somehow had to make sense of it in my head by splitting hairs, so as not to fly straight for this family which, with the best will in the world, couldn t give Rose back to me. But when I shut my bag and beckoned for my fur coat, the family standing together, the father sniffing at the

glass of rum in his hand, the mother in all likelihood disappointed by me but what do people expect? biting her lips, tears in her eyes, the sister brandishing a blood-drenched handkerchief, I was somehow ready to concede the young man might possibly be ill after all. I approached him, he greeted me with a smile as if I were bringing him the most nutritious broth ah, now both the horses were neighing; the noise must surely have been ordered from above to facilitate my examination and this time I discovered the young man was indeed ill. In his right side, near the hip, a wound had opened, as big as my palm. Rose-red, in variegated hues, dark at its base and lighter at the margins, slightly granulated, with irregular pockets of blood, open like a mine to the day above. So it looked from the distance. On closer inspection, there was an added complication. Who could look at that without whistling under his breath? Worms, as long and broad as my little finger, themselves rose-red and blood-spattered besides, squirmed up from their fastness within the wound towards the light, with small white heads and lots of tiny legs. Poor young man, there s no helping you. I ve discovered your great wound; this blossom in your flank is dragging you down. The family was pleased, watched me

busying myself; sister told mother, mother father, father a few guests who were coming in on tiptoe through the moonlight from the open door, arms outstretched to hold their balance. Will you save me? sobbed the young man in a whisper, quite dazzled by the life in his wound. That s what people are like in this region. Always expecting the impossible from the doctor. They ve lost their old beliefs; the cleric sits at home and unpicks his vestments, one after another; but the doctor is expected to be able to do everything with his gentle surgeon s hand. Well, as they wish it: I didn t thrust my services on them; should they misuse me for sacred purposes, I wouldn t stand in their way with that either; how could I expect anything better, old country doctor that I am, robbed of my servant girl! And so they came, the family and the village elders, and stripped me of my clothes; a school choir with the teacher at its head stood in front of the house and sang these words to an extremely simple tune:

Strip him naked, then he'll heal us
And should he fail to, kill him quick!
Only a mediciner, only a mediciner.

Then my clothes were off and I looked at the people quietly, fingers in my beard and my head to one side. I was calm and collected and a match for the situation, and I stayed like that, although it wouldn t help me, for now they took me by the head and feet and carried me to the bed. They laid me beside the wall, on the side of the wound. Then they all left the room; the door was shut; the singing ceased; clouds covered the moon; the bedding was warm around me; the horses heads flickered like shadows in the window-frames. Do you know , said a voice in my ear, I don t have much confidence in you. After all, you were only blown in here, you didn't come on your own two feet. Instead of helping, you re cramping my death bed. I d like best to scratch your eyes out. You re right , I said, it s a disgrace. But then I m just a doctor. What was I to do? Believe me, it s none too easy for me either. Am I supposed to accept your apology? Oh, I have to: I always have to put up with things. I came into the world with a fine wound; that s all I have to my name. Young friend, I said, your error is this: you lack perspective. I ve been in all the sick-rooms, far and wide, and I tell you: your wound isn t so bad. Done in a tight jam with two blows of the axe. Many a person offers up his side and hardly hears the axe in the forest, much less that it s nearing him. Is that really so, or are you deluding me in my fever? That s the truth, take the word of honour of a medical officer. And he took it and lay quiet. But now it was time for me to think of saving myself. The horses were still standing faithfully in their place. Clothes, fur coat and bag were quickly grabbed; I didn t want to waste time dressing; if the horses raced home the way they d come, I d only be leaping in a manner of speaking from this bed into my own. Obediently a horse backed away from the window; I threw my bundle into the carriage; the fur coat flew too far and snagged on a hook only by the sleeve. Good enough. I swung myself on the horse. The reins loosely dragging, one horse barely coupled to the other, the carriage lurching behind, the fur coat straggling in the snow. Gee up! I said, but it was anything but brisk; like old men we went slowly through the snowy wastes; a long time resounding behind us the children s latest, if mistaken song:

Now be cheerful, all you patients,
Doctor's laid in bed beside you!

At this rate I ll never reach home; my flourishing practice has gone to the wall; my successor is robbing me, but in vain, since he can t replace me; the loathsome stable boy is running riot in my house; Rose is his victim; I can t bear to think about it. Naked, exposed to the frost of this most unfortunate of times, with an earthly carriage, unearthly horses, old vagabond that I am. My fur coat s hanging at the back of the carriage, but I can t reach it, and not one of my agile pack of patients lifts a finger. Betrayed! Betrayed! Respond to a false alarm on the night-bell and it can t be made good, ever again.

Franz Kafka *Ein Landarzt* 1919
Translated by **Iain Bamforth**
Linotypes by **Helen Wilson**

our contributors

Bruce Charlton has a son, Billy, born very recently, who will not be inducted in the pre-eminence of meta-analysis for some time to come ... Welcome, Billy!
Margaret Craig is a GP in the Possilpark/ Springburn area of Glasgow She s not on holiday again, is she?
Michael Ebdy is a GP in Tarleton, Preston, Lancashire
Deborah Gubbay is a Welfare Rights Advice Worker, Barton Hill Advice Centre Outreach Advice Project, Bristol
Andrew Hicks practices in a rural/village practice on the edge of the Trough of Bowland. He belongs to that select group of ex-trainers who resigned at the introduction of summative assessment
Brian Hurwitz is a GP in central London, and the new and dashing Professor of Primary Health Care and General Practice at Imperial College of Science, Technology and Medicine, London.
David Kernick works as a GP in Exeter,
Toby Lipman in Newcastle, and
Wayne Lewis in westermost Wales.
David Memel is a GP in the curiously named Air Balloon Surgery, Bristol, and a Special Lecturer in Primary Health Care at Bristol University. In what way is his post special, we cannot but ask ...
Frank Minns awaits promotion
Patricia Wilkie is a market leader in the chairing of Patients Liaison Groups, for the RCGP, and the Royal College of Radiologists, to name but two
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A Country Doctor...
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Bruce Charlton

A nation of accountants

Napoleon is out of date. The English are no longer a nation of shopkeepers: we are a nation of accountants.

English society is increasingly dominated by the people who run things rather than by the people who do things. By this measure, the Americans are a nation of lawyers and the Germans are a nation of engineers. Since managers are taking over everything, and the typical UK manager is an accountant, accountancy-based thinking is the basis of our world view. All the familiar buzz words of NHS-speak come from accountancy: accountability, transparency, audit, governance, quality assurance, continuous improvement

The major political trend of the 1990s was the burgeoning alliance between the accountant and the spin doctor. We see it everywhere: the Department of Health, Health Authorities, Hospital Trusts. What they do is audit: what they speak is advert.

Scratch New Labour and you will find the same shade of grey associated with John Major s administration; but painted over with a brittle shell of brightly coloured populism. The regiments of drab accountants are still there; but hidden behind ranks of public relations commissars. We have entered the age of bureaucratic populism.

It is the world of dual NHSs. On the one hand, the everyday NHS, characterized by the grinding domination of guidelines, standards, charters, form-filling and the added fear of a new inspectorate. And on the other a triumphal virtual NHS which exists only in the sound-bite culture of bullet points and brochures. The link between everyday and virtual NHS is provided by what Mr Blair calls the forces of conservatism : in other words, the people who actually do the work. Meanwhile the gap between spin-doctoring and real doctoring gets wider by the week.

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English life used to be characterized by a paradoxical combination of deference towards authority with a high level of personal freedom. The English believed that governments were basically well-meaning, gave legislation the benefit of the doubt, and seldom said an outright no , even to damaging laws and regulations.

How then did we stay free? The reason was not that our rulers were especially benevolent, but that people s interests were protected by job-based trades unions or professions. Those who lacked effective job-based organization e.g. actors and journalists among the middle class, and farm workers and retail workers among the working class tended to be weaker, poorer and less secure.

This layer of civil society, interposed between the state and the individual, was the factor that kept government in check, and protected us against its excesses. Not any more. This job-based protective layer is exactly what has been attacked and eroded over the past 20 years. First it was the trade unions under Margaret Thatcher, and now it is the turn of the professions. All are under siege: law, teaching, and of course medicine.

Medicine is currently the main target, doctors are to the late 1990s what coal miners were to the early 1990s: the group that must be broken to enable the government to achieve its goals. In his speech opening the party conference, the Prime Minister singled out the BMA for special criticism: doctors are officially public enemy number one.

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Doctors are Problem Numero Uno: so what is the answer? No surprises there. Being England, the answer, of course, is more accountancy. The clinical practice of doctors is to be subordinated to NHS managers (who are easily manipulated by the government). Reaccreditation, NICE, CHI, compulsory continuing professional development , control of merit awards procedures, standards, paperwork, information collection and collation
Gone are English eccentricity and English independence of spirit. Gone is creativity. Replacing them, a mandarin society of strict protocols and deference to authority.

Come back shopkeepers, all is forgiven.